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RESISTANCE TO CHANGE IN PRIMARY CARE: AN EXPLORATION OF THE ROLE OF PROFESSIONAL IDENTITY

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Abstract

This thesis contributes to the academic knowledge in the field of professional identity and organisational change. This thesis also has a practical implication as the findings helped to shape an organisational change within the co-funders organisation. The research was guided by the wish to explore the extent to which professional identity affects the willingness of those within Primary healthcare Units to accept fundamental changes in their working practices. Specifically, the aim was to establish the relationship of professional identity to processes of change. As the owners of small businesses who contract their services to the Health Board, the opinions of General Practitioners (GPs) were deemed to be of particular interest.

The study was undertaken using a mixed method design, based upon a Constructivist grounded theory methodology. This was chosen as the ideal vehicle to examine the complex nature of identity within healthcare professionals and how they viewed organisational changes. Research started with unstructured interviews (n-14) and the analysis of the data obtained was fed into a questionnaire (n-97). The questionnaire offered validation of the initial findings.

The findings of the research showed that professional identity has a bearing on the willingness of professionals to accept changes to their working environment. The resistance demonstrated by Healthcare staff, and specifically, GPs, to organisational change could be linked to feeling a perceived threat to their professional identity. Therefore, to undertake a successful organisational change, change managers must recognise that identity is vitally important and can affect the success or failure of an organisational change. Consideration of how any change may be perceived by professionals, within an identity context, must be built into the organisational change programme and revisited regularly during the change programme.

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Chapter 1 Introduction

1.1 Chapter overview

This chapter provides an overview of the research presented in this thesis. The aim of this chapter is to discuss the background of the research presented here. It will discuss the rationale for this research, detail how the research was developed and explain the academic and practical contribution it makes. Finally, the chapter presents the layout of the thesis.

1.2 Aims of the research

The aim of this research is to answer a question posed by NHS Fife as to why they were unable to persuade the General Practitioners, within their area, to run a pilot project trialling a new way to structure and organise their practices.

As a result of considering that question and following preliminary discussion with people within Fife NHS, with GPs and other primary healthcare staff, and looking at the available literature, the area of professional identity appeared to be of relevance. Therefore, the aim of the research was narrowed down to that of understanding to what extent professional identity can be seen to be affecting the willingness of those within Primary Healthcare Units, in Fife, to accept fundamental changes to their working practices. Agreement was reached with Fife NHS that completion of that stated aim would meet their requirements.

From an academic viewpoint, the aim here is, as above, to understand the extent to which professional identity affects the willingness of those within primary healthcare units in Fife to accept fundamental changes to their working practice and also to draw more general conclusions from the specific case of Fife. Explicitly, what is the relationship of professional identity to the processes of change? The professional identity considered here is the identity of General Practitioners (e.g. family GPs).

Examining the academic literature has shown that the area of resistance to change generated by organisational changes within General Practices has not been extensively researched. Therefore, this research seeks to extend knowledge in that area. To achieve this, the factors which influence GPs resistance to the implementation of organisational

changes, and the reasons behind this resistance, are examined. Understanding this will allow conclusions to be drawn which will indicate ways to overcome this resistance.

Following a brief exploration of the literature surrounding the area of concern, it was decided to utilise Social Identity Theory - SIT - (Tajfel & Turner 1979) in this research. This theory suggests that when a group's identity is threatened people who identify with that group will be motivated to maintain a positive image for their group in relation to other groups. This theory is pertinent as it is recognised that the medical professionals, in general, tend to have a strong sense of identity-related to their professional role (Monrouxe 2009). In this case of a perceived threat to a professional identity, from an organisational change, it can be argued that using Social Identity Theory demonstrates that the group is dealing with that perceived threat both by resisting the threat (blocking the organisational changes) and by deflecting the risk onto other groups.

1.3 Background to the research

In the 60 years since the National Health Service (NHS) was created the UK has gone through dramatic changes, socially, economically and culturally. However, it remains the linchpin of our current healthcare service, and there are strong organisational, economic and personal benefits associated with maintaining a robust primary health care sector. Organisationally, within the NHS, the primary sector provides effective first point care, thus, reducing the population’s requirements for secondary healthcare and reducing the patient’s requirements for specialist care. Economically the primary sector reduces the costs of the secondary sector via fewer hospital admissions (Fleming et al. 2000) and socially by improving clinical outcomes (Dadich et al. 2015).

However, medical discoveries, new treatments, and new drugs have resulted in people living longer, albeit often with increasingly complex multiple co-morbidities. As result of this changing social background several commentators (Wanless 2002; Hannah 2010; Christie 2011; Roberts et al. 2012) identified and documented that the NHS must change and adapt if it is to survive the demands, and expectations, being placed upon it by a steadily growing population. The current challenging economic climate is also leading commentators to question the long-term validity of the current NHS (Appleby 2013). Without a doubt, the NHS of today would be unrecognisable to its founding fathers but

further pioneering changes are still required if the NHS is to be fit for purpose in the 21st century.

Health expenditure in the UK has grown rapidly since the NHS was created. In 2011 the UK spent 8% of its GDP on health whereas in 1950 NHS spending was 3% (Harker 2012). As a result of the constantly increasing cost of the NHS, it has been forecast that the UK needs to treble its overall GDP just to maintain the current services provided by the NHS (Appleby 2013). Unfortunately, the rising costs of funding the NHS have come to the fore at a time when the government has had to confront its financial limits. This has led to NHS Scotland being required, by the UK Government, to make savings.

In 2012/13 NHS Scotland had to make cost savings of £272 million to just economically break even (Audit Scotland 2012). The pressure to make these savings has been passed onto each separate Health Board within Scotland. Making savings of this magnitude year on year has eventually brought policy makers to the point where they are required to produce innovative organisational changes to further maintain and increase cost savings.

However, organisational changes, or the need to redesign the way we deliver our health service, are not purely financially led. The NHS of the 21st century needs to also be attuned to meet the changing needs of its patients; it needs to able to provide them with care in the right place and at the right time: an understanding of this is receiving growing recognition from patients, managers and clinicians. McKinlay (McKinlay & Marceau 2008) suggested that the face of primary care is set to change; they state that in America, within 10 years, primary care - or family doctors - will be rare, if not non-existent, and will be totally different to today's practitioners. They predict that many everyday illnesses will be managed by non-physician clinicians often based in retail areas or managed over the internet. They further suggest that medical problems that require a doctor will be treated by specialists rather than general family doctors.

The King's Fund and the Nuffield Trust were commissioned by the UK Government to undertake a review of UK and International models of primary care, focusing on those that could increase capacity and help primary care meet the pressures it faces (Smith et al. 2013). This report proposed a set of design principles to be used "when determining primary care provision that can address the pressures facing GPs, and ensure that both the needs and priorities of patients and the public are met and that primary care will be fit for the future." (ibid, p.5). Additionally, the report makes the case that if policy makers want to develop the scope and scale of primary care services they will need to put in place

imaginative measures that make the most of the “strong history of independence and innovation” (Smith et al., p. 55) within general practice. It is against this background that Fife NHS attempted to make innovative structural changes to the way their GP practices were organised.

However, Fife NHS cannot just implement organisational changes to the primary care sector. GPs are not employed by the NHS; rather they are independent contractors who provide contracted services to the NHS. In Scotland, there are currently around 5,000 GPs who are contracted by their local Health Boards. Funding for GP practices is provided by the Scottish Government under the Global/Core Sum, the Quality and Outcomes Framework (QOF) and Enhanced Services. The Global/Core funding covers the essential day to day services the practice must provide per patient (clinics, immunisations, screening, proactive treatment services and so on) and this payment is weighted by the age and sex of patients, deprivation levels, remoteness and rurality of the practice. This accounts for approximately half of the practice income and is expected to reflect practice workload, relative costs of service delivery and the complexity of the patients. The rest of the practice income is earned via points accrual within the QOF contract or by offering enhanced services. The QOF contract initially was negotiated on an annual basis but in 2015 the contract terms were changed and the terms are now negotiated on a rolling two-yearly basis. The introduction of QOF and the introduction of treatment guidelines has tied the GP more to the healthcare state and, as will be discussed in detail later, has reduced their high level of autonomy.

1.3.1 General Practitioners

General Practitioners form a branch of the medical profession; they are independent contractors who act as primary caregivers for the general population and as gate-keepers to the secondary hospital sector. When the NHS was first set up most GPs worked alone, although possibly with minimal administrative support, and often out of their own homes. GPs were seen to have less prestige than hospital doctors. In the 1960s GPs started to group together into practices with practice premises and employ ancillary staff. This was the start of the small business model for general practice which is still dominant today. These organisational changes in parallel with changes to the way GPs were funded (as discussed above) provided a significant turning point for GPs; they were now providing chronic disease management as well as dealing with patients presenting with new issues.

Thus moving from full autonomy to being much more closely linked to the health care state (Charles-Jones et al. 2003).

It would appear to be the case that even if GPs wish to effect changes in response to the changing social and economic reality of the 21st century they are constrained by bureaucratic and accountability requirements, by limited workforce capacity (Blount & Miller 2009) and increased patient demands and expectations (Lord 2003). Unfortunately, these constraints are also the reasons they need to change.

1.3.2 Devolution of healthcare to Scotland

Since 1999 responsibility for the NHS in Scotland has been a politically devolved matter and so responsibility rests with the Scottish Parliament. One result of this has been the divergence of the structures of the National Health Services of the four nations of the United Kingdom. In other words, the four systems function differently and each of the four controlling parliaments makes independent decisions about the structures and governance of their health systems. This has given us differences in 'structure, competition, patient choice and the use of non-NHS providers[1]. In the English NHS, there is an emphasis on pluralism in provision and competition whereas in Scotland and Wales there is no quasi-market in health care. Likewise in Northern Ireland although there is no policy of encouraging provider competition they have retained a purchaser/provider split. There are also differences in benefits and entitlements such as free prescription within the devolved countries while charges remain in England (Lord 2013).

The 2004 GP contract in England further widened the differences in funding and structure between Scottish and English GPs. At the time of writing, the vast majority of the GP contract in Scotland is negotiated on a purely Scottish basis. This has allowed the Scottish Government to tailor key elements of the contract in response to the public health needs of the Scottish population. Furthermore, additional changes to the Scottish GP contract will be introduced in 2017, these changes will redesign the way in which Scottish GPs are funded, dismantling the payment system, known as QoF (this current QoF system is

[1] http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/revised_four_countries_summary.pdf p2

explained in detail above). These measures will further widen the differences between the ways in which GPs are funded in each of the four home nations.

A further example of the differences between the English and Scottish Health Services comes from research conducted by Checkland et al (2007) around the usefulness of using the terms ‘barriers to change’ when discussing the implementation of National Service Frameworks. While the implementation aspect of the research is worth considering here the National Service Framework doesn't apply to Scotland and so direct comparisons can not be made. The research does provide some interesting insights though and these will be discussed in chapter 5, the discussion chapter.

Given the massive diversity between the four Health Services and the devolved management of the Services, it no longer makes sense to talk about a UK National Health Service. Therefore, this thesis is concerned with the Scottish National Health Service only.

1.4 Development of the research project

This research was co-funded by Fife NHS. The researcher was initially tasked with the evaluation of an organisational change within a Fife GP Practice - the so-called Nuka trial. However, this trail failed during the pilot phase and no other Practice would agree to trial the system further. This led people within Fife NHS to question why the pilot had failed and why no other practice would consider it. They expressed a desire to fund research to answer these questions. However, they produced no clear remit for the research, other than a request to help them understand the failure so they could plan better for future potential changes.

This lack of initial clarity and guidance resulted in the in-depth research aims and the structure of the research being open to the interpretation of the researcher. The researcher made the decision to consider whether or not the professional identity of the actors involved, and specifically that of the GPs, played a part in this failure. The co-funders were kept informed of the decisions made in the project at all times, via regular meetings with an NHS Supervisor. As a result of the co-funders being kept in touch with the progress of the project and the tentative findings from the qualitative data collection being reported to them, the co-funders requested a quantitative element be added to the data collection. This request resulted in the methodology of the project moving from a purely quantitative

grounded theory study to a mixed method grounded theory method – this will be discussed further in chapter 3, the methodology chapter.

The difficulties produced by the lack of clear directives from the co-funders and the consequence of the subsequent changes to the methodology they required will be further discussed in chapter 6, the concluding chapter.

1.4.1 The failed pilot study

The pilot study which started this process resulted from the attendance, of a management team from within NHS Fife, at the first South Central Foundation (SFC) International Conference in Alaska. Among the team were a Fife GP and his Practice Manager. They found the system appealing and their practice was given the opportunity to run a trail implementation of this Alaskan approach to primary health care. With funding from the Scottish Government and Fife Health Board, an initial six-month pilot was initiated. It was hoped that after this initial period the length of the pilot would be extended before being rolled out to other Fife practices. Early indicators from an initial evaluation by the practice staff indicated that they might have found a viable way to restructure GP practices using a different skill mix. This would reduce the workloads of GPs and improve overall patient care by introducing a more seamless model of health care. This system is called Nuka by the Alaskans who created it.

Unfortunately, this Fife pilot study of a Nuka style system did not run beyond the initial 6-month trial and, indeed, was halted early. Disagreements arose among the GP partners and despite the best efforts of the Scottish Government and Fife Health Board the practice refused to continue or expand the pilot. No other practice could be found to take on the challenge of another pilot study. Therefore, the idea of making organisational changes along the lines anticipated had to be abandoned in Fife.

1.4.2 The Nuka system

The Nuka health care system was created in rural Alaska, starting in the late 1990s, with the aim to improve the healthcare experience of the Southcentral indigenous people; importantly it was created in conjunction with the people it served. The resultant system

became a ‘one-stop shop’ for the population who are served by an integrated team of doctors, nurses and other health professionals, such as dieticians, pharmacists and behavioural health consultants. The model is a relationship model which aims to de-medicalise health care. Unlike in the UK system, doctors are seen to be equal members of the Healthcare team; they still have ultimate responsiblity for the well-being of the patient but each member of the team is equally responsible for creating and carrying out patient treatment plans. Equal respect and responsibility are given to each member of the team. The doctor usually only sees the patient when there is a new healthcare requirement, rather than every time they visit the medical centre. Since Nuka was implemented in Alaska it has cut hospital A&E visits by 42%, hospital days by 36%, speciality care by 58%, and routine doctor visits by 30%, all of which have reduced costs (Graves 2013). The ultimate outcome is that the Alaskans are making better use of their resources and improving the healthcare experience they are providing for their patients.

Over the course of 30 years, the health care of the Alaskan Native people went from being among the worst in the United States to being hailed as among the best in the world (Collins 2015). In 1987 the US Congress created an award system to recognise and publicise innovative organisations and the Alaskan Nuka health system became the 15th organisation to win that prestigious award (Gottlieb 2013). The system also received recognition from the American National Committee for Quality Assurance in 2009 (ibid). As one of the founders of the Nuka Healthcare system says Nuka ‘has distinguished itself as a role model health care organisation’ (Gottlieb 2013)

Although there are many similarities between the Alaskan system and the NHS there are also substantial differences. In Alaska the Southcentral area controls more than just health, it also works in partnership with social services, housing, education and other services. In Alaska, funding per capita is higher than within NHS Scotland (and indeed NHS England) at more than $4,000 per year which is comparable to Canada and many Western European countries (Collins 2015). It also covers a much larger geographical area, stretching 1,500 miles from the Canadian border and delivers care to 55 remote communities (ibid). These differences must be borne in mind and recognised, as discussed by Jacobs et al. (2013), as there is still a wide-spread practice, within change research, of ignoring the cross-cultural and institutional differences between countries and organisations (ibid).

Despite these differences, the Scottish Government hoped to persuade a Scottish Practice to trial the Nuka system. Representatives from Fife NHS, who attended the presentations given by the Alaskans, were fascinated by the model of healthcare they laid out and identified it as fitting the vision they wanted to grow for the future of their region. They believed they had found a viable way to restructure their organisation, a way which would reduce costs to the health board, reduce GP workloads and provide patients with a more seamless model of health care. It was decided, with agreement from the Scottish Government, to trial this alternative system of healthcare, the Nuka system, across several GP Practices in Fife.

1.5 The theoretical contribution of this research

A review of the relevant academic literature established that very many research projects have been undertaken around the subject of organisational change and resistance within professional groups (Noordegraaf 2015; Noordegraaf 2011; Burnes 2011; Ashforth et al. 2008; Hotho 2008b; van Dick 2001; Iles & Sutherland 2001; Coram & Burnes 2001) and the medical profession in general (Mccafferty 2014; Bååthe & Norbäck 2013; Grant et al. 2014; Kislov et al. 2012; McDermott et al. 2013; Tallis & Professionalism 2006; Cheraghi-Sohi & Calnan 2013; Huby et al. 2008; Scott et al. 2003; Scott et al. 2001) but, as will be shown in the literature review in chapter.2, no analysis can be found pertaining to resistance to change within GP practices when faced with organisational changes to the way they structured their practices. Given the reliance of the NHS in the UK (and of healthcare systems in advanced economies generally) on Primary Care and the critical role it has as the first point of contact for patients seeking medical care, this is a substantial gap. It was also striking, given the volume of change experienced in Primary Care (and the NHS in general) s and which forms the context for this research, that the literature is relatively silent on learning from failures of trials and pilot studies despite failures being reported relatively frequently (e.g.see Morrell et al. 2004; Bamford & Daniel 2005; Hunter et al. 2015). More specifically, the failure to investigate why trials like that of Nuka in NHS Fife encountered such resistance, misses an opportunity for learning of enormous practical value to all NHS organisations and to health services generally facing similar situations.

This thesis, therefore, aims to expand the knowledge around resistance to change within the arena of Primary Healthcare in Scotland. It intends to show that it is vital to successful

change in Primary Healthcare in Scotland that the identity of professionals involved in an organisational change is taken into account both when designing the content of an organisational change and during the planning of the implementation of the change.

There also appears to be a gap in the literature around the reasons for the reluctance to allow structural change within GPs practices. This thesis aims to contribute to the literature around resistance to change within the professional grouping of General Practitioners, specifically in Scotland.

This thesis aims to explicitly build on two papers from the field of social identity in particular. The first is an academic paper by Leverment et al. (1998) called Professionals in the NHS – a case study of business process re-engineering. This paper looks at the 'effects of a re-engineering initiative on Healthcare professional' (ibid, p.129) on commitment, professional identity and roles and concludes that re-engineering may introduce conflict and uncertainty over professional roles and may lead to damage to morale. The paper was quoted in the 2009 Social Dimension of Health Institute review by Powell et al. (2009) but their comment merely noted what Leverment had said without expanding on it further. This thesis aims to build on that comment.

The second paper which this thesis builds on is by Schilling et al (2012) entitled Understanding professional's reactions to strategic change: the role of threatened professional identities. This article is concerned with understanding professional's reaction to strategic changes within professional services firms in general rather than the NHS. However, it does discuss whether or not change, in general, can be resisted as a result of professional identity and concludes that 'initiator of strategic change…needs to be sensitive to the compatibility of proposed changes with prevailing professional identities.' (ibid p.1242). This paper suggests further research is required within other professional settings, which this research aims to do.

The thesis explores the broader implications of this finding for change in healthcare generally in arguing that failing to take professional identity into account will increase the probability of resistance to the change and potentially affect the overall successful implementation of the organisational change. However, the thesis goes further by building on the Community Operational Research perspective of Midgley et al (2007) and explores implications for Community Led healthcare, as published by Walsh, Kittler and Mahal (2018). Finally, in terms of future research, the thesis will also briefly consider implications for leadership and health systems strengthening from a professional identity viewpoint.

1.6 The practical contribution of this research

The implications of resolving the question of why the Nuka trial failed were considered to be appealing by Fife NHS and deemed to have practical implications. They wanted to understand the reasons behind the GPs reluctance so they could better plan any future interventions within this area. The Fife NHS Management team, despite the failure of the Nuka trial, continued to believe a change was both desirable and necessary. Costs still have to be capped and maintained and services have to be adjusted to meet the needs of the current population. For the general public, a more efficient and streamlined primary healthcare sector will have implications on the quality of care they receive. The Management team was also aware that a large organisational change, namely the Integration of Health and Social Care was potentially on the horizon and wished to be better prepared for it.

As discussed above, as a result of differences between the four home nations of the UK this research is, in terms of the specific case of the NUKA trial, applicable primarily to Scotland. However the implications of the findings for explaining key aspects of resistance to organisational change will be relevant to other GPs regardless of which UK authority they are situated in, and to other Primary Care settings around the world. Limitations, such as this one, are discussed in more detail in chapter 6.

1.7 Outline of design

This research employs a Constructivist Grounded Theory (Charmaz 2006; Charmaz 2004; Charmaz 1990; Charmaz 2000) methodology to explore why GPs were resisting organisational changes to their practices. Grounded theory, according to Goulding (1998 p.56) is ‘a methodology (which) was developed for, and is particularly suited to, the study of behaviour.’ The aim of a grounded theory is to develop a theory which is grounded in the empirical data from which it is derived. The grounded theorist seeks to discover participants ‘main concern and explain how participants are engaged in continually resolving this concern’ (Holton 2007, p270). The inductive nature of a grounded theory study, the aim of which is to develop a unique theory rather than fine-tuning an existing theory, is thought to be especially appropriate for a PhD study: a piece of research which by definition requires originality. The research methodology will be discussed fully in chapter 3. Suffice to say here that to investigate the topic of interest 14 unstructured

interviews of GPs, Practice Nurses and Practice Managers were carried out with a follow-up questionnaire, returned fully completed by 97 people. Two unstructured interviews were also conducted with senior health board managers and informal discussions were held with others involved with running the Nuka pilot study. Interviews were also conducted within a GP practice which, starting in 2015, are attempted to put into place a structural change similar to the Nuka project.

1.7.1 The research process in grounded theory

Research undertaken using a Grounded Theory aims to achieve the discovery of theory from data by systematically discovering, developing and provisionally verifying the theory, via the iterative process of data collection and analysis (Strauss & Corbin 1990). This rigorous method of analysis allows the researcher to engage with a topic or occurrence from the perspective of those experiencing it. As part of the methodology, the research is not limited at the outset by a preconceived hypothesis, theory grows from the data collected. This inductive nature was appealing for this project as the aim of the methodology is to explore an ongoing phenomenon, experienced by the research participants within an organisational situation. Several studies (Corley 2015) have successfully used a GT methodology within organisational research; and as a methodology, it is growing in popularity within management and organisational research (ibid). However, using this approach and being true to the key components of the methodology (i.e. studying the topic without in-depth, prior, knowledge which may influence the research, the emergence of the theory, theoretical sampling, constant comparison, coding, and memo-ing) did generate problems during the research and the writing of the thesis. These issues will be discussed in detail in chapter 6, the concluding chapter.

1.8 Thesis Structure

The main body of the thesis is organised into the following chapters:

Chapter 2 examines the literature surrounding the topics of Social Identity Theory, professional identity and organisational change as related to this research field.

Chapter 3 examines the research design and gives an overview of the thesis. The initial methodology used – Grounded Theory – will be examined from its conception to the version used here, one advocated by Charmaz (2014). This chapter includes consideration of the practical challenges of using this methodology and the development of this research project. Part way through the life of this project the co-funders requested a quantitative data collection element be added to the research. This resulted in a mixed method methodology emerging. This will be further disc used in this chapter. The mechanisms by which the data was analysed will also be considered here.

Chapter 4 continues with the results of the analysis and by presenting the emergent conceptual categories. In this chapter, there is also discussion around the failed Nuka trial. An ongoing second attempt at introducing a Nuka style practice will then be discussed, and we will detail the ways in which this trial is different to the original trial, why it appears to be successful and what we can learn from it. Finally, other pockets of innovation within Scotland will be discussed.

Having established the emerging theory in the previous chapter, chapter 5, further examines the synthesis of the literature, existing theories and the emergent grounded theory presented in this thesis. This chapter situates the data within the established academic landscapes of organisational change and professional identity and depicts the emerging theory. This chapter also discusses the research as it pertains to a Community Operational Research perspective. This perspective and its implications have been discussed in depth within published work (Walsh et al. 2018). It concludes by detailing the academic and practical contribution the thesis makes.

Chapter 6 is the concluding chapter; it provides a summary of the significance of the research and indicates the completion of the aims and objectives as set out in the introductory chapter. This final chapter also highlights the key findings of the research, discusses the potential limitations of the research and reflects on its main theoretical and practical implications, both for NHS Fife and the wider community. The thesis concludes by identifying areas for future research.

Chapter 2 Literature review

2.1 Chapter overview

Traditionally within a PhD thesis, there is an early chapter devoted to considering the available academic literature around the topic under research. This is done to establish the background to the topic and situate the research within the thesis into a recognised academic field. However, the methodology used in this research is that of a grounded theory. While the methodology is discussed fully in chapter 3 it is necessary to point out here that a grounded theory methodology raises contentious issues around conducting literature reviews and these will be discussed in section 2.2. This thesis has followed the advice of Strauss and Corbin (1990) and Charmaz (2006) which accepts that due to academic and procedural requirements it may not always be possible to delay consulting the academic literature. However, in line with the methodology used the bulk of the literature was consulted in tandem with the interviews being conducted and directed by the analyses of the data.

Having discussed the contentious issue around the literature review within a grounded theory study the chapter will move onto detailing the structure of the search strategy used to obtain the background literature. Having detailed how the literature was obtained it will then move on to discuss the literature under the themes of identity, social identity and professional identity. Both the fields of sociology and psychology have broadly similar perspectives around the nature of self and society (Woodward 1997) and this thesis will cover both these viewpoints. However, regardless of discipline, studies on the construction of professional identity tended to draw on two main theories: those of Identity Theory (see Giddens, 1991) and Social Identity Theory (SIT) (see Tajfel and Turner, Ashforth and Mael, Hogg, and Haslam as some of the main contributors) and so that will be the starting point here. Having considered the area of identity and how it relates to the topic under research discussion will then move onto the area of professional identity.

The academic field of professional identity has grown rapidly since the seminal work by Ibarra (1999) which considered how professionals adapted their identities to different roles. Ibarra's work extended ideas proposed by Ashforth and Mael (1989). Section 2.8 will consider these and other theories around professional identity before moving on to consider the relevance of professional identity to the area of change. Given that this research is examining the result of an organisational change, this will be the third area under consideration. This is a field which has increased substantially since the definitive

work of Albert and Whetton in 1985. Having established the main contributors within these three substantial bodies of literature (social identity, professional identity and organizational change) we will then consider how these areas are relevant to the research in question, namely that of the potential barrier created by professional identity within the arena of resistance to change within the specific setting of the Scottish Primary Healthcare Service.

This chapter will also discuss the main relevant controversies associated with the fields of identity and organisational change. For instance, issues raised by Macrae et al (1995) who questioned how people could deal with variations in how individuals perceive others or their own multiple identities and Hogg et al (1995) who mooted that studies often played down the importance of context and situation. This suggestion by Hogg et al is particularly important in this study given that the context drives resistance to change.

As mentioned above this chapter will start by considering the place of the literature review in a grounded theory study.

2.2 The literature review within a grounded theory study

As discussed in the introductory chapter, Glaser and Strauss (1967) stated that consulting the literature prior to the analytical stage resulted in the researcher attempting to force the data into pre-existing categories. They suggest that while a researcher should read around the field of interest, they should not read material directly related to the field of study. However, not reading literature within the area of research can be problematic for many researchers, especially for novices. If this stricture was taken to the extreme it would mean that no researcher could conduct research in their area of specialist knowledge as they were inherently biased by their existing knowledge. Bruce (2007) acknowledges the difficulty of this and suggests that it is enough for a researcher to admit to any theoretical understanding at the start of a study.

Strauss and Corbin have a slightly more relaxed approach to the idea of a literature review and recognise that it might not be possible to delay consulting the literature, due to academic and procedural requirements (1990). They also believe that familiarity with the literature can help researchers understand the data that they are collecting, can provide a source of material for concepts and for making comparisons within data and prompt

stimulating questions during the analytical process. Lempert (2004, p. 254) summarises the issue well when she says:

> "A literature review provides me with the current parameters of the conversation I am hoping to enter. Utilizing comparisons from the literature alerts me to gaps in theorizing, as well as the ways that my data tells a different, or more nuanced story. It does not, however, define my research"

It has also been recognized by Thornberg (2011) that a compelling reason to undertake a full literature review is that researchers do not want to 'reinvent the wheel' instead they should be able to take advantage of the existing body of literature, benefiting from others discoveries and mistakes and building on what others have done.

In this research project, the established academic literature was consulted from the beginning of the project. This was to ensure that the key areas and concepts were understood. However, the literature review continued during data collection and analysis to facilitate the understanding of the material being collected and to help direct on-going collection. Given this stance regarding the review of the literature, the version of Grounded Theory used in this project could legitimately be called Informed Grounded Theory. This theory, suggested by Thornberg (2011) refers to a study which has been grounded in data by the grounded theory method while being informed by the existing literature and theories. Informed Grounded Theory sits alongside, and builds upon the other versions of grounded theory, adding the use of literature to the existing group of methodologies. Informed Grounded Theory is a newer theory which builds directly upon Constructivist Grounded Theory, developed by Kathy Charmaz (Charmaz 2014; 2008; 2006; 2004; 1990) and as such there is a much greater volume of material around the constructivist theory. Constructivist Grounded Theory also recognises that not consulting the literature prior to research is not always possible, although it does caution the researcher to remain aware of apriori assumptions (Charmaz 2006).

Early use of literature can also help the inexperienced researcher to build theoretical sensitivity. For Corbin and Strauss (2008) sensitivity means having insight, "being tuned in, being able to pick up on relevant issues, events, and happenings in data" (p.33). In this study, the period of field work was preceded by reading relevant literature, as mentioned above, and this helped develop the knowledge to understand the data. However, further sources of sensitivity came from the researcher's previous experience within the healthcare field.

2.3 Search strategy

The field of identity covers multiple disciplines, for instance, sociology, psychology, anthropology, cultural studies and social psychology, and has generated a massive amount of literature. A simple search on the Web of Science database, using the terms social and identity from the year 2010 to May 2017, generated 46,835 articles, obviously an overwhelming amount of literature. Thus, it became apparent early on in the literature search that a comprehensive and narrow search structure would be required. This structure would have to provide guidance on which articles were to be included in the search and also the grounds on which articles were to be excluded. It is not, however, the aim of this thesis to present a comprehensive review of the self/identity field (or indeed the organisational literature field) and so to this end, the decision was taken to concentrate on sociological and psychological theories drawing on a social constructivist perspective. This decision was underpinned by argument by Leary and Tangany (2012) who state that there is broad agreement within sociology and psychology within this field and that at its core is the consideration that the self is underpinned by our human ability to self-reflect.

After an initial familiarisation with the general material an initial search strategy was designed and undertaken using the following databases: Ovid (Medline), EMBASE, Web of Knowledge, Scopus and Stirgate (the University of Stirling database of journals). Google Scholar was also checked to ensure full coverage of the literature and ongoing Google Scholar alert notifications were set up to ensure any new literature covered by the search terms were set up. Full text, English language articles were sought using the terms; identity, doctor, profession, professional, medical and medicine. Where references were made within articles to earlier publications these references were followed up and, if deemed to be of importance included in the final review. This resulted in a total of 687 articles in the final database. The abstracts and keywords of each article were read and where the article was deemed to be relevant it was stored within the software package Mendeley, and then read in full.

The decision was also taken to exclude some literature around the field of organisational identity, which claims to have grown from Social Identity and Self-categorisation theory (for instance see Alvesson 2012; Lane & Scott 2007) as the topic of interest here is professional identity not the social identification of organisational members.

2.4 Identity Theory

It has been argued that the idea of identity originated in the 18th century with the moral philosophers of the Scottish Enlightenment (Stets & Burke 2000). However, many identity theorists consider Mead discussing symbolic interactionism in 1934 to have laid the foundation of the current thinking around identity (for example see Stryker 2008; Denzin 2008; Holland & Lachicotte 2007; Fields, Copp and Kleinman 2006; Blumer 2005; Hatch & Schultz 2002; Stryker & Burke 2000). Mead introduced the idea of symbolic interactionism which suggests that how individuals relate to a group depends on them developing a sense of how they are viewed by the group. Mead also proposed that identity should be viewed as a social process (Hatch & Schults 2002) and that identity is developed through transactions with the environment and in a social setting where there is social communication (Beijaard et al. 2004). According to Mead, it is by communicating with others that we learn to assume a role and form an identity. Erikson (1968), a psychologist, contributed to the debate by outlining a chronological and changing concept of identity; identity is not static, it changes and develops over the course of a lifetime. However, there have been criticisms of the traditional interactionist perspective. Elliott (2007) stated that Mead didn't recognise the significance of politics or the complexity of cultural processes while Serpe and Stryker (2011, p 231) suggested that Mead saw society as 'relatively undifferentiated' while many would argue the opposite. Serpe and Stryker also commented that Mead saw self as being a singular entity and so making it difficult to reconcile different roles.

Identity Theory demonstrates that the development of an individual's self-identity is multifaceted. An individual's identity is a continuous process of adaption of their sense of who they are in relation to others. In other words, within an individual's sense of self, they incorporate others - parents, friends, family, acquaintances and so on - ideas of who they are. However, it is not only the influence of others that is important, our environment is also significant. Therefore, Identity Theory espouses that it is a combination of the interactions with others, and the subsequent levels of validation those actions receive, and the environment which develops and shapes an individual's self-identity (Jenkins 2008). Gecas and Burke (1995, p 42) define identity as 'the various meanings attached to oneself by self and others'. They also note the importance of identity as a way of fixing an individual's place in society via their relationships to others.

Given that interactions and the environment are fluid and continuously modifying, identity per se can be said to be a process individuals continually experience, an internal process

which is changing and shifting constantly and is essential to how we stereotype our self and make decisions about who we believe ourselves to be (Giddens 1991). Giddens influential 1991 work *Modernity and self-identity: Self and Society in the Late Modern Age* was premised on the understanding that self-identity is both shaped by and shapes the modern environment and by doing so it contributes and changes social influences. Giddens (1984) earlier considered structuration theory, the extent to which an individual can construct an identity as opposed to being influenced by the situation in which they find themselves. Given that situations are fluid this further contributes to the idea of identity being fluid.

When debating the intricacies of identity within many different professions the term self-identity is frequently discussed (Balmer 2008; Beijaard et al. 2004; Hutchison et al. 2010; Adams et al. 2006; Hall 1987; Gendron & Suddaby 2004) and it has been suggested by Beijaard et al (2004) that self-image is something that each individual develops, it is not an inherent characteristic.

One criticism of Identity Theory, identified by Hogg et al (1995), is that studies have downplayed the importance of context and situation. This was later re-considered with the recent work on Professional Identity which we will examine in detail in section 2.8. Having considered these criticisms of Identity Theory, the decision was taken that within this research the context is important and therefore the context of professional identity will be examined to ascertain its importance as a context within organisational changes within Scottish General Practices.

Researching the internal subtleties of the self has led to studies which explore the extent to which the self-view of an individual can allow for prediction of worker behaviour (Burke 1980). Supporters of the idea of Role Identity (McCall & Simmons 1978) suggest that people behave in a way which is predictable based on the roles they carry out and studies have considered role enactment and role performance. Everyday activities involve the acting out of socially defined norms and each social role has a set of rights and responsibilities, of standards and behaviours (Heise 2002). The perspective of Role Theory and role-based identity has implications for this study of the implications of changes in organisations within the Health Service.

More recent work has also been done in the area of Identity Complexity (Roccas & Brewer 2002) which considers the fact that many people are members of more than one social group. Initially, it was thought that most people identify with one dominate categorisation

and ignore the rest (Macrae et al. 1995) but this didn't explain how people dealt with variations in the perceptions of others or their own multiple identities. For instance, how does a person who is both X and Y responds to a person who is X and Z, does that person identify with the other on the basis of X alone or not identify with them at all because they are not Y? Identity Complexity would suggest that the strength of the feeling about X will determine the response, "Identity Complexity considers the nature of the subjective representation of multiple in-group identities." (Roccas & Brewer 2002, p88).

2.5 Similarities in identity and social identity theories

Commentators have noted that the theories of identity and social identity have many similarities. As Hogg et al (1995, p255) state, 'Both address the social nature of self as constituted by society and eschew perspectives that treat self as independent of and prior to society.' Both theories believe that identities are internalised and used to define self, also that the self is socially constructed and encompasses both the relationship between society and the individual. Both theories state that individuals can have multiple identities and they use similar language and terms to describe this although at times with different meaning. For instance, within Social Identity Theory the term self-categorisation is used to describe the process by which an individual classifies themselves with regard to social categories while in Identity Theory this is termed as identification. Clearly, both terms identify the same process – the process by which an identity is formed (Stets & Burke 2000). Likewise, the term salience is used by both – it identifies a social identity which functions to increase influence in the group within Social Identity Theory but means the probability that an identity will be activated in a specific situation within Identity Theory (Stryker 1980). It has been recognised (Alvesson 2010) that although the importance of the complexity and rate of change in modern organisational life and its effect on identity is debatable, it is still very much worthy of consideration. This is an important point for this study into how a change in organisational life affects identity.

2.6 Social Identity Theory

Social Identity Theory (SIT), which developed within the discipline of social psychology, was created to explain and explore inter-group relations and provide a theoretical understanding of that relationship between self and groups (Turner 1982; Tajfel & Turner

1979; Turner 1975). Put simply, an individual's social identity results from the knowledge that they belong to a social group or category (Hogg & Abrams 1988). Social Identity Theory argues that people tend to classify themselves and others into social groupings or categories defined by identifying 'characteristics' such as gender, age and religion (Tajfel & Turner 1985). It can be said that an individual's identity fixes their place in society and provides meaning to that individual (Slay & Smith 2011).

Ashforth and Mael (1989) argue that social identification is 'a perception of oneness with a group of persons' and that this identification 'stems from the categorization of individuals, the distinctiveness and prestige of the group, the salience of outgroups, and the factors that traditionally are associated with group formation' (p 20). Support for institutions which embody that identity along with the traditional outcomes associated with the formation of a group reinforces the identity.

Social psychologists have known for a long time that people's memberships in social groups can become part of their self-concept and consequently influence how they see themselves and the world (Tajfel & Turner 1979). Group membership has been shown to affect behaviour and evidence has shown that people can base everything from friendships (Hogg et al. 1993) to prejudices (Brown 2014) on group membership alone.

The conceptions, dynamics and functions of groups can be diverse (Lickel et al. 2000) and a distinction has been made in the psychological literature between interpersonal network groups (or common bond groups) and social categories (or common identity groups). Various theorists have argued that there are different processes underlying identification and attraction to these different groups (Deaux & Martin 2003).

Haslam (2004) discusses how as this self-identity develops and deepens, the groups we identify with and the value placed upon membership of these groups is important. Further, the degree to which that group contributes to that sense of self is important. Identifying with a group leads to an identity process whereby group membership becomes assimilated into one's own self-concept (Tajfel & Turner 1979) and, therefore, influences behaviour (Postmes et al. 2005). Understanding this supports the view that Social Identity Theory can enable understanding of how individuals respond within groups (Tajfel 1972) and how they respond within organisations. Within psychology, there have been numerous experiments which have shown how readily people can discriminate in the in / out group situation (Tajfel 1978). Discrimination can result from group members identifying as belonging to a specific group and viewing others as inferior. Identity is, therefore,

concerned with not only our self-view but importantly how we relate to others and how we view the world (Haslam, 2004)

Within the medical arena, Burford (2012) shows that SIT has been used in multiple projects to explain individual behaviour and how that behaviour can influence the groups which people choose to belong to. Indeed, within social psychology, Social Identity Theory (SIT) is considered to be one of the formative and most dominant theories relating to group behaviour (Tajfel & Turner 1979).

2.6.1 Social identity and change

Schilling et al. (2012) say that research has shown three different explanations for how people react when faced with change. They can resist change because of their personality, in that they have a low tolerance to change in general – possibly because they fear a loss of control, or are fearful of the unknown. Or a reaction to change can emerge from self-interest - people think the change will have a negative effect on them or the reaction can be from a belief that the change is not good for the organisation. Schilling et al. (2012), talking about Professional Service Firms, also discuss whether or not change can be resisted as a result of professional identity. This argument is taken from Van Dijk and Van Dick (2009) who, looking at organisational mergers, suggests that a change may be resisted if it does not fit in with the member's self-concept. If this is the case, then the experience of change will be met with resistance. Dutton et al (1994) suggested that for a professional to change, the change needs to be perceived as compatible with the existing identity: it needs to fulfil the individuals need for self-continuity, self-distinctiveness and self-enhancement. Existing research (Eilam & Shamir 2005; Elstak & Van Riel 2005) shows that there is a link between identity threat and resistance to change but they do not show if individuals react to different threats in different ways. Schilling et al. (2012) suggest that the differences in reactions from professionals to threats are dependent on the extent to which they are given the power to shape the change and the roles which arise from the change. The research so far carried out around threat and professional identity doesn't, as far as it has been possible to ascertain at the time of writing, include the context of the primary healthcare unit.

Despite this growing interest in organisational identity, there is relatively little literature around how identities are formed among those who carry out some highly critical

organisational functions, especially professionals (Ibarra 1999). Professions are often thought to arise when an organised group possesses knowledge which has an economic value to it (Pratt et al. 2006). This specialist knowledge gives professionals autonomy and power and society acknowledges professionals by according them a higher level of prestige than non-professionals. Professional identity (discussed below in section 2.8) is one of the multiple identities an individual holds and socialisation into a profession can give an individual a sense of stability, belonging and values. The profession as a group can provide the scripts on which individual professional draw on in their everyday practice, forming the practical knowledge that forms their actions (Hotho 2008).

Work has been done around the changing nature of professions and of the relationships between professions and society (Hotho 2008) and the medical profession has attracted interest given its status as a prototypical profession. However, Kreindler et.al. state that there has been very little work done around the healthcare sector as a whole, although the limited work that has been done has shown that social identity is “a powerful reality in the functioning of the healthcare system”. (Krindler et al. 2012, p.366). The healthcare sector is a specific case in kind, given that it comprises lots of professional groups of unequal power - doctors, nurses, physiotherapists, pharmacists and so on – and each of these groups has strong identifications towards their particular profession. For the purpose of this thesis the published literature around those professionals who work within general practice – Doctors and Practice Nurses – is the most relevant and will be considered in most detail. There is detailed work around other professionals – lawyers (Monson & Hamilton 2010), teachers (Beijaard et al. 2004) and accountants (Hamitlon 2013) for instance and other health professionals and allied health professionals – such as those who work in hospitals (Cruess et al. 2014) and others such as social workers (Fook 2016) and physiotherapists (Hammond et al. 2016) – but given the volume of material around this it will not be considered in detail here.

The organisational changes over the last 25 years within the NHS has substantially altered the way in which medical professionals function and seek to maintain their professional identity. This has been highlighted by authors who have commented on the difficulties some appear to have in controlling professional autonomy and jurisdiction (Hotho 2008). Social identity theory can be used to provide insight into how professionals interact and into how they deal with challenges to their professional identities and the potential changes in their professional boundaries. Hotho (2008) showed how a small group of General Practitioners (GPs) who had moved into a management function changed their

'professional scripts' to accommodate their career move. They differentiated themselves from their old peer group and sought out new relevant in-groups, ones which allowed them to be part of yet separate from mainstream GPs. This attempt to differentiate from the existing reference group and seek new in-groups is a typical consequence of change.

Doctors have traditionally been trained to expect clinical autonomy and their training has been along narrow professional lines which do not take into account the wider professional or organisational factors within their employing organisation. This can lead to tension between 'management' and 'workers'. However, General Practitioners are slightly different as most of them are, in reality, self-employed sub-contractors who run their own practices and as such must be more in tune with business requirements.

Clinical autonomy coupled with professional self-regulation is central to the medical culture. The monopoly on knowledge the medical profession has created allows them to control how their work is done and their profession is regulated. Thorne (2002) discusses how the medical profession can traditionally adapt to change by initially being resistant, then over time by negotiating the meaning of the change and incorporating it into existing structures and processes of the profession in order to gain control and jurisdiction over it. These changes then become reinterpreted as the profession use their cultural and social authority to re-define and present the changes.

A profession can segment or stratify so that different levels exist within the profession. In medicine, for instance, hospital specialists are seen as the elite group while GPs are seen to undertake more routine aspects of care. However, professional identity is relational and legitimacy has to be actively constructed and reproduced in relation to others (Currie et al. 2009). In medicine, this legitimacy has traditionally been strengthened by the idea of the 'quack' or amateur, conceived as a dangerous alternative to the professional. The creation of new roles can be seen as a threat to traditional roles, threatening existing professional jurisdictions and identities (Freidson 1988).

2.7 Self-Categorisation Theory

Social Identity approach, which incorporates social identity and self-categorisation theories, suggests that an individual must identify with a group in order to acquire and internalise the norms of that groups. Within this approach, Self-Categorisation Theory suggests that when an individual defines themselves in terms of a group identity they will

internalise the norms and values of the group and come to identify themselves and other group members with these norms (Turner 1982). Turner (1982) built upon the work in social identity and explored the process of Social Categorisation Theory (SCT). This theory aims to differentiate between categories or groups of people (Ashmore et al 2001) and it is a crucial aspect of Social Identity Theory as it furthers understanding of how and why an individual chooses which group they wish to be a member of. It also helps to explain why individuals naturally generate bias, stereotype and discriminatory behaviour when deciding on group membership (Haslam 2004).

This process of categorisation involves understanding our levels of similarity with others – given that our social identity is often generated and supported by those groups we believe we 'fit' best with (Abrams & Hogg 1990). Similarities can be based upon inherent characteristics such as age, race, gender and personality traits recognised as important by the group, such as honesty or emotional responses. Liking shared activities, such as specific sports, or even appearance can also be seen a basis for definition.

2.8 Professional identity

The concept of a professional identity has become widely recognised – this can be seen by the growing levels of literature acknowledging its importance across multiple disciplines and within multiple professional spheres (for example see: Helmich et al. 2017; Morgan 2017; Cruess et al. 2015; Moss et al. 2014; Hotho 2014; Gill 2013; Wackerhausen 2009; Beddoe 2011; Ibarra 1999) In general, Professional identity can be said to be 'an individual's self-definition as a member of a profession and is associated with the enactment of a professional role' (Chreim et al. 2007 p 1515). It has been argued by Costello (2005) that professional identity can be considered to be a core identity, overriding other identities. Clouder et al (2012) have also proposed that when multiple identities are in evidence simultaneously, they are often considered to be hierarchical and the identity which is most in tune with the context will take precedence. This suggests that in a work context the work related, or professional, identity will take precedence.

As often happens when there is a substantial body of literature on a topic, especially a topic which is considered under different disciplines, the term 'professional identity' has been used in different ways in different pieces of literature. It has been used to mean the identity of a member of a profession (doctor, lawyer, teacher and so on) and also the

identity of someone who works within a professional role, as opposed to an unskilled role. These different uses have resulted in different definitions of the term. The first definition is that of 'an individual's self-definition as a member of a profession' and their strong self-identification with that profession (Chreim et al. 2007, p1515) while Cascio and Gasker (2001) state that professional identity is a self-definition within a professional role, the identity being defined by a combination of skill, capabilities and status merged with work and life experiences which together create an image of self or professional identity. More recently Caza and Creary (2016) and Slay and Smith (2011) have continued to debate the definition of the concept of professional identity.

A sizable body of work has been published in which professional identity for doctors (Hotho 2008) nurses (Kirpal 2004) social workers (Cascio & Gasker 2001) and lawyers (Sommerland 2007), among others, have often been considered as being synonymous with having a strong sense of shared purpose or identity, such as via skills or regulatory bodies. There has also been research published which considers professional identity in non-traditional professional roles such a managerial roles and client-facing roles (Singh et al. 2006; Grint 2005; Ibarra 1999) and around workplace identity (Jaros 2012; Rees & Monrouxe 2010). Some more recent literature in the field of professional identity has been around the topic of how professional identity is formed and how it can be taught (Daicoff 2014; Cruess et al. 2015; Cruess et al. 2014).

It has also been shown that not only is the formation of professional identity important but longevity in a role or career stage is also important (Kram et al. 2012) as it instils confident in that identity. This is important when considering how professionals will react to challenges to their identity. Hotho (2008) and Couder et al (2012) both identified that identity conflict has been found when professional identities and organisational requirements clash - such as with the example of the Nuka trial in this thesis – see section 5.7, chapter 5.

Theories of professional identity also encompass the concept of socialisation (Cooper & Robson 2006; Empson 2004; Anderson-Gouson et al. 2002; Anderson-Gough et al. 2001). Socialisation is the process by which an individual comes to understand the expected behaviours, the norms, the values and develop the required social knowledge to assume or perform a role and to participate as a member of an organisation (Chatman 1991). Chatman suggests that as an individual is socialised into a role they are encouraged to align their person beliefs and image to match that of the profession or organisation.

Although Cooper and Robson (2006) use the profession of accounting in their example of how individuals are socialised into a profession, of how standardised rules and practices guide expected behaviours, the same can be said of medicine.

It can be argued that, to a certain extent, an individual does not choose to have a professional identity. For some, it may be a hard earned privilege, a welcome part of their personal identity, but for others, it may be an unwanted consequence of choosing to belong to a specific profession. For instance, within social media some professions are required to uphold their professional status even while 'off-duty', also some health professionals may not want to be identified by their professional identity, they may not want their professional identity to be acknowledged in social or recreational situations – to avoid being forced into work-related conversation, or asked for informal advice or diagnosis. Low et al (2012, p32) sums up a professional identity as a "bundle of desirable attributes that give a professional body its status in society".

As discussed in the introductory chapter, it was decided to use insights from Social Identity Theory and Professional Identity as a framework to understand why primary health care workers, and especially GPs, had responded in the way they did to the organisational change implemented by the Nuka pilot and why they had blocked the change. This resulted from the fact that during the analysis of the data it became increasingly apparent that professional identity, and the main components of professional identity, were emerging as a key theme (see chapter 4, section 4.3.7 for discussion of this theme). However, as other authors (van Os et al. 2015; Scheepers & Ellemers 2005) have indicated it is often difficult to assess the presence of identity threat in higher status groups. These groups have the opportunities to "express their confidence in the ability or worth of the group, even when anticipating a possible status-loss" (Scheepers & Ellemers, 2005, p. 193). Also, as Lupton (1997) discusses, asking whether or not the professionalism of doctors is under threat is pointless, 'as doctors still see themselves, and are perceived by the general public, as "professionals", albeit bearing different meanings and responsibilities from the previous notions of professional practice' (Lupton 1997, p.493).

However, general consensus within the existing academic literature indicates that in the past changes in organised medicine have led to changes in professionalism and professional values (Kalble 2005) and this can, arguably, be said to be happening today. Professional identity and values are associated with technical competencies, self-regulation, setting standards for self and having unique responsibilities. Professionalism

is about competence, integrity, altruism and the promotion of public good. To some extent, these strong professional values and identities are under threat. They are under threat from changes within society, the economy and medicine itself. However, it must be recognised that it is the very strength of these professional values which allow the profession to remain strong and in a position to resist change. Weakened values or a weak professional identity will reduce the scope for resistance to changes. Therefore, it is in the best interests of the profession for members to fight to resist de-professionalisation and to protect their identity. It is the strength of their identity which gives them strength and power as a profession.

This strength is being threatened; the idea that the medical profession can be trusted to self-regulate has been questioned (UK Government 2005; UK Government 2013) and there have been calls for the medical profession to redefine its values and expectations (Hannah 2010). The medical profession, in general, is feeling undervalued and vulnerable, challenged by unprecedented change (Iedema et al. 2004). The 2016 strikes by Junior Doctors over pay and conditions is an example of how extreme the strength of feeling currently is within the medical profession. Even in 2016, strikes within hospitals were rare and were, indeed, unheard of until the 1978 strike of nursing staff at Normans-field Hospital for learning difficulties in Middlesex. (Nursing staff at the hospital went on strike and refused to return to work until a consultant psychiatrist was suspended from duty.) That the 2016 strike action was undertaken is a concrete example of the stress being experienced within the medical profession. The profession is already feeling stressed, under pressure and feel that their worth is being threatened, so not in an ideal place for the acceptance of potentially sweeping organisational changes. In other words, resistance and barriers to organisational change will be more likely to appear given the context of the generalised threat.

Resistance to a specific change can be a result of perceiving that change to be unsympathetic to core professional values, i.e. too bureaucratic thus impinging on the autonomy of the professional (Spyridonidis et al. 2015). Therefore, it follows that changes must be perceived to incorporate professional values, including autonomy and expertise, which allows the professional to create and sustain a role which they feel meets their identity requirements. Doolin (2002) and Ashforth and Johnson (2001) proposed that identity is negotiable, so it can change because of interaction with others or within social contexts suggesting that changes can be accommodated by professional identities if they are negotiated if they continue to propagate professional values and are acceptable to the

individual. Thus, this thesis argues that to implement a successful change, identities must be accommodated and they must co-evolve with that change in such a way that the professional accepts the change and no longer perceives it as threatening.

This reconstruction or not of an identity will be dependent upon the strength of the perceived threat to professional values. Spyridonidis et al. (2015) found that a perceived identity threat could be linked to the amount of experience an individual holds or the length of time they have been in a role. He found (and this was confirmed in the data analysis of the interviews conducted here) that more experienced doctors were less threatened by a role change as their identity was more deeply embedded within themselves. Whereas more junior staff felt '…their status had been devalued, their clinical competence as experts not appreciated, and they were not able to maintain a sense of professional distinctiveness.' (Spyridonidis et al. 2015 p. 408). Another factor at play, as was suggested in one of the interviews conducted here, could be that older professionals are able to 'try on' different identities to see if they fit their sense of self - this confirms research conducted by Ferlie et al. (2012). Certainly, in the Nuka trial in Fife NHS, which is discussed in depth in chapter 5 it was the oldest, and most senior, partner who championed the trial while the younger partners felt uncomfortable with it and it was eventually the combined influence of the GPs not involved in the trial which resulted in the early termination of the trial.

It has also been shown that a common response to identity threat for a member of a higher status group is to accentuate their social dominance (Morrison 2009). Therefore, it is not unreasonable to expect that doctors, when faced with a threat to their identity, will attempt to maintain their professional high-status identity by means of a downward comparison with other professional groups, in General Practice that would be with regard to nurses and other care workers. This downward comparison was evident in the interview data, in the sense that GPs explicitly commented on their years of training, their perceived greater skills and the differences between themselves and nurses (see chapter 4, section 4.3.5 for evidence around this point). In more than one practice the GPs actively blocked the idea of a Nurse Practitioner or a Practice Manager becoming a partner, citing education and training as the reasons. While these assertions may (and do) come across to some observers as appearing irrelevant, they are a factual reflection of the difference in initial training the different groups have so are hard to dispute. However, they don't take into account individual circumstances – a senior practice nurse could arguably have better skills, more knowledge and an equal number of years training as a newly qualified GP. As discussed later (see chapter 4, section 4.4.2), the use of nursing practitioners is growing

in America: they can provide a cost-effective solution to GP shortages albeit while posing a challenge to the dominance of doctors within medicine. Indeed, in February 2016 the Scottish Government announced they intend to fund training for a further 500 advanced nurse practitioners. This perceived challenge to doctors' dominance by nurses is not new. In 1984 Professor J Mitchell (Mitchell 1984) a doctor, started a debate around the professionalisation of Nurses when he felt they were intruding on the role of the doctor. In the paper, Mitchell states that 'I believe some nurses see it [the nursing process] as a bid for independence from what they regard as medical domination.' (ibid, p. 217), and suggests that nurses are attempting to exclude doctors. This suggestion was strongly refuted by others (Tierney 1984; Rowden 1984) and deemed to be inflammatory and evidence of the medical profession attempting to continue to subjugate nurses.

Another, arguably subtler, identity management strategy which some doctors are seen to practice is one of patronisation (van Os et al. 2015). This strategy on the surface appears to be a supportive, teaching stance but it is also associated with 'treating others condescendingly' (Ibid, p1020). The educational element of patronisation is shown by the desire to teach nurses, and indeed have them take over less appealing GP work. However, by doing so nurses, and other groups of healthcare workers, are deemed to be people of lesser knowledge or skill or aptitude who need to be taught. This attitude can be deemed to be degrading and diminishing of others and is intended to maintain the superiority of the GPs. Indeed, this attitude of superiority was seen again and again in the interviews conducted here. The nurses interviewed, on the other hand, believed they place more emphasis on team working and on the worth of the multi-professional team than the doctors do. The professional identity of the nurses seemed to be equally bound up with identifying with the team as well as their profession. As an aside, this might be considered to be important given the current push towards integration within health and social care departments. Indeed, the literature on social identity recommends and gives emphasis to the idea of shared identity as a factor for intergroup cooperation (Kreindler et al. 2012). Integrated education between the professions will be considered further in the discussion chapter (chapter 5, section 5.4.1).

Unfortunately, there has been little academic work done around the re-construction of professional identities within medicine. Fitzgerald and Teal (2003) conducted one of the few pieces of research that have looked at this. Recently Dadich (2015) has explored how GPs deal with changing identities, although that research concentrated on GPs involved in youth work in Australia, and as she indicated that research has limited scalability.

Understanding how professional identity affects GPs specifically is important: as Degeling et al. (2003, p649), pointed out “understanding different professional cultures is crucial for understanding each profession’s response to the reforms”.

Having considered the areas of identity, social identity and professional identity discussion will now move onto the topic of organisational change. This area is considered important given the failed Nuka trail, which prompted this research and which was a failed organisational change within the context of one Scottish General Practice.

2.9 Organisational change

As with the field of identity and professional identity the academic arena of organisational change is enormous. In 1995 Van de Ven (quoted in Fernandez & Rainey 2006) identified over one million academic articles associated with the field of organisational change. Again, this thesis will look at a small subsection of the total field, concentrating on some of the more prominent authors. For a broad survey of the recent change management, over a ten year period, within the public sector literature see Kuipers et al (2013) and see Armenakis and Bedwian (1999) for an earlier review.

Interest in identities at the level of organisations has been increasing since Albert and Whetten’s seminal work in 1985 (Albert & Whetten 1985). They argued that an organisation’s identity was formed by a set of claims which were central, distinctive and enduring. Although they didn’t explain exactly what these terms meant – what constituted distinctiveness for instance - they did explicitly recognise that organisations may be characterised by multiple identities. These multiple identities could be ambiguous, complementary, unrelated and contradictory. Over the years the concept of organisational identity (OI) has been used in inconsistent ways leading Whetten (2006, p220) to complain that “the concept of organisational identity is suffering an identity crisis.” However, the study of organisational identity is now recognised as key in efforts to understand strategic change (Ravasi & Phillips 2011). Jacobs et al (2013) suggest that changes in an organisation’s identity can also be experienced as a threat to an employee’s personal identity, given that employees often identify with their employing organisations. However, as discussed earlier the professional identity of a doctor generally overrides any identity associated with their employing Health Board, in the case of GPs, or hospital.

According to Burke (2014), organisational theory literature is focussed on continuity and stability. Therefore, unsurprisingly, the main focus of the organisational change literature is on managerial-functional aspects and it is dominated by management ideology (Hotho 2008b) and as such, it concentrates on the management of resistance to change. There has been work describing the process by which healthcare professionals experience the role of management and it is argued that there is an inherent tension between the clinical values of health professionals and managerial imperative (Forbes & Hallier 2006). It has also been suggested that change, in itself, is not a problem and that it is important that managers do not perceive change as some 'amorphous mass' but appreciate that change comes in many shapes and sizes (Stace & Dunphy 2001). Further, Knotter (2012) identified that participation in the change process by the organisational members is necessary for a successful change. However, levels of participation can be limited where a change is mandatory, when it is implemented from the top-down.

A review of the change literature highlighted four main perspectives around the classification of change. These are hard or soft; planned or emergent; episodic or continuous, and developmental, transitional or transformational. Although it would appear that the final category is of greatest relevance to this research we will briefly discuss each of the classifications in turn.

Paton and McCalman (2000) refer to two types of change 'hard' and 'soft'; this terminology has more recently been reported as 'difficulties' and 'messes' respectively (Senior & Fleming 2006). Hard change tends to mean mechanistic change, one which is reasonably static and has quantifiable objectives with immediate incremental change and short time frames. Examples of hard changes are often found in manufacturing, such as changing a factory layout or processes to improve efficiency (Paton & McCalman 2000; Senior & Fleming 2006). On the other hand, soft, complex problems tend to reflect non-technical change such as a people focused change. As with anything involving people and change soft problems can have a high level of emotional involvement (Paton & McCalman 2000). Of course, a change may not be simply either a soft or hard change but can be a combination of the two.

Planned change is a term which was first coined by Kurt Lewin to distinguish between change which was consciously embarked upon and planned by an organisation, in contrast to change which may have come about by accident or impulse (Burnes 2004). Kurt Lewin (Lewin 1951) became the pioneer of planned change when he introduced the

three-step change model in 1951. Lewin's model describes a planned change; a planned change can be defined as one which is pre-meditated and is the product of reasoning and action.

The 'planned change' approach largely dominated the theory and practice of change management until the 'emergent change' approach began to gain prominence in the early 1980s (Pettigrew et al. 2001; Burnes 2009). The emergent change approach describes changes which 'emerge' in an unplanned and apparently spontaneous way. This can be in response to another decision which impacts in an unexpected way or as a result of factors out with the scope of management decisions (Iles & Sutherland 2001).

The emergent approach suggests that change is a continuous, accumulative, open-ended process of adaptation in response to changing circumstances and conditions. It views change as a process that develops over time (Burnes 2004). It appears reasonable to suggest that even planned changes will likely display some elements of emergent change

Continuous change describes changes which are evolutionary, uninterrupted and cumulative; often these are related to the continual improvement of organisations (Burnes 2004). The continuous change is said to be local, it requires organisations to make regular modifications, and be self-organising. This type of change is driven by instability and reactions to alterations in context, it is perceived as developmental and on-going with small modifications and daily alterations cumulate over time (Kickert 2010). Episodic changes tend to be intermittent, sporadic changes, they could be the result of a new initiative or a response to market changes (Pettigrew et al. 2001).

Developmental change is linked with organisational development and can be either planned or emergent. It can be described as a change which improves or develops an organisation, '…either through introduction of a new process, or through refining and improving an existing function.' (Mccafferty 2014, p36). Transitional change describes a change which brings about a shift, moving an organisation from the existing state to a new desirable state, this sort of change is usually episodic and planned. Transformational change is similar to transitional change, but with a more radical shift between the new organisational state and the original state. Transformational change requires a change from one state to an essentially different new state (Marshak 1993). Change of this scale requires a shift in organisational norms and assumptions, which indicate 'soft' changes as classified by Paton and McCalman (2000). Transformational change can include

restructuring, significant changes in processes, strategy and culture (Iles & Sutherland 2001).

Having looked at the four main classifications of change it is important to note that there has been disagreement about them. As Dunphy and Stace (1988) acknowledge in practice it is hard to control and plan change, which can give rise to issues between the classifications of planned and emergent change. Furthermore, in practice change managers are often ignorant of the academic literature (Bamford & Forrester 2003) and the academic explanation for what they do instinctively. However, within this research, it is considered to be useful to describe these terms as they are prolific in the change literature and can be used as a foundation for understanding the change processes involved here.

2.10 Organisational change models

As Armenakis and Harris (2009, p135) point out 'Organisational change is very complex and not to be taken lightly.' Over the last 50 years as a result of the extensive changes in business practices, there has developed a large body of literature around organisational change (Drummond-Hay & Bamford 2009) which draws on the fields of psychology, sociology and economics. Unsurprisingly, given its multidisciplinary nature, this body of literature displays a considerable amount of disagreement around the most effective and appropriate change methodologies which change managers should use (Bamford 2006). However, there is general agreement that change is an ongoing feature of modern organisations.

Planned organisational changes are not just fine-tuning to existing systems or structures they are usually large scale and implemented to change the way an organisation functions, and so by definition affect people (Kim 2015). Change can also be explained as an exercise in social influence in which the aim is to change an attitude or behaviour (Brattilana & Casciaro 2012). Within the NHS organisational change can be defined as any change which affects the institutional status quo or challenges the norms (ibid). The institutional status quo in the NHS is based on a model of medical professionalism, one which defines role divisions among the professionals and the organisation (Peckham & Exworthy 2003). Battilana and Casciaro (2012) show that the degree to which an organisational change differs from the institutional norms must be taken into account.

There are multiple change models in current usage, both practical and theoretical, which have been developed to help organisations and organisational change managers to design and implement changes. Change models are important as they help to connect the academic theory with the on-the-ground practice (Burke 2014). Each model embodies different ideologies and explores different aspects of change and they frequently consider different stages of the change journey and organisational skills (Kezar 2001). For instance, models often target specific stages of change and specific skills. For example, The 'Big Three' (Kanter et al. 1992) defines three stages, those of catalyst, articulate and finally the implementation of the change. Fernandez and Rainey (2006) suggests that there are various models and frameworks which are based, to some extent or another, around Lewin's original steps or phases of change as discussed in section.2.9 of this chapter.

Traditional change management models are linear, they are goal centred and they are determined by management (Burke 2014, Armenakis & Harris 2009). They tend to be driven by strategic considerations (Pieterse et al. 2012). There are multiple, well-established change models discussed in the change management and organisational development literature. These include Action Research (AR), often used for its focus on problem-solving and diagnosing interventions for change (French & Bell 1990), Burke's Simple Phase Model (SPM) which built on AR to provide 4 distinct phases of change (Burke 2011). Rothwell and Sullivan's (2010) Change Process Model which built further on these models, synthesising them and '…presenting the research-based competencies required of change leaders.'(Kim 2015, p.140). Despite these changes and the updates made to the traditional Action Research model, newer organisational change models remain consultant driven, linear and phase focused.

2.11 Organisational change in the NHS

Much of the literature on organisational change has focussed on the private sector, on for-profit firms (Burke 2014; McNulty & Ferlie 2004; Fitzgerald & McDemott 2017) but there are aspects of it which can be translated to the NHS, in this area, whereas Burke (2014 .p.137) suggests "organizational change theory barely exists". This was confirmed by a large-scale review by Coram and Burnes (2001) and Golembiewski et al (1982) who considered if the models and knowledge from private businesses could be successfully applied to the public sector and concluded that they could be. The nature of the NHS is a top-down model of organisation which is not dissimilar to many private businesses and

when looking at the research into organisational change management it is important to focus on the similarities between public and private rather than the limiting factors of the differences (Cunningham & Kempling 2009; Fernandez & Rainey 2006). However, it is thought that there is currently a limited usage of the organisational change literature by public sector organisations (Fermandez and Rainey 2006). More recently Kuipers et al. (2014) again noted that there is still a gap in the literature around organisational changes within the public sector.

2.12 Resistance to change

The concept of resistance to change is well accepted within the management literature (McNulty & Ferlie 2004; Scott et al. 2003; Kim 2015; Burnes 2011a). It is widely agreed that two-thirds of organisational change projects fail (Coram & Burnes 2001) and that they fail for a variety of reasons. It is also agreed that employees resist changes if they perceive the outcome to be unfavourable, and risk and uncertainty are often the main triggers of resistance (Kim 2015). Burnes and Jackson (2011) consider one of the significant reasons for the failure of change interventions to be '…a lack of alignment between the value system of the change intervention and those members of an organisation undergoing the change.' (ibid, p.133). This is interesting in the case of the NHS given that there is generally considered to be a mismatch between the values of the clinicians and the management team. One author explains this mismatch as '…the clinicians wanting perfect healthcare, whereas the chief executives are striving for efficiency and cost effectiveness' (Drummond-Hay & Bamford 2009, p330). This was evidenced in the interviews conducted here – the Practice Managers expressed disbelief at the way GPs thought they could overrule laws regarding working practices if they didn't consider them to be in the best interests of the practice (see chapter 4, section 4.3.5).

Oreg (2003) found that personality and context also have a bearing on the acceptance of change. However, there does not appear to be consensus on what causes resistance and how to overcome it (Van der Voet 2014). Schilling et al (2012) suggest that research has shown three different explanations for how people react when faced with change. They can resist change because of their personality, in that they have a low tolerance to change in general – this could possibly be because they fear a loss of control or are fearful of the unknown. Or a reaction to change can emerge from self-interest - people think the change will have a negative effect on them personally or the reaction can be from a belief that the

change is not good for the organisation. Professional identity is not considered. Meanwhile, Scott et al. (2003) suggest resistance stems from one or more of the following key areas:

- Lack of ownership
- Complexity of the change
- External influences
- Lack of appropriate leadership
- Cultural diversity resulting from professional subgroups
- Dysfunctional consequences giving rise to adverse behaviours

2.13 Professional identity and organisational change

Identity and professional identity is briefly considered in 'traditional' organisational change models, for instance, Beaulieu et al (2008) consider professional identity to be an important consideration if an organisation is to be restructured. While considering an organisational change in Canada they argue that how family doctors define their role will have consequences for other professionals within the system; their roles and how they function. However, Beaulieu et al do state that the topic has not been given adequate attention. Indeed, in general, the topic has not really been considered in any depth, theorists have tended to concentrate more on change at an organisational or at an intra-organisational level (Coram & Burnes 2001). Schilling et al (2012), talking about Professional Service Firms, also discuss whether or not change can be resisted as a result of professional identity. This argument is taken from Van Dijk and Van Dick (2009) who suggests that a change may be resisted if it is not "in concordance with the organisational members' self-concept". If this is the case then the experience of change will be met with resistance. Dutton et al (1994) suggest that for a professional to change, the change needs to be perceived as compatible with the existing identity: it needs to fulfil the individuals need for self-continuity, self-distinctiveness and self-enhancement.

The established change management practices do not consider how to manage people such as independent contractors (like GPs) rather than direct employees. The relationship between GPs and the Health Board is one of co-dependency; the Health Board needs GPs to provide a service and the GPs need the Health Board to remunerate them for

providing that service. However, GPs have a strong professional body (the Royal College of General Practitioners), they are used to a considerable degree of autonomy and they cannot be forced to accept changes in the same way as a salaried employee. To manage a successful organisational change involving substantial changes to the working practices of GPs all these points must be fully addressed within the change process.

2.14 Professional identity and resistance to change

One of the main theoretical contributions made by this thesis is that before any organisational changes are implemented the effect the change may have on the professional group affected by the change must be considered. One way to improve the success rate of the change process would be to build in safeguards to ensure that professionals don't perceive the change to be a risk to their professional identity as this will potentially result in the change being resisted and blocked. Arguably, this solution is assuming that the professional identity of the professionals in question is fixed, or those holding the identities are fixed in place. Indeed, part of the process of developing Nuka in Alaska was to re-staff the service, with a large percentage of doctors leaving as they didn't agree with the new system, with doctors happy to assume the identity the system required.

To consider if a professional identity is fixed the literature gives us the example of clinical managers as being one group who may change, or adjust, their professional identity within the medical profession. Kippist and Fitzgerald (2009) discussing the case of hybrid doctor managers consider the term 'organisational professional conflict' (ibid, p. 642) which they define as professionals experiencing an inconsistency between the professional's vocation and the requirements of their employer. They believe the case of doctor managers demonstrates this phenomenon where the needs of the patients and requirements for professional autonomy clash with the organisational needs of budgetary restrictions. Research has shown that attempting to combine two different roles (in this case doctor and manager) can result in lower job satisfaction and lower organisational commitment. Research has shown that hybrid doctor managers find they must negotiate between two distinct roles, which is in the long term not thought to be beneficial for the healthcare organisation (Kippist & Fitzgerald 2009). Role duality, in this case, seems to result in professional conflict and so does diminishing the belief that professional identities can be changed at will, implying that they are indeed fixed. Interestingly, an example of this fixed identity was seen in one of the interviews conducted for this research, in which

a senior manager in the NHS had previously practised as a GP. The manager in this case staunchly defended the rights of the GPs to their autonomy and categorically refuted the idea that a GP might possibly be interested in the financial side of their business at the expense of benefits to the patients.

The other question raised above was whether or not those holding an inflexible identity are fixed in place, i.e. in a specific role or organisation. As discussed earlier, in Alaska those who weren't willing to change the way they worked left the organisation. While the wholesale removal of those who resist a change may be appealing, it is not really a possible solution for those who resist organisational change within the National Health Service. Although having said that, it is possible for GP Practices to only hire people who they feel will fit in with the ethos of their practice, and that ethos maybe one in which change results in an adjustment to the traditional professional identity. As will be demonstrated in chapter 5, there is a GP Practice in Scotland who are currently progressing radical organisational changes and have made the decision to only hire the people - GPs and other staff - they feel will help them do that.

To return briefly to the example which initiated this research – the NHS Fife Nuka pilot scheme – this organisational change was attempted within a practice of autonomous medical professionals – General Practitioners - and their medical practice. No consideration was given as to the ways in which the pilot would affect people on an identity level. The GPs who halted the trial did so despite empirical and anecdotal evidence that the pilot was working. This indicates that something more was at stake than the day to day running of the pilot scheme. There appears to have been a sense of threat felt among the non-participatory GPs, a threat possibly to their professionalism, and this was not taken into account. It follows that when working with professionals, who appear to have a strong sense of professional identity the consideration of professional identity would appear to be vital.

2.15 Review of changes in the NHS

In 2009 the Social Dimension of Health Institute published a review of improvement models used in health care entitled 'A systematic narrative review of quality improvement models of healthcare' (Powell et al. 2009). This is a report which was welcomed by NHS Quality Improvement Scotland as a learning tool for change within Scotland. The report

considered how various models and tools, which first originated in industry, were being used in healthcare settings and how effective these tools were in that unique environment. The tools they considered were: Total Quality Management (TQM); Continuous Quality Improvement (CQI); Business Process Reengineering (BPR); Rapid Cycle Change; Lean Thinking and Six Sigma. They concluded that regardless of the method or approach used there was sufficient evidence from the academic literature, considering organisation change in healthcare, and from their review to suggest that there were '…a broad set of conditions which needed to be in place for successful implementation' (Powell et al. 2009, p.7). They suggested that the conditions included the '…active engagement of health professionals, especially doctors…' (ibid, p.7), and that any successful implementation must be shaped by local context. The report noted that there were '…long-standing inter- and intra- professional 'turf wars'; an emphasis on individual proficiency rather than team-working; a history of challenging relationships between managers and health professionals…' (ibid, p.12) which needed to be taken into account in the planning of any change or improvement programme. It also noted that doctors and other professional groups have the ability to resist and undermine change efforts. However, nowhere did it consider the underlying causes of these so-called turf wars nor suggest professional identity should be taken into consideration. Yet unless this source of resistance and barrier to change is accommodated, changes will continue to be blocked and, ultimately, fail. The report did note that Leverment et al.(1998) had commentated on professional identity but this topic was not explored further in the report, or in Leverment's original paper. Intriguingly It was also noted that a change based round a Business Process Reengineering (BPR) had resulted in '…more junior nurses felt that they risked losing their professional identity.' (Powell et al. 2009, p. 96).

The Powell Report (2009) shows that the organisational change methods currently being used within the NHS are the traditional, linear, models. These methods do not consider professional identity per say, although the report does make a passing comment on the topic. This research would suggest that the reason most of the attempted changes considered in the report were not successful was a result of not taking professional identity and the resistance that generates towards organisational changes into account.

2.16 Chapter Conclusion

This review of the literature relevant to this topic has identified the substantial amounts of academic material relating to the fields of identity, professional identity and organisational change. Despite the large volume of literature, this analysis has shown that there is a limited amount of research, therefore highlighting a gap, around the topic of whether or not professional identity has a bearing on the substantial numbers of failed examples of organisational changes (see chapter 5 section 5.4 for discussion around this). This gap has led to the question of whether or not professional identity can be considered to be a barrier to organisational change within General Practices in Scotland. As discussed by Hogg et al (1995) context is important and professional identity has not been discussed within this context. This emerging gap in the literature has allowed this research to focus on how the fields of professional identity and organisational changes intersect and the effect they can potentially have on each other. These ideas will be pursued further in chapter 4, Data Collection, and chapter 5, the Discussion chapter.

The chapter started by considering the place of the standard academic literature review within a grounded theory study before moving onto the search strategy used. Given the considerable body of literature involved it was necessary to follow a defined strategy. The Theories of Identity and Social Identity Theory were discussed along with Self-categorisation Theory. The related field of Professional Identity was then debated. This was then related to the Organisational Change literature and resistance to organisational change was considered. The chapter finished with a discussion around how the field of Professional Identity was tied to that of resistance to change. Understanding how these fields intersect informs the research and helps to direct the data collection. As discussed in section 2.2 this literature was gathered and considered in conjunction with the data collection and the accumulated knowledge shaped the data collection.

The following chapter further considers the details of the methodology and methods used in this research and details why they were considered to be the most appropriate methodology to be used when researching the effect professional identity may have on the acceptance of organisational change within GP practices in Scotland.

Chapter 3 Design, data collection and coding

3.1 Chapter overview

This chapter provides a description of the design of this study and details the data collection methods. This research design was initially a purely qualitative Constructivist Grounded Theory study using semi-structured interviews to gather data. However, as the research progressed, and in response to the analysis of the interview data, the co-funder of the project requested that a quantitative element be included, they asked for 'numbers'. In response to this request, the decision was made to gather additional data using a mixture of online and paper questionnaires. While initially, the issue of including a quantitative data collection stream raised issues surrounding research paradigms, ultimately, making this change had the benefit of strengthening and confirming the data already collected. This new data also confirmed that the full saturation point of the categories had been reached (see this chapter, section 3.5) and provided clarification of the theory which had emerged from the initial qualitative data. However, adjusting from a purely qualitative methodology did present difficulties and these will be discussed further in section 4.4.1. Despite the initial epistemological and paradigm issues created by changing research design mid-project, in the end, it was felt that the strengthening of the final results justified the change. Furthermore, having to take the funder's requirements into account and work with a degree of flexibility also provided a good learning experience of working within a demanding and non-academic environment.

Therefore, the methodology used, in this thesis, can be categorised as a grounded theory methodology using a multiple method design utilising a sequential explanatory design (Creswell 2011). The idea of using a mixed methodology within a grounded theory study is a fairly new idea and has resulted in a recent symposium (Walsh 2015) in which the idea was vigorously debated. This will be discussed further in section 3.2 and section 3.4.

This chapter starts with a discussion about Grounded Theory and why it was felt to be the most suitable method for this research. The philosophy of the foundations of this method is considered as well as the steps which were undertaken to conduct the research. This is followed by a discussion around the theoretical questions raised by the inclusion of adding the quantitative strand to the research. Finally, the research setting and population will be detailed along with the relevant ethical and consent aspects of the data collection phase.

3.2 Methodology

From the focused viewpoint of the co-funder of the project, this research aims to discover to what affects the willingness of those within Primary Healthcare Units, in Fife, to accept fundamental changes in their working practices. From an academic viewpoint, the aim here is to draw more general conclusions from the specific case of Fife. Specifically, what is the relationship of professional identity to processes of change? Given these aims, a primarily qualitative approach was initially determined to be the most appropriate.

Having reached that decision, the next consideration was paradigms. The positivist and other naturalistic paradigms were rejected as not fitting with the aim of understanding the lived experiences of people within general practices. Therefore, the framework which appeared to be the most appropriate was one based on a constructivist approach (Charmaz 2000).

Constructivism is a philosophical approach based on the belief that individuals construct their own understanding of the world they live in (Bryant & Charmaz 2007). Constructivists study both the how and, sometimes, the why of a situation (Charmaz 2014). A constructivist approach also recognises that the researcher plays an active role in the construction of the meaning of the data they are viewing, both through their interaction with the participants and with their perspectives. Social Constructivism proposes that knowledge and understanding are constructed through the experiences of individuals and so, consequently, there is no one single description of a phenomenon. Therefore, the epistemology adopted for this research was one of social constructivist. Consistent with a social constructionist epistemology, a qualitative research design was felt to be most appropriate in this research as it offers the opportunity to discuss the experiences of individuals, exploring ‘how’ and ‘why’ questions, in this instance, about why there was resistance to changes in general practices. However, social constructionism lends itself to a range of different qualitative methodologies including thematic (Braun & Clarke 2006) and narrative (Riessman 2008) analyses.

Examination of the qualitative methodologies available indicated that the three methodologies best suited to this research were Phenomenology, Discourse Analysis and Grounded Theory (Starks & Trinidad 2007). Phenomenologists enquire about lived experiences and how individuals make sense of the world around them while Discourse Analysts ask about knowledge, meaning and identities. Grounded Theorists consider how social structures and processes influence the way things are accomplished through a

given set of social interactions. Each of these methods addresses questions of meanings and understanding; differences emerge as a result of the way in which researcher's frame research questions, sample participants and collect data. These approaches were not considered appropriate for the current research study due to the more descriptive level of analysis they offer with no specific emphasis on processes or theory development.

Having examined each of the potential methodologies grounded theory appeared to offer the most appropriate methodology for this research. It provides a thorough, rigorous and logical method of analysis, and it allows the researcher to initiate the research without a hypothesis. Not being tied to a hypothesis provides the researcher with the freedom to explore a research area and allows issues to emerge from the data collected (Bryant 2002). Not being tied to a hypothesis was appealing here as this is an exploratory piece of work. Furthermore, grounded theory appeared to place most emphasis on explaining complex social processes or actions relating to a study area. Grounded theory, according to Goulding (Goulding 1998 p. 56) is 'a methodology (which) was developed for, and is particularly suited to, the study of behaviour.'

As the current research aim is to develop an exploration of why there was resistance to changes to working practices in general practice, using the experiences and understanding of the people working within general practices, a grounded theory approach was deemed the most appropriate methodology. Studies undertaken using Grounded Theory tend to involve the discovery of theory from data by systematically discovering, developing and provisionally verifying theory via the iterative process of data collection and analysis (Strauss & Corbin 1990). It has also been suggested that grounded theory makes its greatest contribution in areas in which little research has been done (Jones & Alony 2011). The grounded theory methodology has also been extensively used in healthcare settings and, particularly, within the nursing profession (McCallin 2003; Thomson et al. 2013; McGee et al. 2007). The principles of grounded theory will be discussed fully in section 3.3 of this chapter.

After collection of the interview data, along with its concurrent analysis, the co-funder requested that a quantitative strand be included in the research. This raised questions around the paradigm being used and around epistemological considerations, see section 3.13 for further discussion around these points. It also brought to the fore ethical issues around the fact that the co-funders were able to request this change and this is discussed in the Concluding chapter (chapter 6, section 6.8). However, ultimately it was decided that

ultimately quantitative questionnaires, used in conjunction with the qualitative data, would provide a greater understanding of the data gathered qualitatively and provide confirmation of the emerging theory. This data triangulation has been noted by Bryman (2012) to enhance the quality of information and provide mutual confirmation. While the use of qualitative and quantitative methods, in general, has been receiving academic attention for the last 20 years of so (Bryman 2012; Walsh et al. 2015b) within grounded theory studies it has remained fairly uncommon although not unknown (Walsh 2014; Knigge & Cope 2006; Kan & Parry 2004). It is certainly true that grounded theory is taught as a primarily qualitative methodology and most if not all the books and academic articles discussing it concentrate on qualitative data collection methods (Walsh 2015). The growing interest in using mixed methods within a grounded theory methodology was demonstrated by a Symposium held as part of an Academy of Management Conference in Florida in 2013 (Walsh et al. 2015b; Walsh et al. 2015a). The symposium showed that grounded theory as a methodology can be used much more broadly than it has traditionally been, indeed Glaser and Strauss depicted Grounded Theory as a 'research paradigm for discovery' and extorted it be viewed more broadly (Walsh 2015 p582). The transcript of the symposium was later published in Organizational Research Methods Journal in 2015 (vol. 18 (4) pages 581 – 628).

Despite the fact that the grounded theory is primarily seen as a quantitative approach it is by its very ethos an approach to data gathering and analysis which encourages researchers to be open to the idea of multiple methods. Researchers are advised that all is data by Barney Glaser, whether the source of the data is an image, in the form of text or numbers, is unimportant what is considered to be important is the appropriateness of the data. Indeed Strauss and Corbin state that '…[qualitative] researchers must think of quantitative procedures as representing not the enemy but rather a potential ally to theory building when its use seems appropriate' (Corbin & Strauss 2008, p32). When the grounded theory approach is followed – data is collected, analysed and followed by purposeful collection of the next wave of data (known as theoretical sampling) - then the nature of the data (qualitative or quantitative) should be irrelevant (Bailyn 2015). As Richards (2015) discusses, qualitative and qualitative data are not produced by different worlds, they are merely a different way of observing the same phenomenon.

3.3 The Grounded Theory method

Sociologists Barney Glaser and Anselm Strauss developed Grounded Theory as an approach to inductively generate theories grounded in empirical data (Glaser & Strauss 1967). Their method was developed in opposition to the then prevalent deductive fundamentalist and structuralist approaches within qualitative research. The essence of their theory was that research does not start with a hypothesis but seeks to generate theory from the research setting or situation. Essentially, the researcher starts from a position of interest, collects data and allows the theory to develop from their analysis. This allows the hypothesis and the theory to emerge from the data (McGee et al. 2007), in other words, it is grounded in the data hence the name of the methodology.

In the 1990s it became apparent that Glaser and Strauss had moved apart on fundamental aspects of the methodology, primarily how its 'principals and methods should be interpreted and employed' (Idress et al. 2011 p. 190). Glaser stressed the emergence of theory by data conceptualisation while Strauss concentrated more on procedure and formalising a set of analytical techniques (Strauss & Corbin 1990; Glaser 1992). This was particularly evidenced by the introduction of a coding framework by Strauss and Corbin. Glaser argued that Strauss's approach was no longer grounded theory but 'full conceptual description' and resulted in 'forcing data' (Glaser 1992, p122).

As a strategy for theory development, grounded theory is potentially powerful in that it reaches beyond inference and potential preconceptions to the underlying processes of what is actually going on. It generates theory which is firmly rooted in the empirical data. Glaser asserted that grounded theory, as first developed by Strauss and Glaser in 1967 offered a 'rigorous, orderly guide to the development of theory that respects and reveals the perspectives of the subjects in the substantive area under study' (Glaser 1992, p. 17)

Over the decades there has been much discussion around the epistemological stance of grounded theory. However, Glaser (2005) states that 'The quest for an ontology and epistemology for justifying GT is not necessary.'[2], likewise, Holton (2007) has argued that classic grounded theory is epistemologically and ontologically neutral. Despite this others have sought to position it. It has been situated as, amongst others, positivist (Charmaz 2000), realist (Lomborg & Kirkevold 2003) and neo-empiricist (Johnson et al. 2006). Charmaz (2000) considers this confusion to be a result of the lack of explicitness in the

[2] Online journal so no page numbers available

original 1967 work of Glaser and Strauss. Although Charmaz (2000) and Bryant (2002) viewed the original grounded theory as being positivist they have argued that researchers can use the principles and guidelines of a methodology without subscribing to the original epistemology. Constructivist grounded theory, as advocated by Charmaz (2006; 2004; 2000; 1990) is now seen as a legitimate alternative to classic (Glaser 1992) and Straussian grounded theory (Strauss & Corbin 1990; Corbin & Strauss 2008).

Through its rigorous method of analysis, grounded theory offers a way of constructing a theory from data and unlike more traditional logico-deductive approaches, research is not limited at the outset by rigid preconceived hypothesis. The theory is constructed from the data obtained and the 'grounded-ness' or inductive nature of this approach was appealing for this project. Walsham (2006) makes a significant point when he suggests that the researcher should choose a methodology which they enjoy, engage with and, thus, are able to confidently fully defend their chosen method to others. This point was one which drove the selection of Grounded Theory and specifically the Charmaz version of Constructivist Grounded theory in this research.

3.4 Constructivist Grounded Theory

The terms constructivism and constructivist are used interchangeably within the literature, including by Charmaz (2006; 2008). Charmaz states that she determines which term to use dependant on the context of the discussion (2014). Constructivism stems, in part, from Piaget and Vygotsky's learning theory which says knowledge is said to be individually constructed from experiences in childhood (Ward et al. 2015). This suggests individuals constructed their own versions of reality. Andrew (2012) argues that constructivism also refers to the construction of realities that over time become perceived as objective realities. Constructivism, therefore, asserts that reality is constructed by individuals as they assign meaning to the world around them (Appleton & King 2002). Meaning does not lie dormant within objects waiting to be discovered, but is rather created as individuals interact with and interpret these objects (Crotty 1998). Thus, constructivism challenges the beliefs that there is an objective truth that can be measured or captured. Constructivists study *how* and *why* participants create meanings and actions in the area under study (Charmaz, 2006) and so must be aware that any theory is contextually situated in its own reality. This paradigm places reality into the 'mind of the individual rather than being an externally singular entity' (Ponterotto 2005). Using this paradigm ensures that the resultant theory is

an interpretation of the reality and is dependent on the researchers view. Therefore, constructivists must be aware of their pre-conceived assumptions and how they may affect the research.

Social constructivism is another term which is often used interchangeably with constructivism, Charmaz (2000, 2006) can be seen to do this. It has been proposed that constructivism is an individual's view of an experience while social constructivism has a social rather than individual focus (Young & Collin 2004). Social constructivism advocates that 'reality is constructed and reconstructed both individually from the sum of experience and in relationship and conversation of others' (Ward et al. 2015, p.454). Within social constructivism, there is recognised to be an objective reality, it is concerned with how knowledge is constructed and understood (Andrew 2012). The main criticism against social constructivism is that it is anti-realist in that it denies that knowledge is a direct perception of reality (Andrew 2012).

However, Denzil and Lincoln suggest that Charmaz's version of grounded theory falls into the constructivist – interpretive paradigm (Denzil & Lincoln 2000). Interpretivism is defined as people actively creating their own reality: it is where social reality is seen to be the product of its inhabitants (Blackie 2010).

Charmaz considers constructivist grounded theory to fall between postmodernism and positivism and that her version "assumes the relativism of multiple social realities, recognised the mutual creation of knowledge by the viewer and viewed, and aims towards an interpretive understanding of subject's meanings" (2006, p.250). This method constitutes an approach rather than a series of technical steps to follow. It offers a methodological framework which the researcher can fit their own specific research into.

Despite grounded theory being a well-regarded methodology, it can pose uncertainties or issues for a doctoral researcher. Many of these issues arise from the differences between the multiple versions of grounded theory. While this can be seen as a positive aspect of grounded theory, as it shows that there in no one way to undertake a grounded theory study it can also create confusion and uncertainty, and the researcher must be able to defend their methodological decisions.

One of the frequently debated difficulties when using grounded theory is when to consult the literature. Traditionally research students are expected to complete a review of the literature in the field under study prior to commencing data collection; this is to familiarise

themselves with the field and to ensure they are indeed researching something original. However, Classical grounded theory advocates that the existing literature should not be consulted until after the analytical stage (Lempert 2004).

3.5 Saturation sampling

The issue of sampling remained a problem throughout this project. By attempting to remain faithful to the principal of theoretical sampling, it was not possible to determine the number of interviews prior to starting interviewing. The methodology states that data collection should continue until saturation of the categories is achieved. Glaser and Strauss (1967) determine that saturation is reached when no new information is being discovered. Strauss and Corbin (1990) later determined that unless saturation is achieved no theory which is produced will be conceptually adequate. Charmaz (2006) meanwhile considers saturation to have occurred when 'fresh data no longer sparks new theoretical insights' (p.133). However, Dey (1999) challenges the notion of saturation, stating that saturation relies on the researcher to assume when the category is saturated but how can a researcher claim that without doing further work? His term of theoretical sufficiency (Dey 1999, p.257) sits better within the array of definitions. However, as there are no specific guidelines to follow prior to starting the research (except to reach saturation), and reaching a position of data saturation is essentially a subjective 'call' by the researcher, it was determined that for this study data saturation had been reached when only repetitive information was repeatedly being gathered from the interviews and no new information was being provided by the interviewees. The collection of further data, from interviews, at this point seemed to be redundant.

3.6 Memos

Memo writing is seen as one of the fundamental components of the grounded theory methodology. Memos are theoretical notes about the data and the theoretical concepts between categories (Holton 2007). Or in other words, memos are one of the ways through which the researcher transforms the raw data into theory. By writing memos constantly during the project the researcher 'explores, explicates, and theorizes…' (Lempert 2004, p.243). According to Corbin and Strauss (2008, p.218) without memos, a project is likely to "lack conceptual density and integration". As a novice grounded theorist, the

understanding of a memo as being a conversation with oneself helped greatly. However, in this project, the earlier memos generally lack coherency and were at best speculative: although, they did record interpretations and patterns and theory can grow from that.

Charmaz (2006) recommends that memos are used as an analytical tool and advocates the writing of memos to log thoughts generated by coding. She suggests that themes, hunches and the researcher's general impressions are noted in memos. Indeed it can be within memos that the researcher has their greatest personal input into the project. It is also within memos that researchers should acknowledge their personal limitations and preconceptions. Although, this is one point on which grounded theorist disagree. Classic grounded theory argues the researcher must have no preconceptions, must be neutral, while others (Charmaz 2006; Lempert 2004; Dey 1999) consider this is not possible and that is one of the reasons this project leans more towards a constructivist version of grounded theory rather than a classic one. The co-funders of this project (NHS Fife) were also more receptive to the idea of a more constructivist version of the methodology, due to their own experiences and backgrounds. The guidance received from the co-funders had to be taken into consideration within the design of the project. The difficulties generated by the input of the co-funders - people who are not academic and have requirements of their own – is discussed in more detail in chapter 6, section 6.8. Within memos, researchers not following a classic grounded theory methodology can also bring in the existing literature to help them. After all, there is no point in coming up with a great theory only to find out it has already been researched and well documented.

The following excerpt is an example of an analytical memo written during the course of the data analysis. It should be noted that this memo was written to help clarify the researcher's thoughts and aid understanding of the data.

> The interviews say that GPs are open to change which is of benefit to patients. But GPs are stressed, burnt out and finding it hard to recruit so the workload is an issue. Professional identity is being challenged. This leads to questions about fit and environment – need to find out more. Also, what does this mean for change management? It needs to recognise that GPs will accept changes they ultimately feel will be of benefit to patients but not at their expense?

3.7 Analysis

Within a grounded theory project the way in which the research data is coded is integral to the methodology. The coding phase of a grounded study is not the distinct stage it is in some methodologies, this is an ongoing process which starts with the creation of the first piece of data, i.e. the first interview. From this initial interview, the researcher starts coding and thinking about the information they are receiving and each subsequent interview is informed by this analysis and thought. The ultimate purpose of coding is to give the researcher a framework on which to build. Each version of grounded theory has variations on how the coding should be conducted, but here we have used the Constructivist method of analysis.

3.8 Methodological difficulties associated with Grounded theory

Other issues which arose out of using a grounded theory were:

1. how to determine the data which was to be collected when not using an existing theoretical framework,
2. how to establish, and ultimately describe, the interaction between data collection and data analysis,
3. how much data collection is required for a grounded theory study?

These three issues are not only closely intertwined with each other but also with the issue of practicality and what can feasibly be expected within a three-year study with limited resources.

The first point - not having an existing theoretical framework - was dealt with by the decision that the research must start with objectives and ideas, and not a blank sheet. This was also partly because the research was initiated by one of the Funders and they had pre-conceptions about what they wanted to know and what they wanted to achieve from their research investment. The choice to use Charmaz's Constructivist grounded theory was beneficial here as this suggests that grounded theory is not purely an inductive process and some interaction between experience, induction and deduction are required. The early literature review also resulted from this choice of methodology. The academic requirement of the First Year Review also requires most PhD candidates to have more than just a sketchy idea of where their research is heading.

The second issue was how to establish and describe the interaction between data collection and analysis. The iterative process of data collection and analysis is considered to be one of the basic tenets of grounded theory but the issue arose of how to do that in a study where at times several interviews a day were being held. To transcribe in-between each interview would have considerably extended the research period and potentially could have resulted in respondents no longer being available to interview. The solution here was to use extensive field notes and memos after each interview.

The final question of how much data is required was solved by extensive reading of grounded theory texts and seeking advice from established users. Barney Glaser, at a seminar in Paris, attended by the Researcher, claimed that there was no right or wrong answer to how much data and was dependent on the circumstances of each piece of research.

3.9 Data Collection

The setting for the research was the Fife NHS region of Scotland, an area with 58 GP practices. The region covers cities, towns and rural areas. The Nuka trial took part in one practice in Fife. Data collection for the research took place in a variety of GP practices across the region. They covered all 3 geographic regions - 2 practices were city based, 3 in towns and 3 in rural areas. Interviews took place within a mixture of workplaces and private homes. In several cases, more than one person worked at each location, for instance in one practice the Practice Manager, a Practice Nurse and a GP were all interviewed. These interviews took place individually (the Practice Nurse was interviewed at her home) and without the knowledge of the other team members.

3.10 Pilot study

As recommended by Bryman (2012) prior to data collection a series of pilot interviews were conducted. The rationale behind conducting these practice interviews is to fine-tune interview questions and to allow novice interviewers to practice new skills. Once the format and structure of the interviews were determined four face-to-face pilot interviews were conducted. The initial intention was to conduct a loosely structured interview following a minimal list of predetermined questions and prompts. However, it became apparent during

the first pilot interview, with an academic - who is an experienced Grounded Theorist - that this was not the best structure to follow if the aim of the interview was to encourage people to open up about their feelings about their workplace and their motivations at work. Following discussion with the more experienced researcher, this structure was modified to an unstructured interview which had one set question – the first question – and a list of topic areas which should be covered. The aim of the first question was to start the interviewee talking about a topic they knew and were comfortable with. The interview after that initial question would flow like a conversation rather than as a question and answer session. The first question was determined to be 'Tell me about what it's like to be a GP / Practice Nurse / Practice Manager. Not the everyday tasks you do but what it's like for you'. This question proved to be a good way to get people talking and led into a discussion about their role and workplace.

The second practice interview was also with an academic and this time followed the structure detailed above. This interview started with the question 'Tell me what it's like to work in academia' and led to discussion based on the topic area's which the actual interviews would follow. This interview proved to be an excellent environment to practice interviewing skills and to receive constructive advice. Reflection on the interview identified that subconsciously, loaded questions or inappropriate wording was occasionally being used. This awareness allowed the interviewer to guard against this in subsequent interviews.

The third and fourth pilot interviews were conducted with Practice staff and held at their workplaces. These interviews were conducted in exactly the same way and under the same conditions as the actual interviews and were recorded and transcribed. The experience of conducting these interviews and how it felt was noted in a research diary, in the same way the actual interviews would be. Following these interviews feedback was sought from the interviewees as to the content of the interview, how they felt during the interview and any improvements which could be made. As a result of this feedback and the experience gained alterations were made to the structure of the interview.

The pilot interviews proved to be extremely useful as both a learning tool and a self-evaluation tool. The phrasing of topic questions was practised along with a variety of ways to facilitate an informal interview without directing the line of discussion. These practice interviews allowed the actual interviews to be conducted with greater skill, which was of importance to the rigour of the study. Care with data collection is also paramount in

ensuring the degree of credibility which can be assigned to a study. Finally, transcribing and coding these pilot interviews helped develop experience in examining and coding data.

3.11 Sampling

The two key considerations for sampling methods, according to Morse and Field (1995), are appropriateness and adequacy. Within this research, the appropriateness of the sample was determined by the research topic and the adequacy of the sample was determined to be one which fully answered the aim of the research.

Contacting potential interviewees was facilitated by Fife NHS as a co-funder of this research. An email was sent to all staff in GP Practices within Fife, from the office of the Head of Organisational Development. This email explained the purpose of the research and had a flyer attached to it (Appendix 1). The flyer explained more about the research, ensured confidentiality to anyone who took part in the research and provided the researcher's contact details. The expectation at this stage was that interviews should equally cover the three main groups of staff within GP practices – GPs, Practice Nurses and Practice Managers.

While having the backing of the office of the Head of Organisational Development was useful in that it enabled contact with the research population it may have also resulted in people being less willing to take part in the project. Several of the respondents who contacted me did query the confidentiality of the research and whether or not their line manager or colleagues would be aware that they had taken part in the project.

As respondents started to make contact it became apparent that the sampling within the three groups of staff was being skewed by the Practice Managers. The final sample frame for the 14 initial interviews consisted of 5 GPs, 3 Practice Nurses and 6 Practice Managers.

Several of the interviews were held during hours when the respondents were not working – in each case because the respondent worked part-time hours. The group which had the highest response rate was the Practice Managers and this was determined to be because they controlled their own work schedules – they were able to plan the interview into their working day, while the other groups had to plan the interview into their lunch breaks or their time away from work.

As well as being biased by their occupational group the respondents were biased by being self-selecting. Each of the respondents chose to take part in the research and many of the respondents did so because they had an interest in research or the research process. For instance, one of the GPs also worked part time at a University teaching undergraduates. However, it is worth noting that as with any research using theoretical sampling the recruitment of participants will rarely be on a representative basis as they are pre-selected on the basis of the knowledge they have about the topic under investigation.

Initially, it was hoped that the research population might be increased using snowballing techniques. At the end of each interview requests for the interviewee to mention to their colleagues that the research was taking place were usually met positively but no further interviews were generated this way. The information email requesting people take part in the research was sent out on three separate occasions and the research was promoted, both by Fife NHS Managerial staff and the researcher, within Fife-wide forums. Several of the interviewees also offered to mention the research at regional meetings they attended. However, after the initial group of respondents, no other interviews were obtained.

3.11.1 Sample size

The question of sample size and how big is big enough is a hard question to find an answer to. In qualitative research sample sizes are generally smaller than in a quantitative project and one of the reasons for this is that only one example of data or code is sufficient to ensure that data becomes part of the analysis (Mason 2010). Charmaz (2006) claims that within a Grounded Theory project research requirements should drive the sample size and she suggests that a smaller project may reach saturation point of sampling quickly, while others claim that the homogeneous nature of a sample will also affect the sample size required (Morse 2000). Guest et al (2006) estimates saturation point for a homogenous population could be reached in 6-12 interviews while Francis et al (2010) estimated saturation point after 13 interviews of 14 general medical practitioners and Marshall (1996) estimated data saturation was reached after 15 interviews of 24 medical practitioners. Using multiple research methods will also reduce the size of sample required as the multiple methods offer comparative data (Flick 2014). Guest et al (2006) found that in a grounded theory research project which contained 60 interviews, 73% of all codes were identified within the first 6 interviews and 92 % of all codes were identified within the first

twelve interviews. They stated that there were very few codes or themes missed within the first 12 interviews so data saturation would have been met after 12 interviews.

Grounded theorists are told that when they are finding no new data then their codes are saturated and they have enough data. The difficulty here is twofold – either the researcher over collects data to ensure that all the themes are identified and all the codes are saturated or they shorten the collection period wrongly believing they have collected enough data. The reality of working as a single researcher also results in the practical aspect of the time it takes to collect and process the data.

Having examined published grounded theory studies there does not appear to be a clear answer to the question of how much data. Published studies range from 10 interviews (Marks et al. 2015) to hundreds (Wilson et al. 2006). There are numerous examples of grounded theory studies where the number of interviews is less than 20 (Nishio et al. 2015; Mikkelsen et al. 2015; Garcia & Lopez 2015; Kislov et al. 2012; Walsh 2014; Blase 1982; Lupton 1997; Lensges et al. 2016) and Creswell (2013) suggests that grounded theories are most often based on a limited number of interviews (20 – 30) but he does not challenge those studies based on smaller samples as inadequate, depending on the quality of data gathered and the strength of the analysis.

Mason (2010) researched published PhDs to ascertain common sample sizes. For grounded theory projects he discovered the largest number of interviews used was 87 while the lowest reported number was 4. Francis et al (2010) suggest that one way to ascertain an adequate sample size is to set the general principal at 10 interviews plus a further 3 interviews to ensure that no new themes or data is gathered.

So, to answer the question, how much data is enough, the literature appears to have many different answers. Indeed, Strauss and Corbin (1990, p.292) state that ‘sometimes the researcher has no choice and must settle for a theoretical scheme that is less developed than desired’. Due to sampling constraints in this research, this has happened, although the small sample size falls within general advice within the academic community.

3.11.2 Theoretical sampling

One of the basic requirements of a grounded theory study is that theoretical sampling is used. This means that data from interviews is analysed as it is obtained and the next

interviewee is selected on the basis of the information you wish to follow up on and the best person to provide you with that information. This way data collection is led by the emerging theory (Giske & Artinian 2007). According to Glaser and Strauss (1967), theoretical sampling allows categories to be saturated and this allows relations to be established between categories. This implies that the researcher decides what data will be collected and where to find it on the ground of speculative theoretical ideas. Therefore, theoretical sampling leads to saturation sampling as the researchers continue to attempt to sample the same data until no new examples are obtained and the researcher is not gaining anything different from subsequent interviews.

Theoretical sampling was not possible in this study given the way in which respondents were obtained. However, this lack of methodological rigour should not be seen as detrimental to the research as many authors believe that the approach taken by Glaser and Strauss was never intended to be dogmatic (Bulawa 2014) and the methodology can be adapted to suit the research environment. Indeed Glaser and Strauss (1967 p8) state "Our principal aim is to stimulate other theorists to codify and publish their methods for generating theory" which suggests that their purpose wasn't to create a prescriptive methodology. Other authors also believe that a divergent grounded theory methodology should be used as researchers see fit (LaRossa 2005a; Amsteus 2014; Joannides & Berland 2008).

The difficulties associated with acquiring respondents was not foreseen at the planning stage of the project (as it was assumed that the explicit and high-level support of one of the Health Board Management Teams and the Head of Organisational Change would assure participation but this proved incorrect) and so adjustments had to be made to the project to accommodate this. It was decided that the most appropriate course of action was to not run the second round of face to face interviews as initially planned but to consolidate theories generated by the analysis of the initial interview with questionnaires (as requested by the co-funders) emailed to all NHS Fife Primary Care staff – a sum total of 3,400 people.

At this stage, after the face-to-face interviews and analysis, the decision (in conjunction with the project co-funders) was also taken to concentrate on one example of change which several interviewees had spoken about and two, a Practice Manager and a GP, had direct experience of. This was an attempt by Fife NHS to run a pilot study in which a GP Practice had sectioned off part of its patient base to trial a model of healthcare successfully

operating in Alaska, called Nuka. Given the direct relevance of this experience with the topic of this research, it was decided that this failed trial would be explored in more detail.

This model of data collection, starting with a broad base, narrowing to some specific or extreme cases and then broadening out again to test theoretical findings has been referred to as an 'hourglass strategy' (Bruce 2007). Examining specific or outlying cases within this type of strategy allows the researcher to look for contradictions and to determine the validity of their overall findings.

3.12 Interviews

The interviews were all conducted over a four week period. Each interview lasted on average one hour. Interviewees were given the opportunity to ask questions before the interview started and a Consent form was completed. The interview started with the same question, adjusted for the person's occupation and then developed as a conversation. The question of identity was not specifically raised during the interviews as according to Pratt et al. (2006) doctors are unlikely to explicitly talk about their identity or indeed professional identity. For this reason, the interviews, and the later questionnaires used the ideas of work and perceptions of work when the opportunity arose. An interview guide was used as an aide memoir to ensure all the topics of interest were covered. All interviews were tape recorded and fully transcribed at the first opportunity; each transcription was a verbatim record of the interview. Transcribing the interviews personally, although time-consuming, did facilitate close contact with, and intimate understanding of, the data, a feature which is of vital importance in a grounded theory study. Re-reading the transcription and listening to the recording on several occasions helped to deepen that understanding of the data while ensuring the transcriptions were accurate. Immediately after each interview notes were taken about any thoughts or impressions from the interview. Field notes were written immediately after each interview. The aim of these was to ensure memories about how the interview went, personal feelings, thoughts about the interview and about non-linguistic cues were captured whilst fresh.

3.13 Mixed methods research

Mixed methods research is defined as 'integrating quantitative and qualitative data collection and analysis in a single study or a program of inquiry' (Creswell et al., 2004 p7). As mentioned above (chapter 1, section 4) the decision to undertake a questionnaire-based survey was made after a request to include a quantitative element in the research was made by the co-funder (Fife NHS). The paradigm issues arising from this is discussed in the following section. However, ultimately this decision was beneficial to the research and proved to be a valid way to confirm findings and explain them with a larger sample than for the interviews. As Bryman (2012, p.111) points out qualitative studies often 'produces surprises, changes of direction and new insights' and in this research, these surprises let to the decision to seek a more comprehensive account of the area under study using both qualitative and quantitative methods. In a grounded theory study, decisions about how and what data should be collected are driven by the methods used and here the methods pointed towards another direction to ensure the validity of the theory. Using another data method was also important to ensure that the categories had been fully saturated when more interviews were not forthcoming. Additionally and equally importantly, another reason for using the second form of data collection was to test out the emerging theory, to gather data to see if the theory was valid and to explore it to its limit. According to Oktay (2012), it is also important to see if there are any cases which disprove the theory. This negative or divergent case analysis can help to prove the validity of the theory. Of course, if the researcher is able to find a case which does not fit the theory it doesn't mean the theory is wrong or invalid but enables the researcher to further deepen their analysis.

Using mixed methods is now well respected as the third form of research, alongside qualitative and quantitative (Creswell 2013; Creswell & Trout 2003, Brewer & Hunter 1989). Johnston et al (2007) show that the usage of mixed methods have progressed to the point where it has been recognised as a research approach or paradigm in its own right. Tashakkori and Teddlie (2010, p 273) have developed nine core characteristics of a mixed methods approach which can be used as a reference point for research design and when undertaking such research.

1	Methodological eclecticism
2	Paradigm pluralism
3	Emphasis on diversity at all levels of the research enterprise
4	Emphasis on continua rather than a set of dichotomies
5	Iterative, cyclical approach to research
6	Focus on the research question (or research problem) in determining the methods used within any given study
7	Set of basic ‘‘signature’’ research designs and analytical processes
8	Tendency toward balance and compromise that is implicit within the ‘third methodological community’
9	Reliance on visual representations (e.g., figures, diagrams) and a common notational system

Table 1 - Contemporary ‘Core’ Characteristics of Mixed Methods Research

In this study mixed methods is defined as ‘the collection or analysis of both quantitative and qualitative data in a single study in which the data are collected concurrently or sequentially’ (Hanson et al. 2005). Dunning et al (2008) showed that using a mixed methodology can overcome the traditional divide of traditional qualitative and quantitative methods and provide a comprehensive way to assess and interpret data. Mixed methods can also be seen to be on the continuum between the two extremes of qualitative and

quantitative methods (Creswell 2011; Tashakkori & Teddlie 2010; Teddlie & Tashakkor 2006).

O'Cathain (2010) identifies three justifications which researchers can use to justify the use of mixed methodology within their research; comprehensiveness, confidence and facilitation. Using both the strengths from both qualitative and quantitative methods helps to ensure the breadth and complexity of the issue are fully investigated, confidence in the findings from examining the data from multiple angles and facilitation where one method (here the interviews) helps provide information for the second method (questionnaires).

Triangulation of data was discussed by Brewster and Hunter (1989) in their book *Multimethod Research: A synthesis of Styles* where they called for 'social scientists to more consciously and systematically develop strategies for combining different styles or methods in the same research project' (p. xi). This triangulation of data, or using more than one method (albeit at the request of the co-funders) did allow for a more developled or comprehensive view of the phenomenon under ovbservation. This is one of the acknowleged strengths or triangululation of the data (Morse 2010).

3.13.1 Paradigm issues

Much has been written about the use of mixed methods and the way in which contrasting paradigms and philosophical positions are reconciled (Hanson et al. 2005; Doyle et al. 2009; Creswell 2011; O'Cathain 2010) with qualitative and quantitative research methods frequently described as belonging to different epistemological and ontological positions. The former being grounded in an interpretivist or constructivist paradigm and the latter in a positivist or post-positivist paradigm. The paradigms are also described as being oppositional – subject – objectivity, induction – deduction, relativism – realism, holism – reductionist and so on (Creswell 2011). These different attributes can be seen as problematic and traditionalists would argue that these differences mean that qualitative and quantitative methods cannot be used together (Doyle et al. 2009). This confusion could result in researchers struggling to find a paradigm stance and adopting a pragmatic paradigm in the belief that this will fit in with most research questions. Indeed, Hanson et al (2005) contend that viewing mixed methods purely as that, a method, allows the paradigm to be determined by the researcher and the research problem, not by the underpinnings of a philosophical meaning. Pragmatists would say that any method can be

used in conjunction with any other if that is what is best for that specific research question, so the end justifies the means. The research question should take centre stage and determine the researcher's course of action, not a theoretical paradigm.

Pragmatism is one of the paradigms most closely aligned with mixed methods. Pragmatism highlights, or personifies, the way in which practical consequences and the effects of concepts and behaviours are vital components of meaning and truth albeit at a level of pragmatic understanding. Greene and Hall (2010, p 132) state that:

> Pragmatic inquirers may select any method based on its appropriateness to the situation at hand...the results of pragmatic inquiry are viewed as assertions that become warranted in terms of their transferability in different situations...an active and iterative process of establishing warranted assertions as they are applied in new experiences.

Towards the end of the last century, a variant on classic pragmatism – 'subtle realism' – was developed and has become gradually more significant (O'Cathain 2010). Subtle realism recognises that there is an external reality but that we can only ever experience this through human observations, which must be acknowledged to be unavoidably partial and uncertain. Therefore, given the partial and uncertainty of the observations any knowledge claims inevitably will also be uncertain. This could result in the possibility of several noncompeting views of any aspect of the social world that is being studied (Hammersley 1992). Subtle realism can accommodate both qualitative and quantitative methods. Another valid approach would be to adopt different paradigms for different strands of the research and accept the resulting tensions as an opportunity to better understand the phenomenon being researched (Greene & Caracelli 2003). While this idea of using different paradigms for different strands of the research may be quite difficult for some researchers, as they have to modify their value sets for the different strand, that proved possible here as the strands were completely separate, were undertaken at different times and with different aims. Added to this is the underlying flexibility taught by the grounded theory method and so using different methodologies and paradigms didn't feel threatening or difficult.

Onwuegbuzie (2002) argues that positivist and non-positivist philosophies actually lie on a continuum and mixed methods inhabits the middle ground between the two, reaching out to both, enabling both to work together. While Goldman (2010) suggests that positivist methodologies can be viewed through a social constructivist lens. Hall (2012) suggests that researchers using mixed methods can take one of three approaches:

1. Ignore paradigm issues
2. Use one paradigm to cover all strands
3. Use multiple paradigms to cover different strands

In this research, the third option was taken. The best method for phase one (the quantitative phase) was a Constructivist grounded theory to explore the phenomena under consideration while in the second phase (the qualitative phase) a post-positivist questionnaire was required to evaluate the initial findings. Constructivism says that there are multiple realities and this seems to be sympathetic to the idea that multiple methods should be used if deemed necessary by the researcher and the research question. Constructivists seek to explain the reality of others through detailed descriptions, again this seems sympathetic to the idea of mixed methods if required to complete the explanation (Doyle et al. 2009).

Despite the inclusion of a quantitative strand of the research coming as a result of a request from the co-funder, rather than being planned for within the design of the study, with hindsight this was not the disaster it might have first appeared to be. The original grounded theory methodology was flexible and open to the change and adding in questionnaires did confirm the theory emerging from interview data. Having the second strand of data collection also allowed additional, albeit simplified, questions to be asked to further test the emerging theory. Including the questionnaire also allowed the research to reach an extra body of people who had not responded to the invitation to the interview and therefore gathered more data than would otherwise have been possible.

3.14 Questionnaires

The aim of this research is to explore why Primary Healthcare workers were obstructing organisational change to the way they work. The qualitative interviews raised some interesting questions around whether or not GPs felt they were able to do the job they were trained to do and if they were able to give their patients the attention and treatment they wanted to. They also introduced the idea that GPs and other Primary Healthcare workers seem to feel threatened by organisational change, although the GPs to a greater extent than the other groups. This led to the question why was it? Because of the strong identity of the GPs? To answer these questions using a questionnaire a hypothesis was developed ‘Is organisational change perceived as a threat to professional identity?’. A

short questionnaire was developed, using a combination of open and closed questions, to answer the following specific questions:

1. Do GPs feel their identity is threatened – helping patients is one of the major components of a doctor's professional identity and the interviews showed this was of paramount importance to medical staff so this was questioned
2. Do GPs feel a mismatch between their fit and environment – as questioned by the Fit-Environment theory (Edwards & Cooper 1990; Rounds et al. 1987; Spitzer et al. 2015)
3. Are changes threatening their identity and will these changes be resisted?

A copy of the questionnaire can be found in Appendix 4

The questionnaire was piloted with 5 people – a mixture of academics and medical staff. A link to the SurveyMonkey online questionnaire was emailed to all Primary Healthcare Staff within the Fife area, by the office of the Head of Organisational Development – a number of 3,400. The questionnaire was linked to within a staff bulletin. The bulletin was sent out on two separate occasions three weeks apart. Paper copies of the questionnaire were also hand delivered to 10 GP practices within Lothian Health Board area and 5 within Forth Valley Health Board area. The reason for the wider geographical spread of the paper questionnaires was to attempt a comparison between Fife GPs and those out with the area. One interviewee had made comment about there being a 'Fife attitude' and it was felt important to test this out with a control group. Having the second group also allowed for more generalisation of the results. The total population for the online survey was 3,400 the total population for the paper questionnaire was approximately 80. The response rate was low, as is to be expected with this target group and taking into account the method of promotion (i.e. by the employer in a bulletin most staff are likely to ignore). The paper questionnaire distribution was limited by geography, although it did cover 2 separate health board areas – Lothian and Forth Valley. Of the 15 practices approached in Lothian, 8 refused to distribute the questionnaire to staff while of the 10 practices approached in Forth Valley only 4 agreed to distribute the questionnaire. A total of 98 fully completed questionnaires were returned (72 online surveys and 26 paper questionnaires) and analysed. The return rate for the paper questionnaires was much better than the online return rate, although having to return to practices several times was time-consuming and having to provide envelopes and stamps for the return of questionnaires completed after the final visit to the practice was expensive. Analysis of the closed questions was done in SurveyMonkey and the answers to the open questions, a total of 156 comments were

transcribed into NVivo for analysis. The analysis of these comments was kept separate from the analysis of the interviews initially and then once they had been analysed independently they were amalgamated.

The usage of questionnaires is not without issues. The respondents are self-selecting, either from a group email which was sent out by Fife NHS or those who choose to complete a paper questionnaire and so may not be representative of the total population. While creating the questionnaire one of our aims was to keep the questionnaire as short and concise as possible. This was to ensure completion was quick and easy, thus encouraging full completion and maximising response rates. As part of this aim, the only classification information requested was a job title, although unfortunately, we had no way of verifying the response. Deliberately limiting classification data also had the dual function of reassuring respondents that the results were totally confidential and non-attributable. However, the limited size of the questionnaire did mean that the questions had to be very specific and only cover our key issues. Traditionally response rates to questionnaires are low and this one was no different – just under 3% of fully completed questionnaires were returned, despite follow up emails and phone call/visits to the practices who received paper questionnaires. The limitations and biases introduced by this form of data collection will be covered in more depth in chapter 6.

Having looked at the research design and given an overview of the project, this chapter will now give details about the methods used to analyse the data obtained in the interviews and questionnaire. Analysis within a grounded theory study is conducted following an established rationale which shapes how the data is analysed. Therefore, a detailed explanation of this process was deemed to be necessary prior to the discussion, in the next chapter, of the findings from the analysis.

3.15 Analysis defined

When the term ‘analysis of data’ is used, this simply means that the data is reduced and organised into categories and that category or individual piece of data is named or classified with a code name. A code sums up the nature or meaning of the piece of data (Flick 2014). For instance, in this project the following data from interviews were all coded as ‘arrogance’:

…well its like they are working for me I can do what I want.

…they just looked at me in horror that a prescribing adviser would speak to a Dr like that…

…if you're the doctor then you're better than the staff and the patients.

The analysis within this project was conducted using a grounded theory approach. Within a grounded theory project the way in which the research data is coded is integral to the methodology. Using this methodology, the coding phase is not the distinct stage it is in some research projects, this is an ongoing process which starts with the creation of the first pieces of data, i.e. the first interview. From this initial interview, the researcher starts coding and thinking about the information they are receiving and each subsequent interview is informed by this analysis and thought. The ultimate purpose of coding is to give the researcher a framework on which to build an understanding of the data.

As discussed earlier there are epistemological and methodological differences within the three main versions of grounded theory - those created by Glaser, Strauss and Corbin and Charmaz. Much has been written about how to conduct a grounded theory study (for example Glaser & Strauss 2005; Corbin & Strauss 2008; Strauss & Corbin 1990; Charmaz 2008; Charmaz 2000) and while there are many similarities between the versions in general and in how each author suggests data analysis should be approached, there are also many significant differences. The elements which are considered to be integral for any grounded theory study are:

- Data gathering and analysis are simultaneous
- Coding starts from the first interview/field notes
- Memo writing starts with the first interview/field notes
- Theoretical sampling directs the search for patterns and discrepancies
- Theoretical saturation is reached once no new information is being obtained
- The final theory identifies a social issue or process which accounts for most of the observed behaviour.

(list adapted from Flick 2014 p. 399)

3.16 Coding in a grounded theory project

In many qualitative research projects, one of the first steps of coding is to create a list of pre-determined categories or a coding framework, data is then coded against this list, and concepts derived from this framework - it is a three-step process (Blackie 2010). However, in a grounded theory project the process of creating codes, categories and concepts is all considered to be part of the coding process; this is a one-step process. This one-step approach to coding is central to the development of a grounded theory. Nevertheless, the actual process of coding is one of the main ways in which the major grounded theories differ, as each of the theorists has developed different coding techniques. The differences between the different methodologies have been explored by different authors (for example Evans 2013; Howard-Payne 2015; Health & Cowely 2004). Unsurprisingly, these differences have become a source of contention. Glaser (1992) condemns Strauss and Corbin for 'forcing their categories upon the material and for obstructing the process of emergence rather than supporting it by their way of coding' (Flick 2014, p402). Charmaz is also criticised by Glaser for 'questioning the understanding of categories as emerging' (ibid, p.402): whereas Charmaz's version of grounded theory, being from a Constructivist stance, considers theories to be constructed rather than discovered.

We will now look at the different coding techniques created by Glaser, Strauss and Corbin and Charmaz.

3.16.1 Constructivist grounded theory

In this project, Charmaz's Constructivist grounded theory was followed. Charmaz advocates a two stage coding framework using a focussed level of coding. The initial coding (similar to the Classic GT open coding) asks questions of the data and attempts to label segments of data with a short name that both summarises and accounts for it. Charmaz recommends that initial codes are 'provisional, comparative and grounded in the data' (Charmaz 2006, p.48).

As mentioned above, there are many ways in which transcripts can be approached for coding – word by word, line by line and paragraph by paragraph being the main ones. Word by word coding is generally used when approaching documents, line by line coding, or naming each line of data with a code, works particularly well with detailed data such as transcripts of interviews (Charmaz 2006). Line by line coding helps to break the data up

into categories, can reveal processes and can help direct the line of enquiry. Charmaz (ibid) provides guidelines for coding by giving examples of line by line coding from her own work. This show excerpts from interview transcription with the codes written in the margin and these proved helpful in understanding how to actually code transcripts. In this research, the transcriptions were coded by dividing the transcript into sections of complete thoughts rather than on a line by line basis. This stance was decided upon after the transcription of the pilot interviews as being the most suitable approach given the nature of the interviews.

This initial coding can point to gaps in the data directing further data collection. Both Charmaz and Glaser suggest coding with gerunds (a verb which functions as a noun, or in other words a noun which is formed by taking a verb and adding the suffix 'ing') as a way to help detect processes and remain grounded. Using the words of the respondent where possible also helps you stay in touch with the data. The results from this initial stage can also guide the subsequent sampling of research participants.

Once the initial codes have been generated the next step is focused coding. These codes are more conceptual and more directed than the initial codes. Focused coding takes the most significant and/or frequent of the initial codes and aims to determine which of these make the most analytical sense, allowing us to understand the data. According to Charmaz (2006 p.63) 'theoretical codes specify possible relationships between categories you have developed in your focused coding'. Charmaz (ibid) helpfully gives examples which deal with generating codes from discrete paragraphs of text from an interview she conducted. Charmaz's version of grounded theory does not use the axial coding suggested by Strauss and Corbin but she does advise developing subcategories and using them to link between categories, with the aim of using the categories, subcategories and links to reflect how the Researcher made sense of the data.

This is not a linear process and involves much to and fro-ing between already coded transcripts. Looking at the data again in light of the new focused codes may derive new ideas and concepts. Unlike in Classic GT, Charmaz sees the GT process as constructing a grounded theory rather than the positivistic attitude of discovering a theory.

Ultimately, it is the researcher's ability to move from descriptive coding to conceptualisation which sets the grounded theory method apart from other qualitative methods. Grounded theory is an iterative process, the researcher moves between data collection and analysis, memo writing, coding and creating models. For a study to truly fall

under the auspice of that of grounded theory it must offer a conceptually abstract explanation for an underlying pattern of behaviour or issue or concern in the social setting under study. It must not simply describe what is happening in a setting, it must explain. Thus, a grounded theory study is not just the reporting of the facts but the creation of probability statements about associations between concepts developed from the data. It is in this way that grounded theory analysis differs from thematic analysis. In thematic analysis, unlike in grounded theory methods, themes are generated but not related to each other and as such a theory is not produced.

In this project, we have set out to explain why Primary Healthcare workers are blocking organisational changes which, to others, appear beneficial to them and their patients. A thematic quantitative study would report the themes behind what is happening, that organisational changes are being blocked or resisted, but a grounded theory will conceptually explain why changes are being blocked or resisted. It will theorise the underlying, unspoken themes and look for plausible explanations for the behaviour.

Glaser and Classical Grounded Theorists (Glaser 1999) believe that you only need transcribe the portions of the data which is relevant to the study. However, in this case, complete interviews were transcribed. Although time-consuming it was felt that this better preserved all the data and did not risk the loss of any less obviously relevant data due to misidentification. The first round of coding was unquestionably descriptive. Making the move to conceptualisation involved asking questions of the descriptions – what did this really mean, what is this an example of, when did it happen, where did it happen and so on.

In this research, coding started with the coding of short sections covering one thought or topic, these sections were then condensed into a single word or phrase which eventually became the initial code. These codes were then compared, organised and interpreted with regard to one another, and other data sources such as memos. Saturation of the codes was reached as analyses of new transcripts ceased to add to the existing codes and were seen to be repeating information which was already coded.

Regardless of the unit of data or how coding proceeds a study is coded by all grounded theory methods using constant comparison methods (Glaser & Strauss 1967). This can be defined as the ‘simultaneous and concurrent process of coding and analysis’ (Jones & Alony 2011) to establish analytic differences and, thus, make connections across each level of analysis. This comparison of data with data, aiming to find similarities and

differences forces the researcher to really study and understand the data, this leads to conceptualisation, to making sense of the what the underlying message of the data is. Memo writing (basically notes written by the researcher with the aim to understand what they are seeing) is an integral part of this understanding.

Throughout the literature discussing the grounded theory method the advice to not force data into preconceived codes, categories and theories arise again and again (Charmaz 1990; McCallin 2003; Birks & Mills 2011; Cutcliffe 2000). Indeed this was one of Glaser's criticisms of Strauss and Corbin's version of grounded theory (Glaser 1992). Every researcher holds preconceptions and assumptions which may influence how they make sense of the data and they must be aware of this. Charmaz (2006) suggests questions to ask of the data, which aim to reveal your preconceptions and safe guard against imposing them on the data, and strategies to guard against preconceptions emerging in writing and reporting of findings.

3.16.2 Coding: techniques and varieties

Within the different stands of grounded theory methodology there are several diverse ways suggested for coding. Figure1 below shows the different coding steps used by the different versions of grounded theory. These steps will be discussed in detail below.

Glaser	Open coding	Selective coding	Theoretical coding
Strauss and Corbin	Open coding	Axial coding	Theoretical coding
Charmaz	Initial coding	Focused coding	

Table 2 - Coding techniques

In Classical GT Glaser recommends three stages of coding: open coding, selective coding and theoretical coding (Glaser 1999). The aim of open coding is to break down and understand the text and to attach a meaning to that text. It does this by examining the data for similarities and differences, for themes and processes. This open coding is generally descriptive. The open coding (also called initial coding by Charmaz) breaks the data into defined portions which are grouped together to form categories. The term 'categories' is used frequently by grounded theorists but its meaning remains vague – different versions of grounded theory define it differently. Indeed, Strauss and Corbin in the first edition of their book in 1990 define categories as a classification of concepts, but in the second

edition, it was defined as a type of concept which stands for phenomena (LaRossa 2005a). For the purpose of this study, the term categories is taken as meaning a variable, something which represents dimensions of concepts, or a way to join similar concepts under an overarching term, thus a category.

Open coding can be used to different degrees of detail – it can be applied at a line by line level, a paragraph by paragraph level or at the level of a whole interview or text. The level used will depend on the specific project and is determined by the researcher.

Open coding involves constant comparison, and it is the constant comparison of the data which helps lift the descriptive coding to a conceptual level (Holton 2007), this ongoing comparison also helps the researcher form themes and, as mentioned above, categories – also sub-categories and core categories. The core category can be defined as the main concern of the research, the category which covers all the data. Open coding is complemented by the memos researchers use to make sense of what they are discovering about the data, to note the meanings of the codes used and to record why decisions were, or were not, made. These documented thoughts are often subsequently used to make sense of the data and support the ultimate theory (Charmaz 2014).

Researchers are advised to ask the following questions of the data to help them decipher what the data is telling them:

1. What? What is the issue here?
2. Who? Who is involved and what is their role?
3. How? Which aspects of the phenomenon are talked about
4. When? How long? Where / time / location
5. How much? Aspects of intensity
6. Why? What reasons are given
7. What for? To what purpose
8. By which? Means/tactics and strategies for reaching goals

(list adapted from Flick, 2014, p407)

However, in this project the following criterion was used for the open or initial coding stage as it appeared more meaningful for a ‘first pass’ of the data collected for this project:

- Code words and phrases that describe or evoke strong emotions.

- Code words and segments that describe actions - using gerunds (verbs ending with “-ing”-to emphasize actions)
- Code material that reflects symbolic interaction concepts, such as a sense of self, expectations of social roles, assessment of the judgments of others, and justifications for actions.
- Look for “red flags,” such as phrases that reflect assumptions (“everyone knows,” “always,” “never”).

The next step in Classic GT, following open coding and the discovery of the initial and core categories, would be selective coding; this is where the analysis concentrates on the codes which are related to the core category. This stage results in the core category being filled to, what is termed, the saturation point. Saturation is considered to have been reached when no new information is being discovered (Birks & Mills 2011). The final stage, the theoretical coding, results in the core category being sorted, theorised and cross-referenced with literature and a theory or process being identified. Theoretical codes are conceptual and identify possible relationships between categories developed by focused coding.

One of the key components of grounded theory analysis is that the researcher makes comparisons within the data and asks questions of the data at all stages of coding. In this later stage of coding, the questions which are asked are different to those asked in the open coding phase. Here the researcher asks questions about the content, the conditions under which something occurs and its consequences. Glaser (1978 p.74) suggested the 6 ‘C’s’: cause, context, contingencies, consequences, covariations and conditions.

Strauss and Corbin (2008) developed another type of coding, Axial coding. This aims to relate categories to subcategories; it specifies the properties and dimensions of a category. Strauss and Corbin considered axial coding to be an intense form of analysis done around one category at a time, in terms of paradigm items (conditions, consequences, and so forth). This results in cumulative knowledge about relationships between this category and other categories and subcategories” (Corbin & Strauss 2008, p32). Charmaz (2006, p60) explains this type of coding as follows: it ‘reassembles the data you have fractured during initial coding to give coherence to the emerging analyses. In a project using the Strauss and Corbin version of GT, Axial coding would be used in-between open and selective coding.

Coding performed in the first stage and the later stage of data analysis has a different purpose and outcome. In the early stage of coding (the open or initial coding) the aim is to narrow the scope of the study. There is a mass of data and no focus (as there is no hypothesis) so that focus must be found. Initial coding is very close to the data and solidly attached to it while later coding is more focused and abstract.

The final step in the coding process, in Classic Grounded Theory, would be to formulate a theory and to check that theory against the data. This is initially done by defining the core category.

As with any methodologies, there are pros and cons in their usage. Unfortunately for the novice researcher it is often the case these only become apparent once you start using a method. One limitation found within the coding method of any of the ground theory methods is the very real possibility of ending up with a massive number of codes and categories and no idea of how to deal with them. None of the champions of the method really address this issue; there are no suggestions on knowing when to finish coding or when to finish theoretical sampling. It is very much left to the individual researcher to decide when to make the break, which potentially could be problematic for a PhD researcher.

In summary, the three versions of Grounded Theory discussed here are fairly similar, in that they choose similar routes to achieve the same aim. The epistemology of each of the strategies can help the researcher decide which approach to use. Charmaz uses a constructivist approach to construct a theory while the others use a more positivistic approach to find a theory. Glaser's approach uses data flexibly and is less orientated to the traditional models of science, unlike Strauss and Corbin who develop a paradigm model and suggest criteria for coding. Glaser's famous quotes 'All is data' and 'Just do it' (Glaser 2014 seminar in Paris) illustrates this less rigid approach. Ultimately, each researcher must use the approach, or mix of approaches, which best suits the project and available data. However, as Glaser (1998) states, until you actually conduct a grounded theory project you don't really understand the methodology.

3.16.3 The coding process in this research

Although Charmaz (2006, chapter 3) provides guidelines for coding data and even provides examples of coding from her own data, the coding process is still open to a large

degree of autonomy and decisions pertinent to each individual project have to be made. The first decision for this project was the definition of the unit of analysis. Was the data to be analysed at a line by line, at sentence level, paragraph level or unit level? A unit or chunk of data is ultimately determined by the coder but tends to be an idea/concept covering several lines or sentences. After studying the first transcript, and with experience gained from attempts to code the pilot interviews, it was decided to transcribe within units of meaning, i.e. by information, rather than being forced to generate excessive codes by going line by line or missing codes by looking at a paragraph level and potentially being overwhelmed with information. Over-coding and over-fragmentation of the data is a practice which Glaser (2011) warns against as it can produce an unusable amount of coding which does nothing more than hinder the researcher making it harder to recognise patterns.

Following Charmaz's guidelines, coding in this way in actuality meant taking a few lines of transcription and identifying ideas within them. Charmaz (2006, p.46) suggests the use of gerunds when coding. Gerunds generated by this data included 'resisting', 'overloading', 'coping strategies', 'changing' and 'burning out'. The gerund, or label, which is chosen, should echo the meaning of what is being expressed in the data, it can be a word used by the interviewee or one which the coder feels captures the essence of what is being said. For example, the table below Figure 2 shows an example of a chunk of coding with the coding beside it. The interviewee was talking about how they had moved to part time working as a way of coping with their workload. The word coping wasn't used in the interview but that code or label seemed to best capture the meaning behind the words.

Part-time working	I think if I worked 5 days a week there is no way I would have lasted this long I feel when I go into work on a Wednesday I'm fresh, I'm enthusiastic I'm ready to get stuck in again by Thursday night I'm drained I'm like a zombie, both emotionally and physically
Coping strategy	

Table 3 - Example of coding

To move from the initial coding to a more focused coding a code needs to be found which encompasses a section of initial codes across many different transcripts, it may even be that a new code needs to be created which covers similar or related codes. Here NVivo was helpful in that it can conduct word searches and create word clouds – see figure 1 below - to help identify where the same similar initial codes were used in different transcripts, thus helping the coder to build up a broader picture of the overall data.

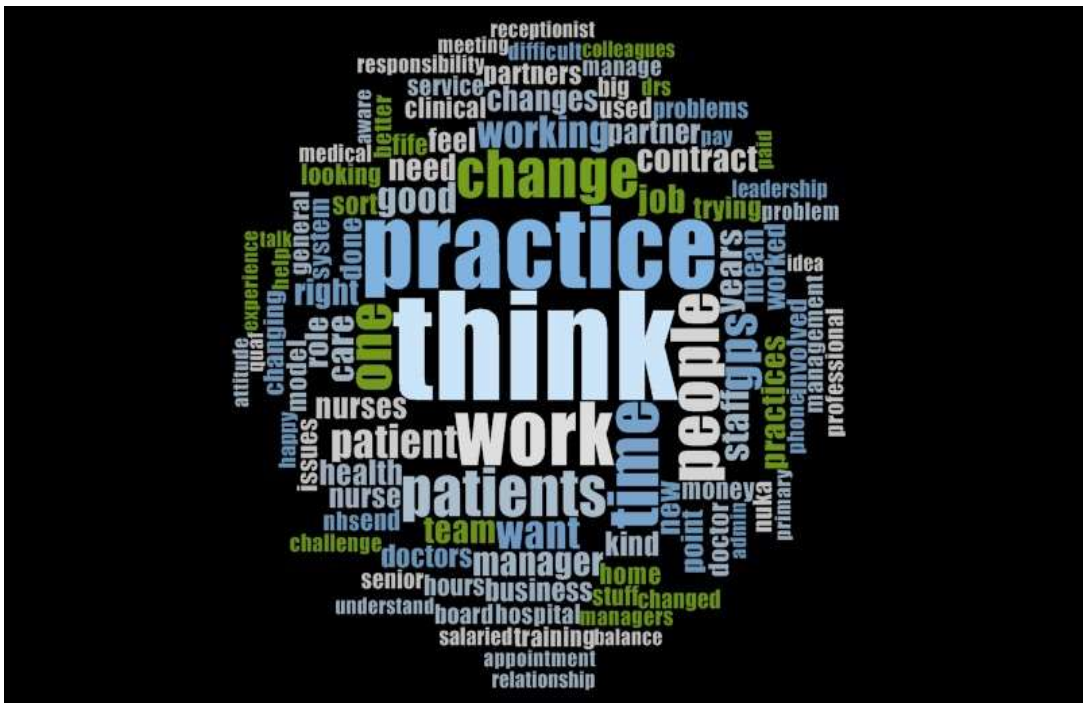

Figure 1 - NVivo word cloud

Being immersed in the data is crucial for the coder at this point. When coding later transcripts codes emerged which clarified decisions made in earlier transcripts. For instance, the code 'coping strategies' developed mid-way through coding and clarified thoughts about why an earlier interviewee had decided to work part time in a teaching role while also working part time in a GP practice, that could also be seen as a coping strategy, although that GP had framed it as a way to remain fresh and engaged with his patients.

3.16.4 Focused coding

Once the initial codes have been generated, in this case, 62 initial codes were created, the coder moves onto focussed coding. Charmaz suggests that focussed codes should

be ‘more conceptual than earlier codes and they should be used to categorise the earlier codes. This is a task which could be done successfully within NVivo. Nvivo also helped to determine the most commonly occurring code across all the transcripts: these were changing, challenging, overloading, burning out and controlling. These codes were turned into categories by encasing other related codes within them. The most commonly used codes were determined across all the interviews, grouped together into themes, sorted, re-grouped and re-sorted in NVivo. However, there came a point when the easiest thing to do was to group similar codes and themes together on large sheets of paper. The themes which emerged were around coping, identity and change.

Charmaz (2006: p 139) suggests that the researcher needs to find a category which carries the “weight” of the analysis – this category becomes the core category. The way that was done in this project was to take a print out of one transcript and seeing if the selected code in that transcript carried over to other transcripts. Codes which were considered in this scenario had to encase other similar codes (for that individual transcript) and they had to agree with the impressions gained from memos and knowledge from the rest of the data. For instance, there was no point in considering whether or not a category was potentially a core category if no other transcript mentioned it.

The task of interrelating categories is a challenging one. Glaser and Strauss in their original work on dying used matrices to show how categories relate to each other. Miles and Huberman (2014) show how matrices can be used to develop relationships among categories and examples given in their book allowed the further interrogation of the categories in this study.

3.17 Analysing questionnaire responses

As discussed earlier, the second method of data collection was required in this project to provide validation of the findings from the face to face interviews. Therefore, a questionnaire was sent to all GPs, Practice Nurses and Practice Managers in the Fife Health Board region, a total of 3,400contacts. The questionnaire was sent out within a weekly bulletin produced by Fife NHS for its community staff. A limited number of paper-based questionnaires were also delivered to GP surgeries within Edinburgh and Forth Valley.

The questionnaire was a mixture of open and closed questions (see Appendix 4). The questionnaire was deliberately kept short to encourage people to complete it. Analysis of the closed questions was straightforward and it produced simple quantitative results.

Responses to the open questions were analysed using NVivo (in the same way that the interviews were) although the data was kept separate from the interview data. Unlike the interview data the questionnaire responses were coded all at once after the questionnaire was closed, and not immediately a response was received. There would have been no value in using this methodology as the wording of the questionnaire was not going to be altered by the results being received. Inevitably the coding which was done on the open responses was influenced by the findings of the interviews and coded similarly. It was recognised that this could result in the data being forced in categories rather than being able to 'speak' for itself and great effort was made to ensure this did not happen with new codes being developed as required. In total 3 substantive new codes resulted from coding the open responses in the questionnaire. These are: privatisation, unrealistic demands, recruiting crisis. New sub-codes which were generated included surviving and changing structure.

3.18 Conclusion

In sum, within this project, the data was condensed and analysed by means of thematic codes and concepts in a two level process. Themes emerged as a result of the data analysis which allowed the formation of rational associations between the transcripts. This analysis was augmented with the knowledge emerging from the simultaneous focused literature review.

Having considered how to analyse the data which was gathered as part of this project the next chapter will detail the analysis which took place.

Chapter 4 Emergent Conceptual Categories

4.1 Chapter overview

Having looked at the way in which the data was analysed, this chapter will now discuss the data which emerged from the analysis of the interviews and show how it formed the basis of the emergent theory. The analysis of the questionnaires will be discussed in chapter 5 (section 5.2).

Inevitably, with a grounded theory study a lot of codes are created and not all of them will be relevant to the final theory. It may be that a code might only have one instance of data attached to it. When this is the case, codes are discarded or included into a more general code: this amalgamating of codes can also happen naturally at the focussed stage of coding when sub-codes are combined. Within this research, when codes were discarded as no longer being directly relevant, a note was made of the code and this note was referred to over the course of the theory building to ensure no relevant data was lost. Appendix 5 lists all the codes which were created and shows which codes were discarded and why.

The main categories which were created, Shifting Culture, Maintaining Professionalism and Resisting De-professionalism, will be discussed in turn. Each of these categories incorporated similar codes to build up a full picture of each category, and these will also be discussed. This first step of grouping sub-codes into categories helps to scale up the emergent theory from the micro and in-depth initial data to a richer, more conceptual theory. The data which determined each category will be considered and segments of raw data, extracts from field notes, memos and the research diary will be used to provide rich descriptions and explanations. Where appropriate, literature used as a source of data will also be presented. A more detailed look at how the data engages with the literature will follow in Chapter 5, along with discussion about how the categories relate to each other.

4.2 Shifting culture

4.2.1 Introduction

The category Shifting Culture describes the way practice staff feel that the culture of their profession is changing. There was a general feeling expressed that day to day the work of the practice was changing, that the role of the nurses and doctors was changing and the expectations placed on them, by the media, by their patients and by the Health Board was changing. Changing was a very strong category from the initial coding sweep. It seemed to underlie a lot of the discussion held with GPs, Nurses and Practice Managers. Changes, in themselves, were not uniformly seen as a bad thing; indeed if it was seen as beneficial to patients it was generally, eventually, accepted. However, that is not to say that changes were welcomed, often they were feared as a source of stress despite the, albeit, sometimes reluctant acceptance of them. Another aspect of changing processes or the way people work is that not only can changes be seen as threatening, but it can also be seen as admitting that the current system is not working. This admission could be seen as admitting that there is a problem with the affected profession thus undermining that profession. Changes can be seen as striking at the very heart of a professional identity, especially when that professional identity is deeply embedded in the individual's identity psyche.

The sub-categories which made up the main category of Shifting Culture include:

- getting harder;
- managing businesses;
- generational shift;
- expectations

All of these categories were associated with the idea that expectations were shifting – expectations from patients, from society in general and the health board. Given that the health board is controlled by the government these expectations can also be seen as political.

Although these sub categories are fairly self-explanatory we will nevertheless look at them in more depth. The following graphic illustrates the categories, the sub-categories and their components.

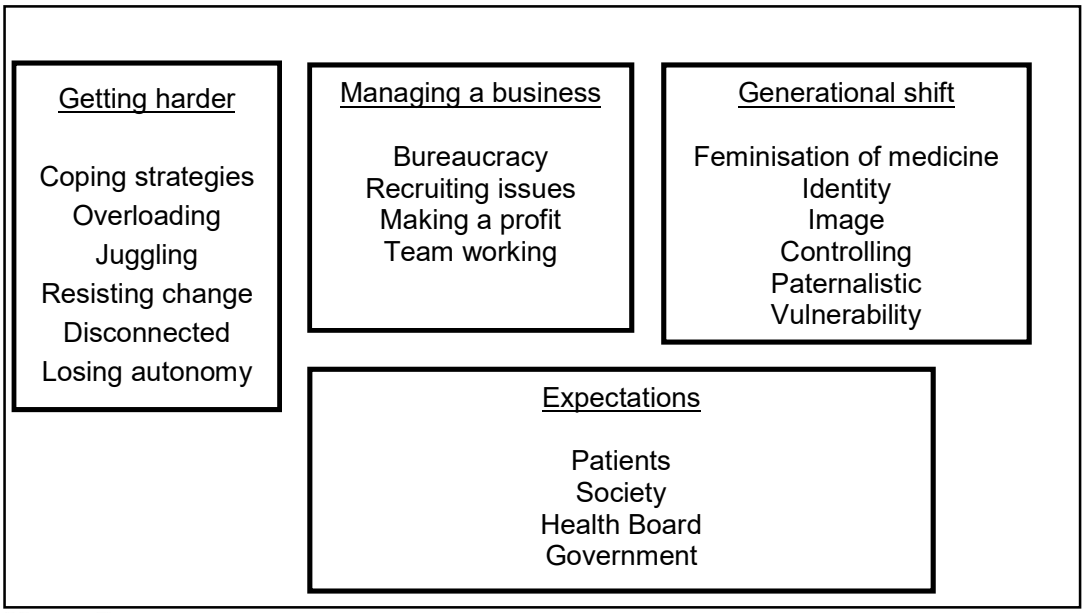

Figure 2 - Shifting Culture

4.2.2 Getting harder

Interviewees said that they feel their daily jobs are getting harder, for a number of reasons – lack of time, lack of resources, lack of support and lack of facilities. Practice Staff talk about the detrimental pressures generated by the GP Contract and how it has reduced their autonomy changed the way they interact with patients and increased their workload.

> ...it was always going to happen and GPs had too much free reign compared to other specialities for too long but it's a bit sad because some of the things which have changed haven't been good changes emm and they have enforced things on us which we were doing already and everyone says they are tick box exercises but it's a lot of that and it's a lot of unnecessary stuff so you're seeing patients which don't need to be seen to the detriment of patients who are unwell but don't fit Quaf boxes, people who just have depression, pain management issues, things like that which don't really fit we're not making the space we used to for them. (Practice Nurse)

> …latterly it's got a lot more top down driven with the pressures of Quaf and finances and everything else which is put on us so we're less autonomous now,

> we're doing what we're told now whereas previously we had this ability to structure our days and our jobs as we wanted to do it, we can't do that now. (Practice Nurse)

> We're trying to make things fit round what we're asked to do and that means we're not able to spend as much doing what we would maybe want to do with patient's emm you can't spend half an hour with someone anymore, you only have 10 minutes. (GP)

As mentioned in the introductory chapter, society is changing - economically, socially and politically - and the public's attitude to doctors is changing. The medical profession has traditionally enjoyed the trust of the public which has enabled them to be self-regulating, autonomous and generally held in high esteem. High profile scandals, such as the Shipman Inquiry (UK Government 2005) and the Francis Report (UK Government 2013), have led to a breach of this trust. This is evidenced by the increasing level of litigation doctors are now facing, suggesting a more critical attitude toward the profession (Tallis, 2006). Media reporting of events has led to the public questioning the medical profession, they believe they see General Practitioners doing less work (cuts in 'out of hours' work, nurses taking on more of the doctor's tasks) and they are told GPs earn massive sums of money (Norris 2014). Advances in technology have made medical information available to the public via the internet and no longer solely the province of the medical profession; patients are questioning and challenging medical expertise. This change has resulted in a 'decline in deference' (Tallis, 2006 p7). There has also been division and criticism within the medical profession as older physicians judge younger doctors to be unprofessional (Smith 2005). They criticise the younger generation for focusing on work-life balance and claim they lack the 'intrinsic virtues necessary for the medical profession' (ibid, p 439).

4.2.3 Managing a small business

As discussed in Chapter 1, GP practices in Scotland are funded by the Scottish Government via the QOF (Quality and Outcomes Framework). GPs are in essence small business owners who hire staff, maintain premises and provide a service to the public. Along with the potential profit come the difficulties faced by all small business owners.

> …you know there is a tendency for GPs as employers to stick their heads in the sand and hope it will all go away. (Practice Manager)

> …the whole running the business side of things has to be done as well so there is that balancing bit as well. (Practice Manager)

Most practices hire a business manager to run the day to day business and handle the legalities associated with the staff.

> …. your very much Jack of all trades, and while your employed really to support the needs of the Doctors as the employers you become very much involved with the staff and so working in a practice you can become a small community. (Practice Manager)

All the Practice Managers who were interviewed commented that most GPs were not very business or leadership orientated and lacked the necessary leadership skills or understanding required by a profitable small business owner.

> ...they went and trained for all of these years to provide a service but that service isn't management and it isn't leadership and they need to maybe realise [pause] they maybe need to give that responsibility to people who have trained for that and do have those [management] skills.' (Practice Manager)

> ..to help them [GPs] understand just because you're a partner doesn't make you a leader there is skill attached to being a leader and responsibility and things you have to do and ways you have to behave which are really important and if you get it wrong your practice is less successful as a result, and [I need] to try and get GPs to care about that. (Practice Manager)

This lack of leadership skills often goes hand in hand with an attitude that the GP is too busy to worry about the staff and non-patient related issues. This, in turn, makes day to day working harder for the staff employed by the GP practice.

> ..it's more like they just seem to not realise that for example if someone is off sick you can't just phone them up and tell them to get back to work there are laws, they just say no that's not good for us, we are short staffed just get them in. (Practice Manager)

> There is a lot of arrogance amongst them. They displayed poor behaviour on a daily basis towards patients and staff just being rude and aggressive. These issues I addressed with them you know on numerous occasions and was basically told that was the nature of employer, employee relations. (Practice Manager)

4.2.4 Generational shift and feminisation of medicine

There are also concerns among some doctors about the changing nature of general practice, the days of the original GP who was on call for their patients, day and night, is now long gone. Younger GPs are often attracted to the specialism of general practice because of the work – life balance they think it can offer them; this can be particularly attractive for women who wish to work around having children. This increasing number of female GPs is resulting in the feminisation of GP practices, something which in itself is changing the way GPs work and their expectations. In England, the number of female GPs is expected to exceed male GPs at some point between 2017 and 2122 (The Kings Fund 2016). In my own GP practice, there are 11 GPs and 9 of them are female.

> …the work force has changed and is predominantly female now and quite often part time so it has just changed by itself, I don't think we have made that change. (GP)

> I get the feeling generally among younger doctors coming into general practice lots of them work less than full time because they want a better work life balance. (Practice Nurse)

> The younger [GP] is fully committed but probably would apportion off his free time more. The older one would go in on a bank holiday to do a round at the nursing

> home or to see a sick patient so errm you can see a slightly different way of working. (Practice Nurse)
>
> …my father was a GP and I have no intention of working the hours he worked I want to ensure I'm around for my children... (GP)
>
> …none of them [GPs] are working fulltime. For some it's family reasons, because 2 or 3 are female but some it's for their own health reasons and they have already made an active decision for them and those who went out into locum and then subsequently had a partnership one of the caveats of their partnership is that they weren't working fulltime.' (Practice Nurse)
>
> ….it's quite interesting you know the balance between responsibility and rights so the grey waves see the youngsters as wanting the rights without taking the responsibility whereas I think if you pick it apart it's a bit more complicated than that and at the end of the day it doesn't matter as it's going to change as these people become more powerful and you know they will create the environment to suit their own needs. (GP)

Another change within general practice is that some GPs choose the speciality because they see general practice as a way for them to pursue special interests such as teaching, or research or a specialised branch of medicine.

In America, a survey by the Association of American Medical Colleges (Friedman 2008) showed that 82% of female doctors felt that having time for their family and personal life was 'very important'. This is leading them to make decisions to work in specialities which don't have emergencies and long or overnight hours, such as dermatology or plastic surgery. Given the increasing number of women working in medicine in the UK, a similar attitude may lead to a shortage of primary healthcare doctors, as appears to be currently happening in America (Friedman 2008).

There has also been discussion around the generation gap currently seen between older and younger doctors (Smith 2005), the so-called Generation X. Changes in the way young doctors are now educated and the hours they work, along with their desire for a work/life balance, have led to suggestions they are less professional and lacking in necessary intrinsic values (ibid). Canadian research has shown a similar trend. Beaulieu et al. (2008) discuss how there is a feeling among younger GPs that older GPs are judging their younger colleagues on their levels of commitment and the non-traditional idea of having and maintaining a satisfactory work-life balance.

This supposition has the potential to divide the profession across a generational line, the Baby Boom generation on one side and Generation X and Y on the other. The Baby Boomers define professionalism in terms which include the number of hours worked and commitment to the role while the younger generation believes the older generation to be hypocritical and susceptible to early burn out. Indeed in one of the interviews, a young woman who had been raised by a Baby Boomer doctor claimed that her parent was very much absent, and her family priority would be different.

4.2.5 Expectations

Expectations from patients – societal expectations of primary health care staff – are also changing and practice staff commented that this is making their jobs harder.

> that's a difficult one to determine why but I think it's probably just it's not specifically to do with us but what's going on elsewhere in the modern world you know you should be able to see your GP at 8 o'clock at night, you should be able to get your antibiotics then, you should be able to fit in what you do so and that's not an unrealistic thing we kind of all agree with that. It is reasonable to see your GP at 8 o'clock at night the problem is you can't have the same GPs here at 8 pm and at 8 o'clock in the morning and that's the problem the workforce can't cope with that. (GP)

> I think society is becoming more demanding generally so possibly that's just an aspect which is changing which will also include their expectation of general practice. (GP)

> ….patients want to be seen when they want to be seen at a time which suits them and so there is just a huge demand…….. medicine has come back to almost doing the job of the parents and family now rather than trying to fix people. (GP)

Practice staff also commented that there is a sector of society, particularly among younger patients, who are less deferential to healthcare staff. Patients now have access to a wealth of information on the internet and seem to expect an equal relationship with doctors and nurses as a result of being able to research their problems themselves. However, at the other extreme of the spectrum, there are patients who expect the doctor to take complete

control over everything to do with their lives, to be able to fix all their problems – health, social and economic – people who have a dependency relationship with their doctors.

> I think society is becoming more demanding generally so possibly that's just an aspect which is changing which will also include their expectation of general practice. Different areas will have differences but there is a high expectation from some quite demanding patients here. (GP)

> I think people still think you can wave the magic something and not necessarily solve all their problems but you will definately know the answers. (Practice Nurse)

> A lot of people go and see their doctor if they have had a fight with somebody, their wife, their husband or whatever and they are stressed out about it, they do because they feel like they can't cope because this has happened and they don't have the skills to cope with it. (Practice Nurse)

> …if they have anything remotely wrong with them they are down to the GP to fix it, entitlement and dependency… (GP)

> ...there are a substantial number of people that almost abuse the system with this dependency relationship with their GP. (Practice Nurse)

Having looked at the data behind the category of 'Shifting culture' we will now consider the category 'Maintaining professionalism'

4.3 Maintaining professionalism

4.3.1 Introduction

Data from the initial interviews appeared to suggest that GPs were resisting change to their practices, to the way they worked. From the first few interviews, it appeared that 'changing' was going to be a major, and possibly the central, category of the analysis. As discussed above, initial coding gave the impression that 'changing' was a major concern

of the primary healthcare. While the topic of ‘change’ from a cultural perspective (from expectations, from societal changes, generational changes and so on) made up a large part of the previous category Shifting culture, change, can also result from practical, concrete alterations to a previously held norm.

This category of Maintaining professionalism is made up from sub-categories Resisting change and Attitudes which indicated changes from a practice source, these categories contain the following codes:

- inflexibility,
- denial,
- coping,
- relationships,
- burning out,
- paternalism,
- controlling.

These sub-categories and their codes were associated with the idea that change was something to be feared and blocked or resisted. It appears that any substantial changes were to be resisted because they were considered to be a threat to the established norm. The interview data showed that for many staff the idea of changing established working practices was seen to be the cause of a lot of unrest and believed to be the cause of a lot of stress.

Although these sub categories are fairly self-explanatory we will look at the in depth below. The following figure illustrates the categories, the sub categories and their components.

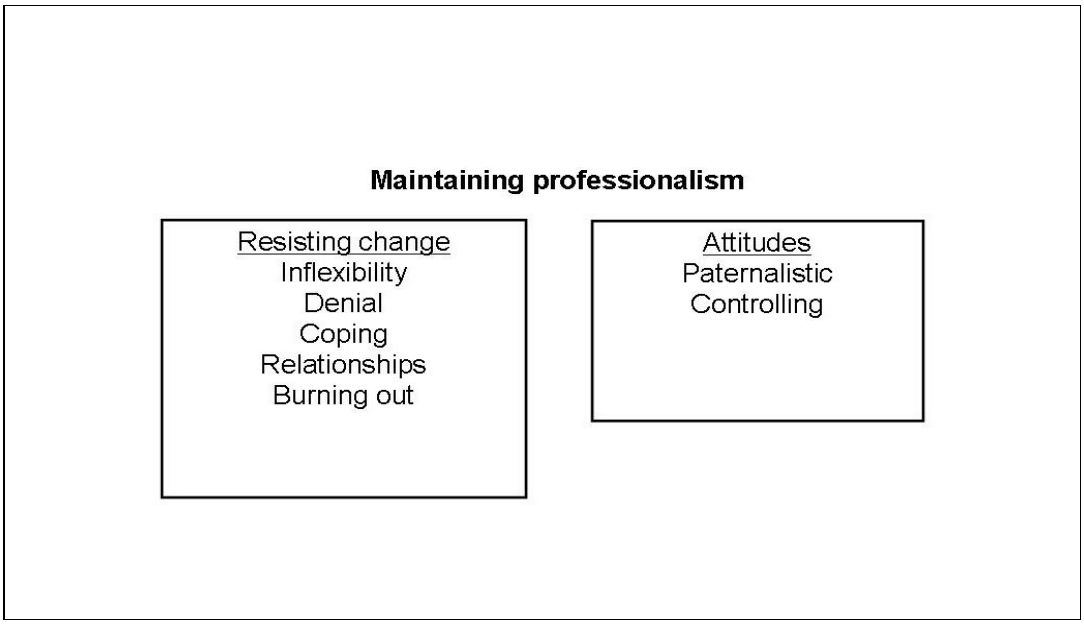

Figure 3 - Maintaining Professionalism

4.3.2 GP Contract

One of the greatest causes of ongoing changes and bureaucracy, cited over and over again during the interviews, was the ongoing changes to working practices imposed by the GP Contract. This Contract was felt to be challenging the fabric of the primary healthcare sector, challenging the way doctors and nurses work, how they regard themselves, and their roles. Practice staff indicated that they are being asked to do more and more for the GP contract and it was one of the major causes of the ongoing demoralisation of the sector.

> …the contract has moved over more to management issues or issues that have required time which is out with patient contact time and that has caused problems…….it's really been a stretch to do that [fullfill the contract] and still do all the things which happen in the background because that doesn't stop so that has been the balancing bit I think. (Practice Nurse)

> It [the contract] is a source of change every year and there is a source of anxiety attached to it… (Practice Manager)

> …so all they have done since is made it harder and harder to get points i.e. the money… (Practice Manager)
>
> …put under considerable pressure now with the contract…(GP)

In general, the Contract appeared to be seen by GPs, Practice Nurses and Practice Managers as being a source of bureaucracy, frustration and stress. They reported finding the system unwieldy, slow and prone to technological problems.

> …the GP contract they have moved away from the clinical measure to other things and trying to have that balancing act that has imposed a lot of kind of challenged for us…(Practice Manager)
>
> …the goalposts are constantly being shifted… (Practice Nurse)

However, despite undeniably being a source of stress the contract was also seen as a 'good thing' by many Primary Healthcare staff.

> I feel so long as the driver is patient care and to provide equity of care then I think that's a good thing about the contract because there must have been poorer practices prior to the contract days, practice who were not found out whereas now you have to prove you're doing it. (GP)
>
> I feel the overall feeling I have about it is that if I feel it's positive for the patients then I feel I will put myself out and I will take it on board and I will put myself under pressure because I feel there is value in it for them and value in it for me because then I feel I have got job satisfaction. (GP)
>
> I have never disagreed with [the contract], every time I have seen the contract I can see some of the underlying theory behind it, I think yes I can see where they are going with it the significant event analysis or trying to identify patient safety issues and make changes… (Practice Nurse)
>
> I think it helped us to get to where we are today it has standardised health care and reporting systems. (Practice Nurse)

In response to lobbying from GP leaders, in 2014 the Scottish GP contract was changed to allow it to roll over unchanged for two years, so for the financial years 2015/16 and

2016/17. That means that all agreements, including the QOF and enhanced services, will remain the same. This rollover period will help GPs cut down on the annual increase in workload which comes with the new contract and allows them to create more stability within their practices and focus on finding solutions to their increasing workloads.

So, in summary, initial analysis seemed to show that for many years some organisational aspects of the primary healthcare sector have been 'tweaked' and small changes have occurred with frequency. These changes were often a result of Contract requirements and were imposed in an attempt to maintain, regulate and standardise service levels and patient care. However, the accumulation of these small changes is seen to be threatening by the primary healthcare sector and stretching staff to the point that, it appeared that, they no longer want, or feel able, to accept any more change. According to some academics, the medical profession is feeling demoralised and rejected, entrapped, embattled and, therefore, withdrawn (Bhugra 2013; Thorne 2002). The interview data concurred with this view and led to the understanding that the Contract is seen as a major cause of unrest.

Conversely, as discussed above, there is a positive side to the GP Contract. Not only is it felt that it has standardised care but it appears to have helped staff to become more comfortable with the process of accepting small changes. Discussion with primary healthcare staff highlighted that staff believe they are used to, and indeed skilled in making and accepting, changes. Much of this belief stems from the fact that the GP contract meant (until the contract was renegotiated in 2014/15) that they had to change their working practices annually to meet the requirements of that year's contract.

> …we all accept that change happens all the time… (Practice Nurse)

> …so that's a change which I implemented in reaction to how someone else was working. (Practice Manager)

> …the GPs would accept it [changes] with reservations if it was going to be helpful but would pick holes in it. (Practice Manager)

Further analysis of the interviews also showed that it is widely accepted by a lot of practice staff that primary care has to accept that bigger changes are required. As discussed

above, the NHS is under new pressures; from the economy, from society and from advances in medicine. GPs and those working in the primary healthcare sector understand this.

> …it's hard to be a GP at the moment because you can see that things are changing and if you're a GP you know some of the change isn't good. I see the change as inevitable… (GP)

> …there is maybe a recognition from a logical and academic point of view that something needs to change but yes whether they will...(pause)…I think they need to change gradually (laughter) I don't know the answer to that but I do think that's right, there does need to be a fundamental shift I do think that we can't actually keep going. (GP)

The quote above shows the dilemma facing a lot of staff – they logically understand change is required but they feel fundamentally threatened by the idea of a change which affects their working practices, their ideas of how they should be treating patients and how primary healthcare staff should be perceived. In other words, the staff feel their professionalism is being affected by some changes, potentially the more structural or organisational changes, and in order to maintain that professionalism they are blocking changes they feel are threatening. This is an idea which will be explored more fully later.

Maintaining professionalism became the second main category generated by the coding. This overarching category contained the initial codes of inflexibility, coping, relationships, burning out, paternalism and controlling. These initial codes, which will be discussed below, grew into the codes discussed below and became encompassed by the category Coping mechanisms.

4.3.3 Coping mechanisms

Overloading of work was shown to be a concern for all staff. Primary Healthcare staff felt that they are being overloaded with work; a lot of tasks which were done in the secondary system (primarily hospitals) are now being passed to primary health care to ease the burden on hospital staff.

…workload, yeah workload and time, trying to find the time to get through the workload, that's the big thing… (GP)

So what's happened over the years is that workload pressures have become greater and greater and people have become more and more stressed. (Practice Nurse)

…constantly pushing things through to general practice, lots of hospital things for obvious reasons financial cutbacks are having an impact, however, there is a limit to how much general practice can take on… (Practice Manager)

…the workload has just gone through the roof… (Practice Nurse)

So what's happened over the years is that workload pressures have become greater and greater and people have become more and more stressed. (GP)

4.3.4 Burning out

One result of this overloading is staff reporting they are unable to cope and more and more are experiencing burn out. Some interviewees reported that younger GPs were burning out within 5 years. A Practice Nurse, talking about GPs in the practices she had worked in, felt that burn out was unavoidable:

…within 5 years they have got burn out and by then they have become cynical and they start to be unkind about patients and they are feeling stressed working in the practice and so they start becoming difficult to deal with for the staff, so maybe for the first 5 years of practice, and the nature of general practice is that it is a challenging environment to work in because of the way they choose to deliver the service and it results in burn-out early on and whenever that happens, it's, that's it and attitudes begin to plummet. (Practice Nurse)

A Practice Manager also commented on burn out, saying it was inevitable:

> …how is it not inevitable because of the strains of their jobs? I see it in one of them [a GP] more and he is showing signs of it in that, this is all confidential, he is turning up at the very last minute to start clinics and being a bit snappy when he wasn't before sort of things but not uncaring just under strain. (Practice Manager)

GPs cope with stress and burn out by reducing hours, taking early retirement and ultimately leaving the profession.

> …many of my counterparts work part time as well, there aren't many people who are full time I think to balance, just to avoid burn out cos it would be quite hard to see patients 5 days a week, to be honest. (GP)

> …none of them [GPs] are working full time. For some its family reasons, because 2 or 3 are female but for some is for their own health reasons and they have already made an active decision for them and those who went out into locum and then subsequently had a partnership, one of the caveats of their partnership is that they weren't working full time. (Practice Manager)

> I think a lot are [burning out] and a lot of friends I have who are GPs, there has been a lot of movement recently. I know of someone who has emigrated to Barra, one of the old [place name] GPs actually, he just felt it was time for a change. A lot of people who are getting to their 50s and their pensions are full are retiring and coming back part time so there is definitely a lot of movement there. (GP)

According to the literature on the topic, burn out can be defined as a three-dimensional phenomenon: withdrawal from and cynicism towards clients, emotional exhaustion and a sense of un-accomplishment (Friedman 2000). Burn out has long been associated with the various people-oriented professions, such as healthcare and teaching due to the intense level of personal and emotional attachment these professions require (Maslach 2000). Also, the environment of these professions tends to be shaped by political, social and economic factors which can result in work environments which are low in resources but high in demands. Although these people-facing environments were traditionally seen as those which produced burn out, in the modern working environments of retail and call centres, other 'high touch' customer service roles are also experiencing staff displaying symptoms of burn out.

Dreary et al. (1996) found that job stress levels could predict burn out, i.e. higher stress levels could lead to higher incidence of burn out. In another study of over 2,000 doctors in Canada (Richardsen & Burke 1991) found that doctors who reported they were stressed had more problems with patients and obtained less job satisfaction than those who did not feel stressed. Unfortunately, this extensive project didn't control for demographics, the personality of the doctor or any other work-related variables. One study which did take personality into account found that the personality of the doctor along with increased job stress was a significant predictor of stress, a type A personality being the most prone to stress (Cooper et al. 1989). Organisational changes were also found to create stress, and those finding change stressful reported more stress from their job generally (Dreary et al. 1996). Therefore, it would appear that for some doctors organisational change adds to stress levels further precipitating feelings of burn out. Similarly, Richardsen and Burke (1991) concluded that higher stress levels were associated with lower satisfaction with the healthcare system in general and job satisfaction was related to fewer specific work stressors and more positive attitudes about healthcare. Logically, then it follows that the happier GPs are in their roles, the less stressed they will be and the less likely they will be to burn out and, conversely, the more stressed they are (as a result of organisational change, heavy workload and so on) the more likely they are to burn out and reduce their working hours or leave the profession completely.

People suffering from burn out tend to feel ineffectual or inadequate and they can lose confidence in their professional ability (Richardsen & Burke 1991). In 2001 the BMJ ran an editorial entitled "Why are doctors so unhappy?" and concluded that "The most obvious cause of doctors' unhappiness is that they feel overworked and under supported" (West et al. 2001, p. 1361). While a recent survey of 564 GPs in Essex found that high levels of burn out were evident: 46% of GPs reported emotional exhaustion, 42% reported depersonalisation and 34% reported low levels of personal accomplishment (Orton et al. 2012). While it could be argued that this survey took place in one county in England and this will have inevitably introduced biases to the study (and therefore its results might not be extrapolated to the whole country), these are still figures worthy of note. Conversely, a survey of 333 doctors in Scotland in 1996 found that higher clinical workloads while leading to higher levels of stress also appeared to be an influence on positive feelings of personal achievement (Dreary et al. 1996). A more recent survey covering GPs in England (Doran et al. 2015) found that 38% of GPs who had recently ceased to practice cited burn out as a reason, along with stress (43%) and overwork (54%). The cost of

burn out within healthcare includes reduced organisational commitment, increased physical illness, absenteeism and greater turnover in staff (Maslach 2000). Thus, the cost of burn out among primary healthcare staff, given the current financial straits of the NHS, needs to be taken seriously and should be taken into consideration when organisational changes are being planned.

4.3.5 Working with GPs

Somewhat surprisingly, something which was highlighted many times during the interviews with the practice staff was what it was like to work with a GP: the attitude of the GPs to other staff and, occasionally patients, was criticised as was their leadership and communication skills.

> …if you're the doctor then you're better than the staff and the patients…(Practice Nurse)

> …there is a lot of arrogance amongst them [GPs]. They displayed poor behaviour on a daily basis towards patients and staff, just being rude and aggressive. These issues I addressed with them, you know, on numerous occasions and we basically told that was the nature of employer, employee relations. (Practice Manager)

> …they [the GPs} didn't want to work as equals with their team members… (Practice Nurse)

> …people were working in an environment of fear and mistakes were being made you know, doctors were unapproachable, unpleasant, staff were afraid to talk to them em their general attitude to patients was very, very poor em they just put up barriers to access, they saw patients as problems rather than the reason the practice existed. One doctor spoke about punishing patients for turning up at the desk without an appointment you know just really poor attitudes towards patients. (Practice Manager)

> They spend a lot of their training time attached to practices where they are being influenced by older GPs they see how they interact with patients and other staff and they learn that's what you're supposed to do. (Practice Manager)

> …we're all [Practice Managers] experiencing the same thing……. we're challenging leadership roles, trying to address patient safety, doctors attitudes to

> staff, trying to do team building, even things like trying to create collective visions for a way forward and its falling foul of the partners because it involves doctors changing and they just don't see the need. They are the bosses and everything is fine as far as they are concerned and they don't see the need. (Practice Manager)

These quotes around the attitudes of the GPs towards patients and colleagues further underpin the idea of burn out among GPs and also point to a perceived arrogance among GPs, a sense of superiority over their colleagues and patients. Or, this attitude could be the result of GPs asserting their professional identity onto others. However, during the interviews, the suggestion was made several times that this manner of dealing with colleagues from other professions, and with patients, is a taught aspect within medical education.

> …its taught arrogance, you know they are taught how to be elite and arrogant right from the word go and it continues throughout their education. (Practice Manager)

> They are taught that nurses aren't equals, that the receptionist isn't an equal and they are regarded as not equal in position and also as people. (Practice Manager)

> …he [a GP] said when he was at university they were taught how to function in an elite, arrogant way, it was part of their training. (Practice Manager)

Many of the practice staff indicated that a large number of the GPs were very controlling, which again goes back to the socialisation they received into the medical profession. There is general agreement within the literature that all the medical professions need to work together to provide the best patient care; however, there is substantial research which shows that doctors have difficulty in working as team members as they have been socialised to be autonomous decision makers (Hall 2005).

> …GPs won't allow it. (Practice Nurse)

> They are the bosses and everything is fine as far as they are concerned and they don't see the need. (Practice Manager)

It appears to be accepted by other respondents that the GPs are small business owners and as such, they feel they should be in control. However, the GPs have been taught to be doctors and not business owners, the practicalities of running and leading a business are taught very briefly during GP training. Leadership issues were apparent in many of the practices visited.

> …they went and trained for all of these years to provide a service but that service isn't management and it isn't leadership and they need to maybe realise they maybe need to give that responsibility to people who have trained for that and do have those skills. (Practice Manager)

> I think that it's [the leadership programme] a start I don't know if it's the answer but I think it's a start in dealing with the already established GPs to help them understand just because you're a partner doesn't make you a leader. There are skills attached to being a leader and responsibility and things you have to do and ways you have to behave which are really important and if you get it wrong your practice is less successful as a result and to try and get GPs to care about that. So I think the leadership programme goes somewhere to beginning to raise the issue of leadership as opposed to ownership with the GPs but I think that the key is in NHS education with the GPs as students and trainees, getting in there at the beginning. But the leadership programmes I know they exist but I've never seen them advertised, I don't know how the GPs get on them or how they recruit to them or how they are advertised. (Practice Manager)

4.3.6 Paternalism

GPs have traditionally assumed a paternalist role, although this medical model has fallen out of vogue with GPs now being taught to assume a more patient-centred model. However, many GPs feel that they have to adjust their 'style' depending on the patient they are seeing – for instance some patients wish to be told what to do while others would prefer to be given their options and allowed to make a guided choice. The interview data highlighted this. It also showed that younger GPs assumed a more paternalistic attitude in an attempt to strengthen their identity as the 'doctor' and also to distinguish themselves from the nursing staff. This suggests that to strengthen their identity as GPs, some GPs

need to be able to apply the bio-medical model to their practice. This is not compatible with the team working approach currently being suggested as necessary by many.

4.3.7 Professional identity in medicine

The idea that doctors are taught to be arrogant and not taught to be leaders or work within teams as equals leads back to the unique professional identity held by doctors. According to Russell, the identity held by doctors is likely to impact on their role within the organisations they work with, yet this theory of having a unique identity has not been extensively explored (Russell et al. 2010). Medicine is often considered to be a vocation and the 'doctor' definition is felt by many doctors to be central to their identity (Cascón-Pereira & Hallier 2011). Indeed studies have shown that even when doctors move out of a clinical 'hands-on role' they still first and foremost see themselves as doctors (Cavenagh et al. 2000; Cascón-Pereira & Hallier 2011).

Members of the medical profession are socialised into it by education and peer modelling (Cavenagh et al. 2000). Medical schools aim to socialise students into obedience towards a code of professional behaviour (Cave & Clandinin 2007). Indeed, socialisation into the profession of 'doctor' starts before a student even enters medical school as the result of the fierce competition to gain a place at medical school. Aspiring doctors are required to be high achievers at school and to develop the characteristics medical schools deem desirable in doctors to be. Cavenagh et al (2000) showed in a comparison between law school students and medical students that the medical students have a greater commitment to their chosen career than law students. This early commitment, Cavenagh suggests, may have implications about the future doctor's flexibility and adaptability when faced with change. This inflexibility to accept change may play a part in GPs reluctance to accept organisational change and be a feature of their professional identity.

According to Ibarra (1999) people at the beginning of the socialisation process start by playing a part, they mimic role model behaviours in an attempt to be like them. Socialisation is complete when they stop mimicking and automatically display the values and culture of the profession. Leonard (2008) gives the example of a medical student who explains "…you put on your white coat in the morning and you are actually playing a sort of role…" (p232). There has been extensive literature around the socialisation of medical students, indicating that it is one of the fundamental ways of socialising into the profession

(Martimianakis et al. 2009; Leonard 2008). However, there has not been a similar exploration of how members of a profession maintain and further construct their identity or about if and how people lose their feeling of professional identity.

This traditional route of socialisation into a profession relies upon the traditional discourse in medicine, one which is rooted in a nostalgic and traditional value-orientated professional identity as the only accepted way to be a doctor (Gee 1999). This may, of course, have the unintended consequence of reinforcing unwanted traditional values and expectations of what it is to be a doctor. Monrouxe (2010) argues that a doctor's professional identity is influenced as much by an individual's "personal, emotional and cultural stores" (p44) as by socialisation. Thus unintended values may be continuing. One cause of this may be the inevitable differences (as a result of cultural and societal changes over time) between the idealised version of the profession, the generally accepted professional identity as portrayed to new members of the profession, and the reality of the day to day experiences as practiced by existing members of the profession (Melia 1987). The existing literature does not explore how this aspect of the development of professional identity in medicine requires new members to take into account the idealised version of a doctor presented to them in a formal setting and by society and the reality of their situation. The extent to which this is or is not achieved may be significant for the doctor's ongoing professional identity and work satisfaction during their career. It has been suggested (Clark 2011) that the socialisation process of doctors and the internalisation of the values and expectations of the profession can result in a blurring of the distinction between professional and personal identity for some health professionals. It can be argued that this blurring resulted in the traditionally strong and all-pervasive identity of the traditional family doctor.

Another unintended consequence of socialisation and the traditional professional identity is that doctors are known to identify themselves with their profession rather than their employing organisation (Russell et al. 2010), in most cases the NHS, and so have little or no allegiance with those outwith their profession. This inevitably will cause problems when the NHS managers require doctors to make organisational or structural changes with which they disagree. Literature (Bååthe & Norbäck 2013; Thorne 2002; Currie et al. 2009) dealing with the interaction between doctors and NHS managers has resulted from this misalignment of professional values. This strong, all encompassing identity of being a doctor is temed as being 'cross-cutting' (Spyridonidis et al. 2015), in other words, it is an identity which overrides any other identity held by an individual. Whatever the individual does, no matter where they work or how they socialise, they are always a doctor (Ashforth

& Johnson 2001). Therefore, identity processes would appear to be fundamental to exploring how GPs are reacting to the changes they perceive are being thrust upon them, how they are reacting to having their professional autonomy challenged and how they are reacting to having to accommodate governmental intervention.

4.3.8 Changes in the medical profession

A profession may also segment or stratify (Currie et al. 2009): in the case of medicine, this is seen by the division between medical and surgical specialities and the generalist family doctors. This stratification can lead to power differentials within the groups. In the case of medicine, GPs are often seen, by those who work in hospitals, as less powerful and subordinate to the hospital specialists. Despite this division, GPs retain their supremacy within the primary care sector.

Tensions between doctors, non-clinical managers and policymakers are also apparent and a sense of mutual distrust can be seen (Currie et al. 2009). Changes in regulation, the introduction of treatment guidelines and control of the profession by non-medical managers have all resulted in an environment where doctors feel they are little more than technicians following rules (Thorne 2002). As Thorne (ibid) suggests, the constant reorganisations of the NHS are resulting in staff feeling a sense of alienation. This alienation is leading to many doctors feeling there is a shift in the balance of power (Thorne 2002) and this is seen as a threat to their professional identity (Schilling et al. 2012).

4.3.9 Identity Threats

Threats to identity are unsettling and provoke responses, both positive and negative (Petriglieri 2011). This much is agreed; however, there appears to be disagreement amongst scholars as to exactly what a threat to identity is, how it is manifested and how it affects identity. Petriglieri (ibid) provides a table which gives nine different definitions of identity threat and she explains identity level threats as "*experiences appraised as indicating potential harm to the value, meanings, or enactment of an identity.*" (italics in original, p644). Professional identity may be considered to be threatened when an individual perceives a risk of marginalisation or devaluation of their role or expertise (Steele et al. 2002). When an individual, or group, experience an identity threat they are likely to respond in a way which attempts to reduce or remove the potential harm (Lazarus

& Folkman 1984). This response could be an attempt to protect the threatened identity or to change the aspect of their identity which is threatened, in other words, they accommodate the threat and remove its 'power' to harm them (Petriglieri 2011). Petriglieri's (ibid) model of how individuals cope with an identity threat is of great help in understanding this issue. However, the model only looks at individuals, it doesn't look at how a group, or profession, behaves when faced with an identity threat. Therefore, it is not clear if all members of the group will respond the same way or if there is interplay between members of a group. There has been literature examining the salience of professional identity within healthcare teams and how the perception of professional identity plays a role in team performance (Mitchell et al. 2011). However, it is still not clear if there is any interplay between individuals, rather than teams, and professional identity threats.

Unlike Petriglieri, Russell et al. (2010) do examine a group, looking at what happens when the social identity of hospital consultants is challenged. Russell (ibid, p230) comments that hospital consultants

> …traditional public image of power and solidarity contrasts with a self-image characterised by a sense of fatalistic acceptance of externally imposed changes and of perceived powerlessness…

This would suggest that hospital consultants are accepting the changes and doing nothing to defend their identity. Other authors (Hotho 2008a) disagree with this conclusion that hospital consultants have this fatalistic view, believing they are open to change and to exploring new forms of social identity. Work has also been done around how professional identity can influence inter-professional interactions, i.e. how it influences how people work in teams (Fitzgerald & Teal 2003).

One of the possible consequences of feeling a threat to professional identity is that it can increase solidarity within a profession (Badea et al. 2010) and intensify defence of inter-professional distinctions (McNeil et al. 2013). Therefore, an identity threat can lead to aggression towards members of other groups (Aquino & Douglas 2003) and this has been shown to be associated with a range of negative responses (Devos et al. 2002). Faultlines or dividing lines (Chorbot-Mason et al. 2009) have been found to be triggered by identity threats.

Friedson's (1994) theory of professional restratification suggests that the medical profession is actually taking a more proactive stance in an attempt to retain its power. This theory of restratification proposes that members of the profession over time will move into areas of power, such as administration or managerial roles. This stratification leads to a new form of medical professionalism, one in which doctors take on organisational and managerial values and adopt a more mediating role between the interests of their profession and the financial and organisational pressures of their employer (Cheraghi-Sohi & Calnan 2013). A study by Hotho (2008) suggested that when GPs become change leaders they construct a new identity which incorporates the identity of doctor and manager; Hotho suggest this reconstruction of their identity proves a new, more attractive identity, for them, it is more attractive than that of a manager or purely that of a GP. Another example of this new form of professionalism comes from Checkland (2004) in which she proposes the idea of GPs as street-level bureaucrats: GPs are reconciling the different pressures from managing organisations, having to follow clinical guidelines and the GP Contract with their everyday practice of taking care of their patients in the best way they can. Charles-Jones (2003) suggests that GPs are actually readjusting their identity to include the role of biomedical specialist rather than purely that of a general practitioner.

However, other scholars have suggested that the changes within the medical profession have been exaggerated. Evetts (2011) argued that the idea of a new form of professionalism is too simplistic as there is evidence of both continuity and change within the medical profession. It has been suggested that the increasing pressures upon doctors have resulted in them becoming more flexible and adjusting their professional identity to suit their new circumstances. For instance, GPs have adjusted their professional identity to incorporate the identity of business owner as well as doctor (Cheraghi-Sohi & Calnan 2013). The fact that the medical profession has a large degree of autonomy over their work enables them to decide how to react to changes; they can use their power to adapt change to their advantage (as in the power to delegate tasks) or to resist enforced change. However, as Timmermans (2008) concludes, it is very hard to actually empirically measure if the professional power of the medical profession has been maintained, enhanced or reduced.

4.4 Resisting deprofessionalism

4.4.1 Introduction

This category is the reverse of the previous category – maintaining professionalism. It explains how GPs are fighting to stop what they perceive to be threats to their professional lives.

The NHS has been historically dominated by powerful physicians who controlled it by virtue of their specialist training, expertise and knowledge. Reforms have resulted in new models of governance in hospitals (Ferlie et al. 2012), but these reforms are only slowly filtering through to GP practices. One of these changes is demonstrated by the way GPs are fighting to maintain the boundaries between themselves and other medical professionals.

The codes which make up the main category of Resisting deprofessionlism fall under the collective name of Maintaining boundaries. The sub codes are:

- professionalism
- traditionalism
- autonomy
- controlling

All these codes are associated with the ideas that Boundaries must be maintained to stop the encroachment of changes. The sub codes will be discussed in detail below and this discussion is preceded by an illustration of the category

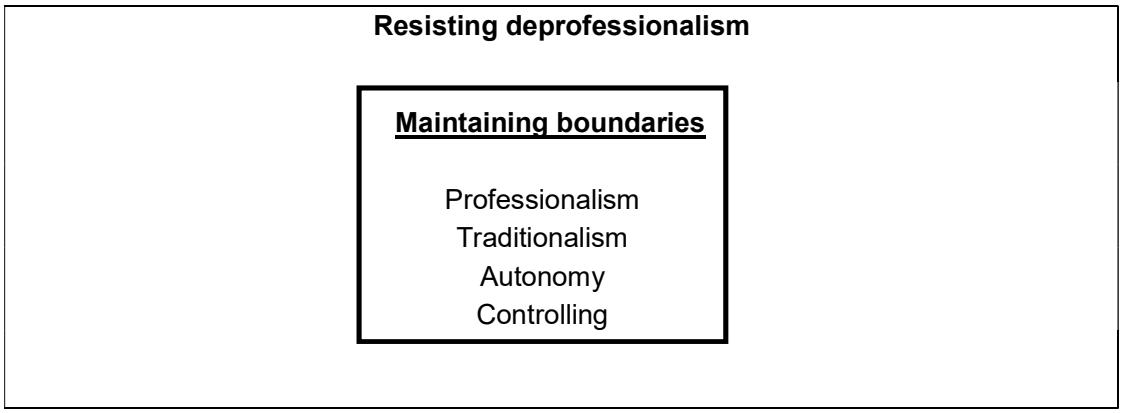

Figure 4 - Resisting Deprofessionalism

4.4.2 Boundaries

The idea that Boundaries must be maintained against the encroachment of others can be seen in the way that other health professionals are now, or are now attempting, to take on work traditionally carried out by GPs. This idea is generally being resisted by GPs, where it is accepted (such as Practice Nurses running clinics) it is because it's beneficial to GPs as it reduces their workloads. This limited work transition is controlled and supervised by the GPs and is deemed to still be within their control. The GPs retain their autonomy and professional control.

Nursing has, over the last few decades, been engaging in an ongoing attempt at increasing their level of professionalism. Nursing work was traditionally carried out by young, unmarried women and was seen as a 'natural extension of womanhood' (Lokatt 2015, p.5). This increasing professionalism is in part derived from the new logics introduced by the Health Service Management teams who seek greater efficiency and accountability, improved education and the fact that gender (i.e. nurses are woman and doctors are men) no longer controls entry into the professions: medicine is losing its patriarchal discourse. One result of this increasing professionalism for nurses is that nursing is gaining considerable influence over the practice of medicine and the traditional boundaries between nurses and doctors are being challenged. From only having the authority to carry out the doctor's orders, nurses are now involved in performing tasks and making decisions which were previously limited to doctors. The rise of the nurse practitioner is seen as a cost-effective way to reduce the workload on doctors and promote the efficiency of the organisation. From a managerial point of view, the profession of the person performing a task is less important than ensuring that the task is completed and it is completed in an efficient and cost-effective manner. This blurring of the boundaries between doctors and nurses is seen as a source of stress to some in both professions. Within the general practice, nurses are being trained to take on work more traditionally done by doctors, and while this is readily accepted most of the time there are also instances, cited in the interviews conducted here, where this is being resisted.

> …practice nurses now have moved over the years to managing these groups of patients, diabetics, asthmatics, heart disease we are managing these patients pretty much on our own.(Practice Nurse)

> 0ur practice nurse also does home visits for us. So she will go out and see our elderly housebound on a less acute level than us GPs. Kind of the sort of people who in the olden days you would have just popped in to see she does that for us. (GP)

> The GPs which I work with don't [write reports or do audits], they delegate those tasks to their senior nurses. (Practice Nurse)

> She [the Practice Nurse] is saying quite clearly this is beyond my level of competence and also the level she is paid to do really because she is paid at a lower level. (Practice Nurse)

Nurses do not want to be given tasks purely as a way of decreasing the doctor's workload or to take the tasks the doctors find boring, they see this as devaluating the nursing profession. The identity of nurses within general practices is being continuously reconstructed.

> We have taken on an awful lot and yet it's never recognised emm so a lot of my other jobs its around trying to work with other groups who can influence that the government to allow us nurses as a professional group to have a voice especially practice nurses because we're are all individually employed so we have nobody to take forward our agenda at all, nobody at all we are all just out there as individuals just trying to do our best and that's frustrating. (Practice Nurse)

The practice of creating Nurse Partners within GP Practices (i.e. the nurse is a full partner in the business of the practice rather than being an employee, sharing any profits or losses made by the business) in recognition of their professional and equal status is one which is being widely rejected by GPs. The GPs appear to see this as a threat to their identity. This blurring of the boundaries between the medical professions can also create a challenge to the professional identity of both the doctors and the nurses. The rise of the Nurse Partners, the practice of allowing nurses to buy into the GP Practice as an equal partner, has not been widely welcomed by Fife GPs – in 2014 there was only one such Nurse Partner despite others seeking the role.

> I have been going on for 15 years about being a nurse partner and people just laugh at me, say oh no we don't want that, it wouldn't work… (Practice Nurse)

> …why would we want to pay a nurse partner who hasn't done the same training as us… (GP)

Nurses, and other professions such as pharmacists, are defending their increasing autonomy while effectively challenging the historical superiority of the medical profession. Medicine has to defend itself, its power and its legitimacy as a profession from both outside sources (i.e. organisational management or health boards) and from overlapping professions. Conflicting expectations from external stakeholders, from patients and from overlapping professions have resulted in boundaries being contested and becoming unstable. There is also the possibility that this weakening of the traditional boundaries has helped to strengthen the influence of patients and patient groups. These boundary threats have forced the medical profession to engage in a continuous negotiation for their previously established boundaries. This blurring of the boundaries is effectively a source of stress and a challenge to the professional identity of GPs. As Kislov et al. (2012) demonstrated when boundaries are changed the new roles succeed best when the existing power structure is not challenged, when doctors are able to retain autonomy, when they are able to provide clinical leadership and retain the right to have overall authority over the team and decision making. Currie et al (2009) support this view; they report that change is acceptable to GPs when it does "…not threaten existing work jurisdictions…" (p. 276).

In America, the rise of the Nursing Practitioner has been impressive, from 30,000 in 1990 to 115,000 by 2005 (Friedman 2008). This has led to tension between the medical profession and the nursing profession, resulting in 'turf wars' (ibid, p. 14) and disagreements over the scope of each profession. Okie (2012) also notes that in America the nurse practitioner is the fastest growing group of primary care workers. It will be interesting to watch the UK to see if there is the same growth in numbers here.

Currie et al. (2012) found that doctors were maintaining their professional dominance by the delegation of more routine tasks to other professional groups such as nurses while maintaining their control of how and when the tasks are carried out. This is reinforcing the fact that the doctor is still at the top of the hierarchy, despite allowing others to do

tasks which had previously been deemed as ‘doctors work’ (Charles-Jones et al. 2003). The delegation of tasks, in reality, causes little upset in the hierarchy of medicine and actually enforces their position as the professional elite (Currie et al. 2012b). Thus, doctors are maintaining the model of medical professionalism, the model which supports their dominance. Brattilana & Casciaro (2012) concur with this model of professionalism, seeing doctors at the apex of the health profession hierarchy. From this, it would appear that changes within medicine tend to reinforce the existing arrangements rather than creating radical change. Currie (2012) suggests that change in healthcare are likely to be “inexorably slow or incomplete, and tend towards the maintenance of pre-existing arrangements for healthcare delivery” (p. 959). However, Currie’s (2012) study used a relatively short time period of 4 years and it may be that greater changes are incremental over a longer time period. Pietro et al. (2000) have shown that professional membership can provide a basis for social categorisation in a healthcare setting and its accepted that professional institutes and the way our society views professions allow the subordinating of other roles to the professional one, i.e. the nurse to the doctor (Cohen 1981).

Having looked at the categories and their meanings we must now turn to creating a theory from the data.

4.5 Building a theory

Having formed the categories and their subcategories these must now be turned into a plausible grounded theory; since merely establishing the categories does not create a grounded theory.

The figure below illustrates the categories and the sub categories which emerged from the interview data.

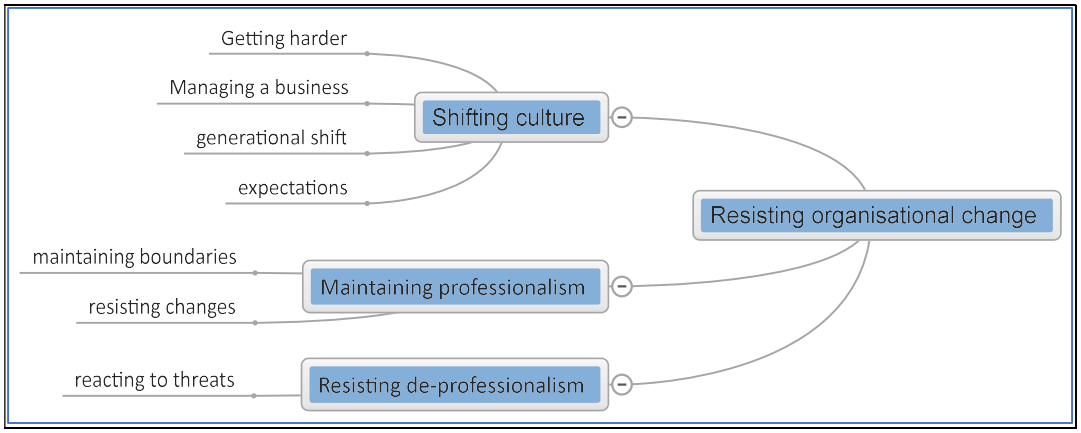

Figure 5 - Categories and sub categories

Establishing how the categories relate to each other is the next step in this process. Asking the categories, who, where and when is one way to do this (Urquhart 2013), these contextualising questions help to explain connections and help the researcher dig deeper into the meanings behind the categories. Charmaz (2006) gives limited guidelines on how to determine how categories are related. Using Urquhart's questions (as above) the 'who' which links the categories is GPs, the 'where' is within General Practices and the 'when' is in response to perceived threats. However, these three questions appear to be too simplified for the current purpose so more in-depth consideration of the analysis is required. Within the grounded theory methodology memos are used to help the researcher understand the data and make conclusions from it.

4.5.1 Memos

As discussed in Chapter 3, memos are an integral part of a grounded theory methodology; they are used to make sense of the data and to help the researcher think through what the data is saying and to make the conceptual leap from developing the categories to establishing the theory. Memo writing helps to clarify thinking processes and Urquhart (2013) provides helpful advice around diagramming how codes and categories work together and how this can complement the writing process

The two memos below were written to clarify thinking about the main categories, their elements and to aid the understanding of them.

Please note – the following memos were written as theoretical memos for the researcher's own use. These have been reproduced verbatim to illustrate the usefulness and purpose of memo writing.

……I think the main categories are 'maintaining professionalism', 'resisting change' and 'resisting de-professionalism'. But are maintain and resisting the same thing? They are the flip side of each other. Maintaining covers the subcategories of controlling, traditionalistic, paternalistic style, developing coping strategies, creating a work-life balance and respectability. While resisting de-professionalisation primarily covers – boundary creep, power maintenance, arrogance. Is resisting change a main category – does it not just say the same as the other 2 categories, it's a result of them? What joins the other 2 categories together? The other categories are a result of being asked to change. Why are they being asked to change? Because the NHS is no longer sustainable – financially, growing population, co-morbidities, cultural changes and so on. The world is changing; the working life of the GP is shifting to fit in with the current world. The culture GPs work in is changing and they are resisting it. Shifting culture covers what is happening better.

Is Shifting Culture a key concept?

The purpose of this memo is to try and clarify a few thoughts around the category shifting culture. The category is quite descriptive but it does cover many of the main categories –it describes how the GPs are feeling. Things are changing. They are under-resourced, burning out, vulnerable, boundaries are changing, and people have less respect for them. The role of the GP is changing; this is the crux of the matter. They fear privatisation, they fear practices closing down because they are not financially viable or they have recruitment problems. They realise that changes are necessary but they don't want to lose who they are or change the way they work. They are prepared to fight. The changes must suit them. The interviews said that GPs were open to changes (eventually) which can be shown that the change is beneficial to patients but ideally changes don't actually affect them. They are happy for small changes (often under the control of the GPs) changes which affect other staff such as changes to nurse's role, nurses taking on more clinical aspects, things GPs used to do. However, not happy to allow nurses to become partners in the practice, there is still very much a 'them and us' attitude. Thus, changes which may seem rational to others they will block because the change doesn't sit within their comfort zone, their self or professional identity. They are resisting de-professionalisation, resisting their loss of autonomy. The shifting culture is present in all aspects of GPs and practice staff issues. Many practice staff believe GPs are not accepting the shifting culture. Ingrained bulling is rife to maintain the GPs power and position – as suggested in several interviews. Everything does seem to relate back to 'shifting culture' and as a result of this GPs are acting to protect themselves.

Following this advice from Urquhart (2013) the following diagrammatic depiction of the categories was developed.

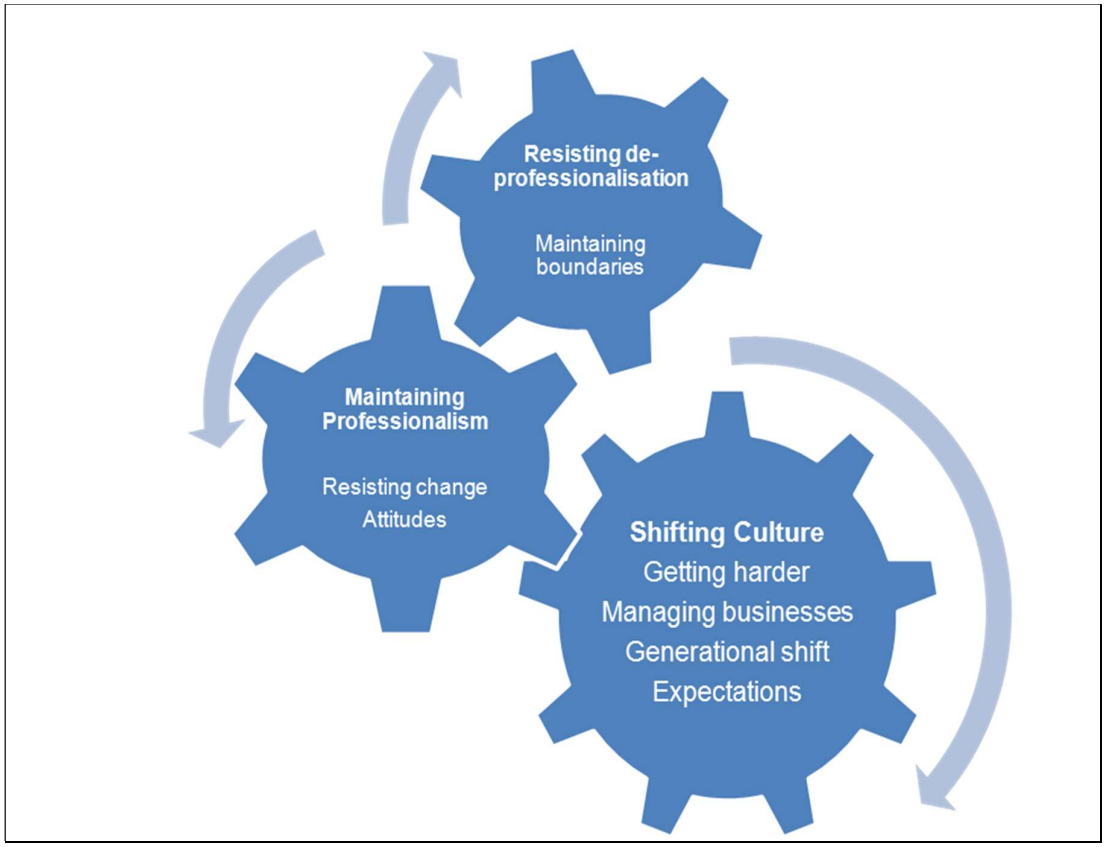

Figure 6 - Categories

This pictorially shows that the cyclic way in which the category of shifting culture is leading to GPs seeking to maintain their professionalism by actively resisting de-professionalisation. The shifting culture is leading to a sense of vulnerability amongst all practice staff but GPs are the group with the power and the ability to make changes happen, or block changes should they see fit to do so. This vulnerability among GPs is leading to them fighting to maintain and defend their professionalism and their professional identity.

4.5.2 Making sense of the data

The analysis of the data has established that staff in GP Practices, and specifically GPs, feel that change is common place within their practices. However, exploring this idea in more depth showed that the changes being experienced were limited and didn't affect the structure of the practice or encroach on the professionalism of the GPs. The changes

tended to be small scale changes to the way people performed their roles and were, reportedly, most often borne by the non-GP staff within the practice.

The changes which the GPs, in particular, were concerned about were the changes which would affect them personally. Changes which they believed would challenge their autonomy, their relationships with their patients, their integrity, and their ability to self-regulate the way they work. In other words, the changes which affect the values and abilities which feed into and form the basis of their professional identity. Changes such as these would result in GPs perceiving their professional identity to be under threat. As discussed in chapter 2, section 2.6, the social identity approach shows how individuals internalise the norms and values of their group and identify with that group. The status attached to being a member of a professional group strengthens the importance of that professional identity, leading to the identity of 'doctor' or 'GP' to become deeply embedded in the psyche of those professionals. This identity related to their profession can take priority over all other identities.

As discussed earlier, in the interviews it was suggested that increasing numbers of GPs appear to be suffering from burn out, they feel under pressure from patients and the Health Board. They are finding their everyday role is becoming more and more difficult and demanding. At the same time GPs report feeling that the values they hold as part of their professional identity - such as doing the best for their patients or autonomous decision making - to be under threat from bureaucracy, from political influences and by the economic reality they work under (i.e. cost cutting efficiencies within their practices and the Health Service in general). Perceiving that their professional values are being threatened is one of the underlying factors which is leading GPs to perceive that their professional identity is under threat.

This combination of the perception that their professional identity is under threat and the fact that they are finding their day to day role to be harder and harder is resulting in GPs actively seeking ways to maintain their professional identity (by blocking changes they perceive as threatening) and resisting de-professionalisation (by resisting boundary changes and management interference). The ultimate result of seeking to maintain their professional identity is leading to them resisting changes which they consider to be threatening either to themselves or their profession.

The starting point of this research was the apparent problem that GPs were unwilling to accept changes to their working practices – demonstrated by the resistance towards the

implementation of the NUKA system (see chapter 5). However, the interview data showed that GPs and practice staff see themselves as being both accepting of change and experienced at making changes. They accept that some changes are necessary and even at times desirable. There is also a theoretical acceptance that change is probably needed if general practices are to continue to provide a service which meets the needs and the requirement of the patients. One of these changes can be evidenced by the growing number of Nurse Practitioners both in the UK and in America. Although it has also been shown that GPs are only willing to allow nurses a pre-determined (by the GPs) level of increased responsibility and are not willing to embrace the idea of Nurse Partners.

The changes, such as with Nurse Partners, which are being resisted are those which are perceived to be a threat by the GPs, to their power, their autonomy, their status, their way of running their business, in sum - their professional identity. Given that in conjunction with the UK, and the majority of Western European countries, America is experiencing the same economic and social issues, this is an international problem and one which is required to be tackled and solved. Unfortunately, despite this being a widespread and acknowledged issue, there is no clear consensus on how Scottish, or UK, general practices can or should change to meet the needs of today's patients; of how they can change to meet the social, political and economic requirements facing them. In the meantime, as a result of there being no coherent plans to change or restructure general practice, there are currently practices in Scotland shutting to patients rather than making the changes required to enable them to continue to run as profitable small businesses[3].

The analysis of the interview data revealed the emerging theory that GPs are willing to accept changes to their working practices, as long as the changes are within what they consider to be reasonable boundaries. These tend to be minor, not substantial changes, changes which do not affect them too much. GPs considered changes which allowed them to remain in control of the practice to be acceptable, but anything which appears to threaten their control, their autonomy or their professional identity is not considered to be acceptable. Changes which are considered to not be acceptable are being resisted. The route of resistance is to block changes. However, the changes are not being blocked merely because they are 'changes', this was shown by the data analysis. The over-riding concept which emerged as a key theme, alongside change, was professional identity. It

[3] http://www.pulsetoday.co.uk/hot-topics/stop-practice-closures/over-8000-patients-set-to-be-displaced-in-latest-gp-practice-closure/20010497.fullarticle

became apparent that changes were being blocked because they are perceived as being a threat to the individual's professional identity. Therefore, it follows that when developing changes the strong professional identity of the GPs and practice staff must be taken into account, not just given a cursory nod if the planned changes are to be successful. Simply telling GPs what to do will not work as the GPs are used to being autonomous, the leaders and the decision makers; following orders from others is not part of their identity.

4.6 Summary of the chapter

This chapter discussed the emerging categories arising from the analysis of the interview data. It determined that Primary Healthcare staff are open to changes and accept the theoretical need for them. This is significant as it shows that staff are open to change and it confirmed that the context of that change is important; in other words, it is important how the change is presented to and justified to staff. The data also showed that GPs are not willing to accept changes which they consider a threat to their professional identity and, importantly, they are prepared to resist these changes. This finding inevitably leads to questions around what changes GPs will perceive as threatening, and how they are able to resist changes. Both of these questions will be discussed further in chapter 5.

The discussion then turned to the results of the analysis of the questionnaire data. In chapter 3 there was discussion about the difficulties associated with introducing a second methodology into the research design. However, the results from this second wave of data collection clearly confirmed and strengthened the findings of the first wave. Consideration has been given to existing literature and where it was found to substantiate these findings it was included here. As discussed within the methodological chapter (chapter 3) since this research was conducted using a grounded theory methodology the literature was consulted in tandem with the data analysis and helped guide and confirm tentative theories.

The following chapter will continue to discuss the emerging theory using existing theories, conceptual models and established literature. Doing this will provide support to the emerging theory that among Healthcare staff, and General Practitioners in particular, there is a feeling that their professional identity is being threatened by the organisational changes being imposed on them by the Scottish NHS and society in general, and will lead to suggestions about how to overcome this perceived threat. Finally, there will be discussion around how this theory can be of use to those concerned with organisational

changes in the NHS in Scotland. It is also important to recognise that this theory, although developed purely within the Scottish healthcare system, may be of relevance to other healthcare systems, both domestically such as within NHS England and Wales and also more internationally within other countries experiencing similar issues.

Chapter 5 Discussion

5.1 Introduction

This chapter discusses the relevance and importance of the findings presented in chapter 4. Having performed the analysis of the interview and questionnaire data, and situated it within the relevant established literature, this chapter will now consider how these findings, and the categories which have been detailed, can be logically developed to create a grounded theory. Martin and Turner, when discussing the use of grounded theory in organisational research, explained that an emerging grounded theory should provide a 'carefully crafted account of the area under investigation' (Martin & Turner 1986, p143) and that the account that emerges should be recognisable to those in the situation. This theoretical explanation, or emergent theory, which is grounded in the data, then facilitates discussion around the topic in question: the aim of this chapter.

Situating the emergent grounded theory within the established academic landscape allows for discussion of the theory and enables us to highlight the various ways in which the emergent ideas presented here supports and adds to the established academic theories. Firstly, the discussion will contemplate how these findings sit in the field of organisational change before considering why professional identity is an important consideration and the barriers to change which it can potentially trigger. The failed Nuka trial and how it highlights a change in which professional identity was not considered will be briefly discussed and the ways in which this knowledge about professional identity can aid the current integration agenda between health and social care.

The theory presented here aims to understand the extent to which professional identity affects the willingness of those within primary healthcare units, especially GPs, to accept fundamental changes to their working practices, and also what the relationship between professional identity and processes of change is. In doing this, the thesis makes two contributions to established theory:

- Firstly, it contributes to the organisational change literature by developing a grounded theory which demonstrates the role of professional identity in resistance to change. As discussed earlier, the role professional identity plays within resistance to change is not well researched in the field of organisational change (Beaulieu et al. 2008).

- Secondly, the thesis demonstrates that an alternative model to the traditional linear change model is required and discusses how change is more likely to be practically achieved by giving attention to issues of professional identity in change situations

In the concluding chapter, these ideas will be further expanded upon by demonstrating how this information was practically translated by the co-founders of the research - Fife NHS - and how the information was used to impact on organisational work they were planning.

However, this chapter starts by considering organisational change within the arena of primary healthcare.

5.2 Phase 2 – data from the questionnaires

Phase 2 of the data collection was undertaken partly to ensure that all the categories were fully saturated and partly to confirm the analysis of the interview data and the emerging theory. The questionnaires were a mixture of open and closed questions (see Appendix 4). The two open questions generated 153 comments. These comments were coded and entered into NVivo in the same way as the data from the interview data. Only one totally new code which was created from this analysis – privatising – two other codes - unrealistic demands and recruiting crisis - were also created although they were similar to existing codes and later amalgamated with those existing codes. The issues surrounding changes to the NHS in England and Wales and the changes to their funding were not mentioned in the interviews so this code wasn't developed during the interview phase. However, the fact that many of the answers to the open questions raised points which were categorised under privatisation was interesting. The fact that no other new codes were developed indicates the existing categories were fully saturated. Although initially analysed separately, once the data from the questionnaires were fully analysed it was integrated with the data from the interviews to give a full picture.

In response to the question, *'I feel a threat to my ability to help my patients'* 57% of the total respondents agreed, 11% didn't know and 30% disagreed. GPs specifically, 64%, felt a threat (27% disagreed while 3% didn't know) indicating that a core tenet of professional identity, being able to help patients, is thought to be under threat.

When asked the question 'I feel we are facing radical changes within healthcare' 87% of respondents agreed, 4% disagreed and 9% were unsure. This showed quite clearly that the Primary Healthcare staff who responded to the questionnaire are fully aware that changes are to be expected. This confirmed suggestions from the interviews. Out of the GPs who answered all but 1 thought they were facing radical changes. Of the GPs who answered the questionnaire, 79% feel threatened by changes to the way they work and 49% responded that they are expecting to have to fight against changes to the way they work. This statistic contrasts with the responses from staff who aren't GPs – only 30% of them feel threatened by changes. This can be explained by the fact that they are employees of the GPs or the Health Board rather than contractors like the GPs.

When asked to comment on their concerns about changes, 76 responses were received. The greatest concern was around the increasing patient demands/workloads and the shortage of resources to meet that demand (38 mentions) followed changes to structure – either management or service structure – (20 mentions) and finally there were 17 mentions of the worry of privatisation.

> …more pressure on primary care to carry out secondary care services (GP)

> …reduction of inpatient services with a move to community care (GP)

> Privatisation of services, less GPs (GP)

Out of all of those who thought they would have to fight against changes to the way they work over the next 12 months, 49% of GPs thought they would have to fight along with 44% of non-GPs.

When asked what their biggest current concern was, 77 staff made comments. 39 of these comments, so more than half of all comments, related to staff shortages, recruiting issues and work overload.

> Shortage of GPs (Practice Nurse)
>
> Vacant positions (GP)
>
> Not enough GPs in house… (GP)
>
> …already overstretched and under-resourced (Practice Nurse)
>
> Continually increasing scope and intensity of workload in primary care with reducing GP numbers, resulting in longer hours and unsustainable stress levels. This job is just too hard now. (GP)

Other comments related to the closure of local services, reorganisations which have no benefit, lack of leadership and privatisation.

One impression received from the analysis of the interview data was that possibly staff, especially GPs, were under the impression that the role they were doing was not one they felt they had trained for – there were several mentions of non-medical aspects taking over their role. To follow up on this idea the questionnaire contained a question asking if primary healthcare staff felt they were satisfied that they were doing the job they felt they had trained for - 54 out of 94 respondents agreed that their role did meet their expectations. For GPs, 58% agreed that their role met their expectations while 27% disagreed (5% were unsure). These results would seem to indicate that the majority of GPs were happy with the content of their role, in that it was what they expected when they trained. This is a good example of using the second wave of data gathering to confirm or dispute an earlier impression.

As with the earlier interview data memos were written to help make sense of the data being analysed. The extract from a memo, below, was written to clarify thinking around what the questionnaire data had actually told us.

Please note - these memos were written as a theoretical memo for the researcher's own use

This memo is about what the questionnaire responses mean and how they back up the interview data.

The responses confirm differences in how GPs and other staff think – differences in responses to some questions. However, the majority of all staff thought radical changes were coming and half of all GPs expect to fight against them. This fact in itself is important as it helps Fife NHS realise the scale of the opposition they face to structural changes. Concerns around recruitment, quality of care were all covered in the interviews. Privatisation was a new concern, but none of the interviews had asked about that so unsurprising. Surprisingly the response to the question about fit as positive as I thought it would be, blowing the idea of a disconnect between expectations and reality out of the role…….

Therefore, the analysis of the responses to the questionnaire backed up the interview findings. It also helped to show the extent to which the staff are concerned and the scale of the resistance which the Health Board may have to face to any organisational changes.

5.3 Change is inevitable

As discussed in the introductory chapter, changes within the NHS are inevitable and as part of this, professional identities within the medical profession are now being challenged in an unprecedented way (Iedema et al. 2004). As noted previously the profession is being affected by scientific and technological advances, government pressures, public pressure for increased transparency and the perceived threat to clinical autonomy from evidence-based medicine. Okie (2012, p1849) notes that the standing, the role and the responsibility of the GP is 'rapidly evolving'. In fact, it has been argued that medicine today bears little relationship to 25 years ago and likewise, the current role of the GP will be obsolete by 2025 (McKinlay & Marceau 2008). This is argued on the grounds that:

- other health care professional are taking over the role of the GP;
- one of the unintended consequence of clinical guidelines is to reduce the doctor's role to one which can be performed by other health care workers;

- the role is becoming unattractive and fewer trainees are entering the primary care training programme;
- the doctor-patient relationship will be changed as a result of internet access and consumerism.

Analysis of the data gathered from the interviews and questionnaires conducted as part of this research, showed that the majority of GPs and Practice Nurses are aware changes are necessary and some see them as inevitable. Del Mar et al (2003) writing about the situation facing General Practitioners in Australia suggests that the GP crisis is evidenced in five ways:

1. GPs earn less than other medical specialists

2. Health care is generally hospital-centric and the GPs are out with that system

3. Recruitment issues for GPs

4. Limited opportunities for research within primary health care

5. Patient trust is dwindling while expectations are increasing

While this list was written about the crisis facing Australian GPs, data from this study shows these points are broadly applicable to the GPs studied here, suggesting that a GP crisis is also in evidence in Scotland, if not the UK. Issues around recruitment were raised in the interviews and in the questionnaires and this is seen to be an increasing problem, while the limited opportunities for research can be seen from the way many GPs have more than one role (one GP in our interview also worked as a university lecturer) and choose to work part-time to accommodate other interests. Patients are generally considered to have less respect and trust for doctors now than a generation ago, which is adding to the medical professions' perceived erosion of professional identity, and many within primary healthcare feel there are definite barriers between them and the secondary sector. These changes are all seen as a threat to the GPs professional identity.

The stress of current working conditions coupled with the fact that many know that substantial changes, culturally and structurally, are required, is inevitably going to lead to stress and disillusionment within the primary healthcare sector. This suggests damage-limitation should be undertaken in the form of blocking changes to minimise disruptions which are going to affect the system. However, this is not likely to be a practical solution to the problems being experienced, as organisational change seems to be required. Thus,

if GPs are to continue to provide their pivotal role within the NHS, policy makers must be aware of how GPs are experiencing the pressures and how they perceive the potential changes, how they consider their identity to be threatened and take this into consideration when planning changes. Changes must not only minimise work-related stress and economic challenges but must also address identity issues.

Identity work is important for three key reasons, according to Alvesson et al (2008). It can help us to understand organisational and individual experiences; it can expose concerns around political or cultural issues and it can help identify and engineer solutions within organisational changes.

5.4 Organisational change

It is well-established that any organisational change manager must be mindful of the potential barriers which can hinder or block their desired change (Scott et al. 2003). Despite this knowlege, much of the organisational change literature to date is dominated by management ideology (Hotho 2008). This is surprising given that it is well evidenced, as discussed earlier, that change within primary healthcare is inevitable.

The data gathered in this research has highlighted that there is resistance to change among primary healthcare staff. It has also been discussed and evidenced, via the example of the Nuka project, that this resistance is a barrier to any attempted organisational change. This thesis theorises that perceived threats to professional identity are at the base of some of this resistance to change. This is an area which has not been fully researched within the organisational change literature. It is an area which it is important to consider because the need for structural changes are currently being brought to the fore in wide-ranging discussions about how to create a viable NHS which can be successfully supported going forward.

5.4.1 Transition theory

Within this research, both the quantitative and qualitative data showed that the Primary Healthcare staff and especially the GPs are aware the way they work has to change, they are aware change is coming, they accept this and they also accept that they cannot continue as they are. However, Bridges (2011) consider the term ‘change’ is not helpful,

not inclusive enough. Bridges states that organisational changes are not purely about change – he defines change as 'situational' (ibid, p3) such as the move to a new building, system or a process change - while 'transition' is the psychological process people go through when faced with a change. What is important is the way people rationalise the change and come to terms with how the change affects them. Bridges (2011) claims transition is the cerebral process which people go through to move from the old situation to the new, it can take time and it cannot be planned or managed by a rational formula. People, after all, are not automatons who will always react in predictable ways (Graetz & Smith 2010). The transition is deemed to have three phases: the Ending Phase; the Neutral Zone; and the New Beginning. In the Ending Phase the old order, or identity, is phased out. It is in this phase that most resistance to change is experienced. The Neutral Zone is seen as the in-between stage, the settling-in stage, while the New Beginning Phase is the final adjustment to the new order or process and the acceptance of it.

Under Bridges's transition theory, the Primary Healthcare staff and especially the GPs interviewed here are still in the Ending Phase – they are aware change is coming, they even accept that they cannot continue as they are, but as a group they are not yet ready to move to the neutral zone and so are still generating resistance. This research has shown that the primary health care staff are aware that organisational changes are probably necessary and some are beginning to anticipate them. Quotes such as those in chapter 4 about the category of changing culture evidenced this. This awareness places the change agents in a good starting position for gaining acceptance for their proposed changes. Starting a change process without that acceptance is considered to be difficult (Drummond-Hay & Bamford 2009). Interestingly, Armenakis & Harris (2009) suggest the use of the term readiness rather than resistance. They present a readiness model (ibid. p. 133) for change, suggesting that change managers need to consider where on the readiness spectrum recipients for change are and plan appropriately. This idea is strongly supported and extended by the data findings in this research. Building on this research by Armenakis and Harris (ibid) this research suggests that professional identity should be considered as a characteristic of the change recipient which affects how the individual reacts to organisational change.

Iles and Sutherland (2001) suggest that systems thinking would be a good methodology to use within planned changes in the NHS, as with its explorative and scientific approach it should appeal to clinicians and allow them to explore their perceptions of the change and the difficulties they perceive from it. Indeed, within the dissemination of this research

the initial meetings which were held with Fife NHS Integration Team, to discuss the findings and how the findings could be used in practice, started with soft systems methodology (Checkland & Poulter, 2010) to explore the starting point of the team. Systems thinking is a useful technique to use in this situation and the suggestion to use it within NHS when planning changes would bear further investigation. Indeed, use of this methodology could be a recommendation for potential future research.

To summarise, any changes initiated by Management, in this case Fife Health Board, need to be initiated with the full awareness as to which transitional phase the staff occupy – in this research the staff interviewed were shown to be in the Ending Phase. This will allow the change agents to design a change programme which accommodates the reactions they reasonably might expect. This is important because unless the change agents begin by addressing the current concerns of the staff they will not be able to help them to move to the next phase.

Applying the Transition Theory to organisational change in the healthcare sector would allow people with strong professional identities to work through the transition brought on by a change. It would allow them to work through the change without perceiving their professional identity to be threatened, and allow change managers to expect, accept, and plan accordingly for resistance in the Ending Phase. Change managers must design organisational changes to accommodate these transitions, rather than viewing the change as a series of practical steps. Ultimately, organisational changes are only achieved if those affected accept them and change accordingly. Unfortunately, when the organisational change involves changing strong, established professional identities it is going to be a slow process, and that must also be accepted and planned for. For instance, GPs are generating resistance to change plans because they are worried about the possible loss of part of their identity as they perceive they will lose a degree of medical autonomy. Despite this being a fear which is not verbalised it nevertheless needs to be recognised, considered, addressed and resolved.

Having discussed organisational change the discussion will now move on to consider professional identity and what happens when professionals, in this instance the primary healthcare worker, perceive changes will affect or threaten their identity.

5.5 Professional identity

Having discussed Organisational change this debate will now turn to professional identity. As was established in Chapter 2 insights from Social Identity and following from this, Professional Identity and its different aspects are used to consider the phenomenon observed within this research.

5.5.1 Medical education

Medical and nursing education is as much about the development of professional identities as it is about teaching medicine to doctors and nurses. As discussed in chapter 2, the transition from student to doctor or nurse is not simply about attaining an academic standard, but about internalising an identity. It is currently argued that students in both nursing and medicine are instilled with a strong professional identity which 'perpetuate hierarchical disciplinary boundaries' (Langendyk et al. 2015. p1). Understanding the processes through which these students develop their professional and social identities will help provide the best education for future health professionals (Monrouxe 2010). Although it is the further identity shift, from hospital doctor/nurse to GP or community/practice worker, which is what we are most concerned with here, the initial step from student to professional is undoubtedly the most profound. The current system of students modelling the behaviour of existing professionals, also known as the apprenticeship model, is probably not the best one for modelling a modern doctor-patient relationship in the 21st century. The current system perpetuates the existing model of professional identity. Therefore, if professional identity is to be remodelled to allow for organisational changes this must be initiated from the very start of the educational process.

This agrees with research which shows that medical education should evolve to include inter-professional education (Burford 2012; Langendyk et al. 2015). This aims to aid the understanding each professional group has about each other and remove any stereotypical views they may hold. It has been suggested that students should be taught that they share an identity, that they are all health care professionals, and that higher or lower status groups within that over-arching group should be identified and challenged. It follows that social identity work in relation to teamwork should take professional identity into account (Burford 2012). The interview analysis showed that many nurses and practice

managers felt that the GPs were not ‘team players’ and this hindered their day to day working practices as well as, at times, limiting the GPs acceptance of changes.

Social identity can also affect how inter-professional teams transmit and receive information, how they communicate in other words (Burford 2012). During interviews, the difficulty of communication between the primary and secondary healthcare sectors was identified as a problem several times. GPs complained that secondary healthcare workers considered them to be less important than the Hospital Consultants.

The professional identity generated by education is taken into the workplace and creates the culture of that workplace, especially in the area of a GP Practice where the culture is generated by the leaders and owners of the practice – the GPs.

The professional identities of the GPs within the Nuka trial and the culture which they created as a result of that identity were in part blamed for the failure of the trial. Indeed the Practice Manager revealed that they personally thought it was the culture of the GP Practice which had ultimately caused the failure of the trial. With hindsight, many months later and after a discussion about identity, the Practice Manager said

> …but the cultural, the deep-rooted cultural challenges weren’t adequately addressed before testing that particular model and I think that if we had gone into that at the very beginning then we would have discovered the practice wasn’t suitable for testing.

The Practice Manager felt the practice was too paternalistic to adapt to a new model of working:

> …[the practice was run on] a paternalistic medical model. It’s very hierarchical if you’re the doctor then you are better than the staff and the patients…

Another staff member said that:

> ...they [the GPs] didn't want to work as equals with their team members. They put up petty barriers like what if we don't like the team we're allocated to em they didn't like the idea of small team working and they didn't like the idea of having their own list they wanted to share patients and sometimes when you have challenging patients it's easier to let them go around the system rather than see through their own management and by having a list you would actually have to see through their management. More challenging for people…(Practice Nurse)

However, it isn't just the GPs in this practice who were having problems with the working ethos behind Nuka. One comment from a member of staff who was involved in the pilot was that:

> I've been involved in delivering teaching to SG3 registrars, level 3 registrars on practice management and in one of the sessions we covered innovation and had a look at some models which are going around including Nuka and they were, some of them were definately interested in it but an equal number were vehemently against it you know, I didn't come into general practice to practice this way I want to have special interests and this model doesn't allow me to do that em it puts on a terrible onus on the doctors having to see the same people for years em you know there is more cause, more potential for error so there is a lot of resistance even from the registrars and it made me realise there is something fundamentally wrong with GP education which needs to be, for this model, for the paternalistic model its perfect but for a more relational model its not the right people. (Pratice Manager)

Other staff, when asked why they thought the project failed cited issues around leadership and autonomy and the cultural norms doctors expect:

> I think it's that difference between leadership and management and how you involve the staff with the decision making and the change. We're very keen to do that but I don't think it's a set of skills which come naturally to doctors necessarily …..but it wasn't something we were used to doing but as GPs I think we like autonomy we like us managing the patient and we get on with it so when you involve other people although we are happy to team-work there is a difference between team working and involving the team if that makes sense (Practice Manager)

Team-working, where the whole team is involved as equals, is integral to the Nuka model. Real teamwork means doctors are 'in the team, not above it', and improving coordination of care means doctors must show deference to the views of other clinical and non-clinical staff. This, as was also highlighted in the interviews, is something that many GPs struggle with.

Taking social and professional identity into account from the start of a professional's education will help to iron out some of the issues currently existing in primary healthcare between team members. Education will better facilitate an identity in GPs which is more in line with the role (leading a multi-professional team) which they need to inhabit in the coming years if organisational changes are to be successful.

5.5.2 Fit and environment

Analysis of the interview data led to the conclusion that a lot of GPs and Nurses were, for various reasons, finding their jobs stressful. This stress was, as discussed in chapter 4, leading to a degree of burn out and resulting in doctors and nurses working reduced hours and even leaving the profession altogether. Analysis of the data suggests that environmental changes, including societal expectations and pressures, are affecting those working in Primary Healthcare resulting in a degree of professional inertia, and thus resistance to change. This inertia, in turn, increases the stress felt by people and therefore increases resistance further. The result of this is people leaving their profession as their roles become less and less attractive. The diminishing numbers in the profession, and with fewer trainees being attracted to the profession, is in turn leading to recruitment problems. It would appear that the environment of GPs is affecting their professional 'fit'. This poor 'fit' appears to then lead them to resist change.

One of the most widely cited theories of stress is the Person – Environment Fit Model of Stress (French et al. 1982). This theory defines stress as the "lack of correspondence between characteristics of the person (e.g. abilities, values) and the environment (e.g. demands, supplies)" (Edwards & Cooper 1990 p.293). When an individual and their environment fit there is thought to be a positive emotional or physical outcome such as a sense of satisfaction and improved overall well-being. A lack of correspondence or agreement between the two can lead '…to harmful psychological, physiological and

behavioural outcomes, which eventually result in increased morbidity and mortality.' (Edwards & Cooper 1990, p.293).

For GPs working in the NHS it can be argued that comfort, safety, autonomy and possibly also status are under attack. Hence, the large numbers of GPs leaving their roles by taking early retirement, switching careers or reducing their hours.

The degree of flexibility within an individual or environment will affect the extent to which an individual can tolerate a lack of match between abilities and requirements and/or values and reinforcers (Winter 2009). When the individual and the environment no longer match, or fit, a degree of adjustment is required. This adjustment can be the individual attempting to change the environment (active adjustment) or the individual endeavouring to change their behaviour to better fit the environment (reactive adjustment). The extent to which a person keeps trying to adjust before giving up is called persistence.

Given that this research was conducted using a grounded theory methodology the field work and analysis were conducted at the same time. As the analysis continued the literature was interrogated to promote sensitivity to the findings. Findings from the first wave of data suggested that the Environment – Fit theory might provide an understanding of the findings and strengthen the theory. The decision was taken to test this idea in the questionnaire which formed the second wave of the data collection. The question 'I feel I am not fulfilling the role I expected' was designed to determine if people did feel a misfit in their role. Surprisingly the response indicated that 58% of GPs were happy with the content of their role, although this was just over half of the sample, this might suggest that for the sizable number of GPs there isn't a misfit between their environment and fit. However, given the basic nature of the questionnaire, this finding would bear deeper investigation.

5.5.3 The evolving GP

Given that change is considered by many to be inevitable what might that change look like? The doctor's role is already changing as a result of advances in technology and medical knowledge. In America, there are growing numbers of Nurse Practitioners (Okie 2012), and this also seems to be happening in the UK with nurses taking on more and more of the traditional GP tasks (running clinics for chronic conditions for instance). With the rise of inter-professional team working is the GP set to become a key part of the team,

spending more time supervising and dealing with administration than performing patient care? This change is something a lot of GPs, according to the data analysed here (chapter 4, section 6), are willing to fight against. GPs are willing to fight to maintain their status quo and by extension their professional identity.

5.6 Why is professional identity important?

Having discussed professional identity above we will now consider why professional identity is important. We have previously (in chapter 4) discussed aspects of professional identity such as boundaries and the ways in which they are used to maintain professional identity. We also discussed stress and how stress and burn out effect professional identity and how professionals deal with identity threats. We will now bring this together to look at what happens when a profession feels that their boundaries are threatened by organisational changes.

5.6.1 Ontological security

The concept of ontological security, taken from both sociology and psychiatry, refers to the behaviour and beliefs of individuals giving them a sense of security. Giddens (1991) refers to ontological security as when a person has a positive view of themselves, of the world and of their future. In sociology, ontological security addresses the ways in which an individual's beliefs and behaviour are inter-subjectively constructed. Identity is one of these constructions so it follows that a strong professional identity helps to provide an individual with a strong sense of ontological security. A threat to that identity, such as an event occurring which is not consistent with the meaning of an individual's life, will threaten an individual's ontological security. Alvesson (2004) suggests that a stable self-identity – or ontological security - is required for an individual's wellbeing within the uncertainty of the working world. A threat to that security can result in the individual feeling threatened (Croft 2012) and reacting to the threat. Croft (2012 p.223) discusses how individuals who feel threatened will take action which 'conform to his/her self-identity'. In the context of this study, an organisational change which is seen as threatening to an individual healthcare worker or to a group's professional identity, could be perceived as a threat to an individual's ontological security and thus be resisted. Therefore, for a change process to

work in an environment such as healthcare, where strong professional identities are held, identity must be taken into account and specifically built into the change process.

5.6.2 Shifting boundaries

Within the medical profession, boundaries have been historically set between medics, nurses and allied health professionals. In modern day medicine, care is delivered by a multitude of professional groups, each with their own distinctive professional identity and culture. However, many of these traditional boundaries have remained. Boundaries are used as a way to preserve identities: professionals use their roles to preserve and defend their traditional boundaries (Powell & Davies 2012). Boundaries are often used to demarcate disciplines, and can also be used to separate specialities within professions. Therefore, boundaries are a product of people. They are often multi-layered, Midgley (1992) talks about primary and secondary boundaries and about the value judgements and rituals associated with boundaries which help to strengthen them. Powell and Davies (2012) demonstrate how well-established boundaries can have a strong impact in healthcare settings and on how people work together. Within a changing environment, these boundaries must be taken into account, and consideration must be given to how changing or threatening these established boundaries may impact identity. De--professionalisation, see chapter 4, can also be seen as a threat to boundaries and as such resisted.

An example of how professionals react when their boundaries are threatened was evidenced by the 2016 Junior Doctors strike. Within the English NHS, Junior Doctors had chosen to run a series of one-day strikes resulting in only emergency cover in hospitals, i.e. all routine or planned operations and procedures being cancelled. Superficially the argument between the doctors and the Government may have appeared to be about pay and conditions and was frequently reported in the media as such, but in essence, it was about an attack on components of the doctor's professional identity. Arguments about pay and conditions have always existed; this is not a new argument, so the question has to be asked why did Junior Doctors chose to strike at that point? When this question was put to the doctor's leaders, they claimed their action was not purely about how much money they were being paid and how many hours they were being asked to work. They said that they were concerned that they would have less control over their conditions, and over how much, and when, they worked. In reality, the Junior Doctors were reacting to resist or block

an organisational change which threatened components of their professional identity and the forcible moving of professional boundaries by the Government. Autonomy and self-regulation, two of the building blocks of a profession, were being challenged by the Government and the Junior Doctors resisted this change by carrying out strike action. It can be argued that the Ontological security of the doctors was being challenged – they were being asked to make changes to their routines, to their behaviours, to the organisational structure they were used to.

5.6.3 Resistance to change

The term resistance used in organisational change at its simplest means 'pushing back' (Deetz 2008). Existing research (Eilam & Shamir 2005; Elstak & Van Riel 2005) shows that there is a link between identity threat and resistance to change but it doesn't show if different threats affect how individuals react to that threat. Traditionally, resistance to change has been viewed as 'collateral damage' (Pieterse et al. 2012, p.800) when attempting organisational changes. Schilling (2012) suggests that the difference in reactions from professionals to threats depend on the extent to which they are given the power to shape the change and the roles which arise from the change. Research so far carried out around threat and professional identity doesn't include the context of the medical general practice. This appears to be a gap in the literature (Kuipers et al. 2013).

5.6.4 Street level bureaucrats

The analysis of the interview data showed the inherent tension felt by primary healthcare staff between the ideals and the realities of their practice, the 'what should be done' versus the 'what is actually done' (see chapter 4 section 3). This demonstrates a parallel with Lipsky's theory of Street Level Bureaucracy (Lipsky 1980) which showed that service workers are caught in a dilemma between meeting the goals of their organisation and meeting their client's requirements. Lipsky defined street-level bureaucrats as 'public service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work.' (Lipsky 1980, p.3). Although it could be argued that GPs are not true public service workers, Lipsky considered doctors as part of his study, Lipsky did define street-level bureaucrats in terms of their work situations and GPs do share the characteristics required by workers in the study (Checkland 2004). One

of the main arguments against including GPs in this theory is that GPs are not employees but independent contractors. However, given that the autonomy of GPs is being eroded by external constraints, targets and limited resources this line of argument is becoming less and less applicable.

Lipsky (1980) stated that public workers, in an attempt to reduce the gap between their organisation's requirements and their client's requirements, do not always deliver services in accordance with the rules of the organisation. Instead, they adjust their working practices in order to manage that gap between what is expected of them and what they can realistically deliver under the confines of the structural reality of their job. This thesis supports this by showing how many GPs feel they are not providing a good service; GPs are passing off work to nurses and other health professionals, and they are implementing initiatives possibly not as originally planned by the Health Board but are modifying them to suit their different contexts. This thesis contributes to this theory by showing that primary healthcare workers are shifting between meeting their patient's needs (by changing what they offer patients, accepting changes to the doctor-patient relationship and so on) and meeting their own needs (by working fewer hours, having a better work-life balance, maintaining their professional identity) without compromising the requirements of the Health Board.

Top-down models of organisational change have been criticised for "failing to appreciate the influential role of front line staff –'street-level bureaucrats'" (Hudson 2002. p. 9). Bottom-up models allow for the actors (in this case GPs and health care staff) to have a greater say in the changes being proposed or implemented. Taking this theory into account, it is reasonable to conclude that a bottom-up model would work best for powerful groups like GPs.

5.6.5 Faultlines

Closely aligned with change and social identity theory are faultline theories. The concept of faultlines was first introduced by Lau and Murnighan (1998). According to Gover and Duxbury (2012) this theory was developed as researchers were considering whether or not diversity among team members resulted in increased creativity and positive outcomes for the team. Unexpectedly, the evidence showed that non-diverse teams were often most productive and the faultline theory was generated to explain why this was so. Initially,

faultlines, or divisions, were thought to occur as a result of the multiple demographic attributes which can divide a group. The example given by Lau and Murnighan is of a group being split into male and female subgroups. In other words, men identified with men and women identified with women. The more characteristics, such as gender, age, and ethnicity, for instance, held in common by the sub-groups the stronger the faultlines become.

Faultlines can also be a result of non-demographic attributes such as personal values, education, work experience or identities. Within the medical profession, faultlines can be seen to occur between different but allied groups such as doctors, nurses and physios. It is generally accepted that faultlines can be hidden until triggered by an event (Jehn & Bezrukova 2010), change and the resistance to that change can be seen as a triggering event. Indeed, Chorbot-Mason et al. (2009) confirmed that identity can be one of the possible triggers for an event which results in the generation of a faultline. Strong faultlines can have negative effects on group cohesion. Work on the effect of organisational change within medicine and faultlines is limited, Gover and Duxbury (2012) being one of the few to have considered this, and they considered it in relation to change within a Canadian hospital. Their finding showed that as a result of organisational change faultlines occurred between clinical and management staff, in other words, they suggested that faultlines were generated by professional identity. This example shows the clinical staff combined against the change agent – management - to resist the change. Gover and Duxbury highlighted that an organisational change generated a faultline, the faultline was caused by social identity and an organisational change. This highlighted the significance a specific change can have within the context of faultlines.

The example given above suggests that change agents need to be aware not only of the identities and group dynamics before initiating a change but also how the recipients will view the change – they must consider if the change is one which will trigger resistance based on the grounds of professional identity. The analysis presented in this research would further confirm this. The analysis presented here strongly confirms that professional identity must be taken into account prior to the implementation of any organisational change as well as the perceived effect the change will have on that identity. It would be interesting to consider if a faultline occurring in primary healthcare as a response to an organisational change would develop across professional lines (i.e. GPs versus other primary care staff such as nurses, pharmacists, Health Visitors and so on) or between clinical staff (nurses, doctors and so on) against the Health Board initiating the change. In

other words, would the faultlines develop as a result of a specific professional identity or as a result of a clinical identity? Interestingly, in the 2016 Junior Doctor strikes nurses and other healthcare workers have shown their support for the doctors but there have been questions raised as to whether in the same circumstances doctors would have been as supportive to nurses or other colleagues.

5.7 Resistance is being generated by professional identity

Following analysis of all the data collected, using a grounded theory methodology, the conclusion drawn is that healthcare workers and in particular GPs, when faced with organisational changes, which they perceive to be a threat to their established way of working, have a tendency to attempt to resist the change. It is well established that healthcare workers, and especially doctors, have a very strong sense of professional identity. Although this identity forms an integral part of that individual's social identity, it is often not an identity they are able to articulate.

Resisting changes as a way to protect one's self from damage or loss is well documented within the organisational change literature (Van Dijk & Van Dick 2009). Healthcare workers and especially GPs resist changes they perceive to be a threat to themselves in an, often unacknowledged, attempt to maintain their existing professional identity. As part of maintaining that identity, healthcare workers are also, at the same time, actively resisting attempts at the de-professionalisation of their specific branch of the medical profession. De-professionalisation can be identified as losing autonomy, losing respect or losing the ability to perform their role as they wish to.

The following diagram (figure 4) depicts a representation of the way resistance to change is generated within a professional field.

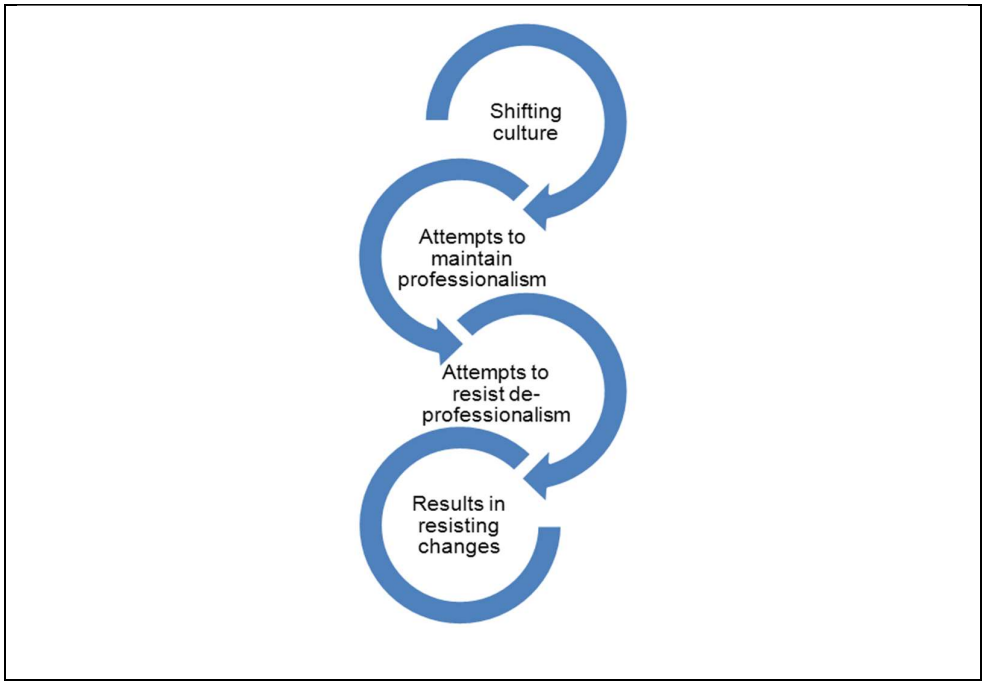

Figure 7 - How resistance is generated

Following the above stages of resistance to change, it follows that prior to the implementation of any change programme, which might be perceived to affect an individual with a strong professional identity, the concept of professional identity must be considered. It should also be considered at each stage of the change process and any signs of resistance should be evaluated for causation. Attention must be paid to any potential issues around de-professionalisation (such as loss of autonomy) and the potential barriers or resistance which may be generated. This is not currently done. Consideration is given to aspects of change and how to overcome resistance among employees but not specifically how to overcome resistance within a professional body, especially a professional body of independent contractors such as GPs. Also, as Suddaby (2015) discusses, some categories of people, such as professionals, may be less susceptible to institutional pressures, precisely because they have a firmly situated professional identity, which allows them to resist institutional pressures.

As discussed in Section 2 of this chapter, traditional change management models are linear, goal centred, follow established steps and are determined by management. They are top down. While it is accepted that there is no one ideal change model (Brisson-Bank 2010) and that tailoring to the specific organisation is required (Dunphy 1988) there is no agreement about tailoring models to take into account strong professional identities and the resistance they can produce. This lack of consideration leads to the following breakdown in the change process:

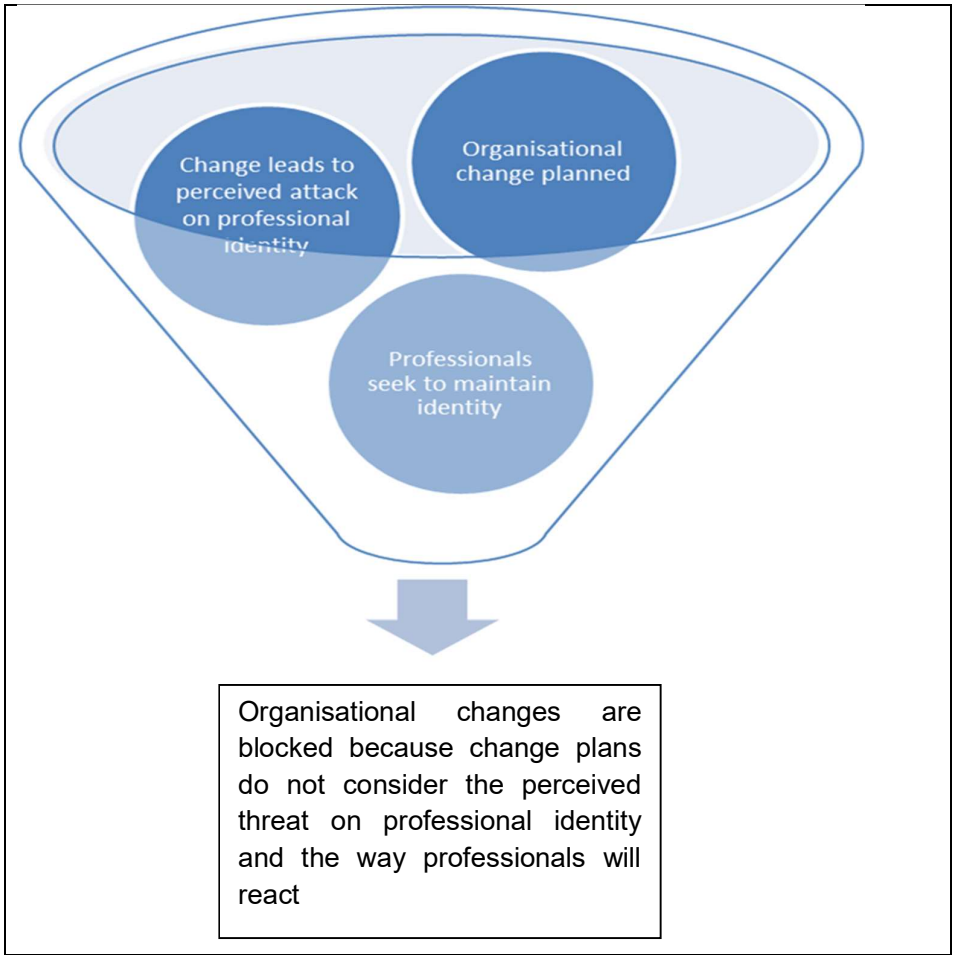

Figure 8 - Breakdown of organisational change plans

5.8 A Community OR perspective on the Nuka trial failure

Rosenhead (1986) coined the term 'Community Operational Research' (COR) when President of the Operational Research Society and substantially raised the profile of community-based interventions, especially in the UK. The relationship between COR and the work of health and social care professionals, managers and other workers, as well as those using health and social care services, is indicated by the growing number of published empirical examples of COR applied to diverse health and social care problems. A prominent early example is Ritchie et al's (1994) collection of 26 studies in community works, a substantial part of which deals with such topics as health needs assessment (Pepper 1994), health strategy planning (Friend 1994), maternal healthcare (Moullin 1994) and also with vital cross-cutting health and social care themes such as community care (Vahl 1994) and evaluation (Taket & White 2004 later further developed by Boyd et al. 2001; Boyd et al. 2007). Since this key publication, others have addressed topics including healthcare quality improvement (Gregory et al. 1994; Walsh & Hostick 2004), diversion from custody for mentally disordered offenders (Cohen & Midgley 1994), mental health and employment (Midgley & Milne 1995), family health (Taket & White 2004), sustainability and health (Waltner-Toews et al. 2004), community health schemes in developing countries (Smith et al. 2009) and critical decisions in the care of older people (Sommer & Mabin 2015). To this may be added substantial theory developments, such as those of Midgley (2006) and Frerichs et al (2016).

The need for community-based participatory research and systems science to address health disparities has recently been highlighted by Frerichs et al, (2016). They argue that systems approaches have not often been combined with community-based participatory research, and they point to the value of the growing Community Operational Research (COR) literature. Nevertheless, COR as an approach to healthcare improvement remains relatively unknown to healthcare professionals compared with the many heavily promoted initiatives from quality improvement, such as those listed by Powell et al (2009), which include, for example, Lean, Business Process Re-engineering and the very high profile Institute for Healthcare Improvement's '100,000 lives'-campaign (Berwick et al. 2006). But after decades of attempts to improve quality and yet contain costs, almost all health services around the world are faced with diverse and severe challenges. COR therefore appears to offer a timely, systemically consistent, effective and vital response to these challenges by helping to create more sustainable health and social care through community-led health and social care systems.

Indeed the search for alternative sustainable approaches to healthcare is seen as internationally urgent in both richer and poorer countries: in developing countries there remain large gaps between goals and achievements and this is mainly blamed on weak health systems (Roberts et al. 2002) failing to deliver what is, at least in theory, already available. Hence, the World Health Organization (2007, p.iv) asserts that "the strategic importance of strengthening health systems is absolute". But the kind of strengthening proposed appears to lead weak health systems towards the quality chasm of unsustainable 'strong' health systems in wealthier, developed countries, exemplified by the US health system or the UK NHS, the affordability of which are frequently discussed. One potential approach then is a systemic reconceptualisation of health and social care, which would require the kind of understanding of boundary conditions that is commonly found in COR theory and practice (e.g. Midgley et al. 2007; Midgley et al. 1998; Midgley 2000; Boyd et al. 2004; Córdoba & Midgley 2006; Midgley & Pinzón 2013; Barros-Castro et al. 2015; Helfott 2018; Ufua et al. 2018).

5.8.1 Systemic reconceptualising of health and social care

The seeds of more radical approaches are readily identifiable in the healthcare debate. The international recognition of the social determination of health and welfare, with the conclusion that "social injustice is killing people on a grand scale kill" (WHO Commission on Social Determinants of Health 2008, p. 26) in both richer and poorer countries (see Marmot & Bell 2012), was a landmark moment praised as "courageous" by Navarro (2009), although he also pointedly criticizes the Commission on Social Determinants of Health report for ignoring politics. Another development is the recognition of the limitations of the medical deficit model, which focuses on the causation of disease and its diagnosis and treatment, and the emergence of an alternative view based on trying to understand how health is caused by the positive medical or health assets, resources or strengths of individuals and their communities. This salutogenic approach, initially introduced by the sociologist Antonovsky (1987; 1979), has been heavily promoted by the Chief Medical Office in Scotland (Burns 2010). There is increasingly strong evidence of peer influences on individual health behavior (Christakis & Fowler 2008), evidence of the benefits of individual and group involvement and participation in healthcare (Gomes et al. 2009) and the emergence of new healthcare information and communication technologies (Weiner et al. 2013). Moreover, the search for efficiency has inevitably led to attempts to overcome

coordination and cost problems by integrating the typically separate systems of health and social care (Naylor & Curry 2015). Integration of care is proceeding both in England (NHS England 2014) and Scotland (Audit Scotland 2015), and is a key feature of the Nuka system in the US state of Alaska (Gottlieb, 2013).

Taken together, these developments point towards a necessary systemic re-conceptualizing of healthcare from being seen primarily as a consumerist problem of individual need for commodified treatment (exemplified by the US health economy), or as a multi-agency service coordination or integration problem (which recent evidence from the National Audit Office, 2017, shows has not so far yielded the expected financial benefits) to a need, as implied by Alderwick et al (2015), for communities themselves to become more effective in systemic prevention, coping and caring. In such community-led approaches, scarce resources are moved away from ever-increasing and unsustainable consumerist service provision to empower, enable and develop communities to plan their own health and community improvement in mutually interdependent patterns of care often viewed as 'co-production' (e.g. see Scottish Government 2007). It must be emphasised though that this is not equivalent to intensifying neo-liberal consumerism by simply transferring greater responsibility to individuals for meeting their own healthcare needs within community controlled healthcare. Instead, co-production of healthcare needs to be seen as a critical systemic process mobilising the resources and efforts of individuals, families and groups in co-producing and distributing the benefits of healthcare. Failure to achieve this is likely to increase costs and/or health disparities, as Frerichs et al, (2016) suggest typifies current health systems.

Yet this international acknowledgement of the need for community leadership in healthcare is decades late in coming. Nyswander's (1956) call to start where the people are, acknowledged by the US public health service (Derryberry 1957), echoes critical perspectives that emphasise moral and practical necessity in deepening engagement in, and control over, socio-economic life. It is striking how these insights and their associated developments in healthcare also reflect postwar developments in OR and systems thinking, like that of Churchman and Ackoff (Churchman & Ackoff 1949), which were coupled with an explicitly ethical perspective (Churchman 1952), leading Churchman (1970) to argue that a 'sweeping in' of perspectives was necessary, not simply to improve effectiveness, but also for ethical solutions to problems seen as systemic in nature. This was mirrored by Ackoff (1981; 1999), for whom the explicitly ethical imperative arises

because those affected by a plan should be involved in making it, and it is better to plan than be planned for.

Echoing these earlier critical and systemic perspectives, as well as more recent work in COR, the need for a synergistic, complementary blending of community-based participatory research (CBPR) and systems science perspectives to address health disparities are highlighted by Frerichs et al, (2016). They identify five synergies between CBPR and systems science: paradigmatic (systemic logic coupled with community perspectives), socioecological (working at multiple system levels to overcome health disparities), capacity building (system models informing community work), co-learning (building on participatory knowledge generation and utilization) and translational (implementation to reduce health disparities). Tellingly, they emphasise that CBPR works by building on strengths at multiple levels, from individuals to organisations, which are highly consistent with the salutogenic perspective noted earlier. They argue that the failure to account for systemic aspects of health policy implementation can lead to policy resistance. Indeed, it can be argued that failure to address a critical systemic feature of the trial of the Nuka system in Scotland – the shaping of vital systemic boundaries by professional identity - was a factor in the failure of the trial.

5.8.2 COR and social identity

For decades, COR scholars have focused on the role of boundary exploration as a feature of systemic intervention, and the critique of boundaries that include, exclude or marginalise either people or issues of concern is an important task in COR practice. The importance of identity in shaping boundaries is gradually gaining recognition in the COR research community (e.g., see Boyd et al. 2004; Cordoba 2001; Córdoba & Midgley 2006; Shen & Midgley 2007). Midgley et al, (2007) see the identities of COR practitioners as an often-missed influence on the way boundaries are determined. Identities, they argue, are ascribed by actors who are interpreting system boundaries under the influence of power relationships, and both identities and power relationships legitimate actor roles, which in turn bring behavioural expectations. Thus, boundary critique (see e.g. Midgley et al. 1998 for a discussion of boundary critique theory and practice, establishing the need to identify and access diverse stakeholder views, including those of marginal groups), and critical self-reflection by COR practitioners on their inevitably-embedded non-neutral roles in boundary formation, can enhance systemic awareness. Midgley et al, (2007) espouse a

pluralist view, rejecting the exclusivity of any particular identity theory in boundary critique. However, their views are highly consistent with the specific identity theory that has proven useful in my empirical attempt to explain the failure of a Nuka trial in Scotland.

With change required, additional concerns stem from Coram and Burnes (2001) observation that a substantial number of organisational transformation projects fail. Burnes and Jackson (2011) consider one vital factor in this to be a lack of alignment between the value systems of the change intervention and those undergoing the change. This is of particular relevance to the UK health service, given that there is generally considered to be a mismatch between the values of NHS clinicians and NHS management which, as Drummond-Hay and Bamford (2009) argue, is at least partly due to clinicians wanting perfect healthcare but chief executives wanting efficiency and cost effectiveness. But this could also be seen as an oversimplification. For instance, Dutton, Dukerich & Harquail (1994) suggest that, for a change in professional behaviour to occur, it needs to be perceived as compatible with the existing professional identity; it needs to fulfil individuals' needs for self-continuity, self-distinctiveness and self-enhancement, and be consistent with accepted professional ideals and boundaries. According to Thorne (2002), the medical profession traditionally adapts to change by initially being resistant, then subsequently it negotiates the meaning of the change, and finally incorporates it into the existing structures and processes of the profession. These changes then become reinterpreted as the profession use's its cultural and social authority to re-define and present the changes back to its members.

It is widely accepted that defined and accepted professional boundaries are not fixed; they can be influenced and changed, but it means that professions strive for control over boundaries. This sheds light on healthcare, where broadened participation has substantially moved the old boundaries defined by clinical professionals (primarily in terms of a medical model giving rise to a 'consumerist sickness management system'), to a wider conception of health systems. The new boundaries may extend as far as redefining patients (and their carers, families and social networks) as key elements of the system involved in the co–production of healthcare. This approach is exemplified by the innovative Nuka system (Gottlieb, 2013) of community led healthcare, which originated in Alaska in the United States and was trialled in Scotland in 2012. What boundary and identity analysis also reveals is how and why community led healthcare may be frustrated in the intense professional context of healthcare, as we all shortly see.

5.8.3 Systemic reflections and lessons for COR

The discussion below largely follows Walsh, Kittler & Mahal (2018). The primary results and discussion around the Nuka topic contained in the paper are taken entirely from this thesis and the discussion around Community Operational Research (COR) is an output of discussion with Walsh and Kittler developed via their specialist knowledge of COR. Therefore, the paper is sited with Walsh as the lead author since it could not have been written without his specialist COR knowledge.

Midgley et al (2007) suggest 12 indicative strategies for systems practitioners to address issues raised by their own ascribed identities. Following discussion with a COR specialist it was felt that these 12 strategies were also particularly salient for highlighting some of the potential general failures of systemic reflection on identity in the Nuka trial in Scotland.

In table 4, the initial and successful NUKA initiative is contrasted with the failed Scottish trial in terms of whether or not each of the 12 strategies was employed. Each is briefly commented on.

Strategy for Critical Reflection on Identity	Nuka Alaska, US	Nuka Trial Scotland, UK
Exploring the relevance of culture (and categories of identity).	P (S)	NP
Allowing sufficient time for relationship building prior to and during substantive intervention.	P (S)	NP
Using established formal as well as informal processes for sharing information about identity.	Unclear	NP
Establishing a strategic partnership with a trusted organization.	N	P (NS)
Involving trusted individuals in brokering new relationships.	P (S)	P (NS)
Ensuring that people with a valued local identity and local knowledge are key decision makers [..] allowing insider/outsider boundaries to be blurred.	P (S)	P (NS)
Recruiting a person to the practitioner team whose identity is closely aligned with that of participants.	P (S)	NP
Adopting methodological principles that align with participants' identities.	P (S)	NP
Using a participative approach to establish an active listening stance.	P (S)	P (NS)
Involving participants in the choice and/or design of methods in addition to involving them in the conversations that the methods structure.	P (S)	NP
Sincerely mirroring key aspects of participants' concerns and interests associated with their identity.	P (S)	NP
Identifying what the participants are looking for in evaluating identity and (sincerely) framing practitioners' presentations of self accordingly.	P (S)	NP

Table 4 - Indicative strategies and omissions in the Nuka Trial (Midgley et al (2007). Reproduced from Walsh, Kittler & Mahal (2018)

Key: P= Present, NP = Not present, (S) = Sufficient, (NS) = Not Sufficient

NB: The table identifies rather than quantifies important omissions and adds an indicative evaluation of the relative sufficiency of each factor when present.

The COR discussion below reflects the discussion within Walsh, Kittler & Mahal (2018).

The failure to *explore the relevance of culture* in the Scottish Nuka. The culture was 'taken-as-given', this was demonstrated within the practice as no consideration was given to explore the current culture of the culture they were trying to move towards. Considertion at this point could have included the views of patients and their families, this has been demonsttated by the patient-centred-and-led inquiry in primary care reported by Walsh & Hostick (2004) Similaraily, the practice staff could have engaged in peer group and multi-group dialogical encounters, as discussed by Gregory et al (1994).

To consider culture properly requires *sufficient time for relationship building* prior to and during the substantive intervention. There was no evidence that this occurred in this example for any of the involved parties. Failure to take this time seems to have strengthened the development of the threat to GP professional identity as a key stumbling block.

Using established formal as well as informal processes for sharing information about identity was not evidenced in the development of Nuka. In Alaska, where the concept of Nuka was developed, clinicians were specifically recruited if their professional and social identities were a close match to the needs of the Nuka approach. However, this didn't happen in the Scottish trial.

Establishing a strategic partnership with a trusted organisation was a less clear feature of Nuka in Alaska, and while the Scottish trial was guided by the original Nuka, which could in a sense be seen as a trusted organization. However, calling this a 'partnership' might be stretching the truth. The Scottish trial was built around accounts, using academic resources and seeking advice but it didn't have input from anyone with direct knowlege of the development of the Alaskan experience.

Involving trusted individuals in brokering new relationships can be seen as a feature of the Nuka in Alaska, as individuals trusted by native Americans developed new relationships, locally and with the US Government, thus developing the new system. The Scottish Nuka trial also involved trusted individuals in the involvement of a GP and a Practice Manager, but the numbers were small compared with the rest of the practice, and it was from the rest of the practice from which the resistance came.

Ensuring that people with a valued local identity and local knowledge are key decision makers failed in Scotland because, although the GP and Practice Manager had local knowledge, it appears the other GPs did not want the boundaries and values of their practice being determined by anyone other than themselves, especailly the Practice Manager, who was not 'one of them', not a GP. Nor did patients have an opportunity to discuss, impact or affect the roles of any of the key personnel. Their primary role appeared to be that of legitimating 'consent giver', as they were consulted on whether the trial should happen, but were then expected to resume a traditional patient role. It can be argued(Midgley et al., 2007) that a central feature of COR is the meaningful engagement of communities, and there is a significant question here about whether the engagement of the patients in setting up the Nuka trial was really meaningful

Recruiting a person to the practitioner team whose identity is closely aligned with that of participants was a vital step in Nuka in Alaska, where as discussed above clinicians and others seem to have been recruited because of their fit with the ethos and values of the system. In the Scottish trial the GP was already in place as a senior partner, as was the practice manager but these two recruits were insufficient to enable the sustainability and expansion of the trial.

Adopting methodological principles that align with participants' identities occurred in Nuka, Alaska, but did not appear to have happened within the Scottish trial.

Neither did *involving participants in the choice and/or design of methods in addition to involving them in the conversations that the methods structure* take place. Similarly, *using a participative approach to establish an active listening stance* did not occur. While this was a vital principle for the success of Nuka in Alaska, it may be that the implementation team for the Scottish trial were over enthusiastic, and either unable or unwilling to take on board the identity issues raised by the trial for the other practice partners and staff.

With hindsight it appears that *sincerely mirroring key aspects of participants' concerns and interests associated with their identity* could have been used as an chance to consider the professional concerns of the practice GPs and practice staff notivovled in the trial.

Similarily *Identifying what the participants were looking for in evaluating identity and (sincerely) framing practitioners' presentations of self accordingly* could have helped in this area too. Instead, it appears that the Scottish trial was shaped with a fixed agenda

that did not take into account the professional or more general social identities of staff and patients, and did not consider how that agenda would impact on them.

It is interesting to see, therefore, that those actors (the other practice GPs) outside the boundary of the trial in Tayriver were able to stop the trial without reference to the patients – they were 'owners' in the terms set out in Soft Systems Methodology (i.e., with the ability to stop the system from working) (Checkland & Poulter 2010). This observation also reveals how '*the participatory boundary of a systemic intervention is not a thin line but a region (perhaps of varying thickness) that must itself be subject to criticism and action if the risks posed by others are to be addressed by the participants in a COR project' (Walsh et al., 2018)*. The Nuka trial could not be separated from, or 'protected' from the rest of the Tayriver practice and, applying Midgley's (1992) theory of marginalization processes, the 'sacred' identity of the other GPs in Tayriver was challenged by the introduction of a new identity that those GPs regarded as profane.

The ascription of a profane status to the GP and Practice Manager who had welcomed the new identity was aided by both existing tensions between doctors and practice managers more generally (in the context of a 'struggle' for professional dominance) and the marginalization of the other GPs in the Scottish trial, giving them no real say in its remit and implementation. As Midgley and Milne (1995) make clear, when those with the ability to stop a system from working are marginalized, there are likely to be repercussions. In addition, there was no dialogical process owned by patients and other members of the community that would have enabled an evolutionary shift in boundaries – one in which the GP's professional identity could itself have evolved into something new. The trial ended, and with it the chance to transform Tayriver healthcare into a new type of community-led health and social care system, which might well have been more sustainable in the long run than the one that survived this short-term trial.

From the critical perspective of COR the Scottish Nuka trial needed to address professional and more general social identity issues by surfacing them through dynamic and reflexive processes of boundary critique. There is an open question here of course: what if the 'community' had refused the trial? Indeed, there is nothing inevitable about local choices by local people. As a consequence, it is suggested that community-led healthcare cannot simply be imposed, but it can be *explored*, as the examples of Tayriver and Nuka, Alaska, show. The Scottish NUKA trial succeeded while it lasted, but only from the viewpoint of its two 'champions'. It failed to become the transformative basis of health

and social care in Tayriver because of a critical systemic failure to manage participatory boundaries and associated identities. The research suggests that everyone involved in or affected by change has social identities that may be challenged in some way. Social identity is not immutable, but any given community or group may be highly resistant even to beneficial change if its identity is threatened.

The lenses of professional identity and the COR theory of boundary critique provides health care practitioners and policy makers with an explanatory approach as to why the trial of a previously successful initiative - contrary to their expectations – was unsuccessful. Community-led healthcare, these insights suggest, needs a high degree of acceptance and engagement by relevant actors to be successful. To achieve this requires facilitated reflection on boundary conditions and an understanding of the importance of processes of marginalisation. This is particularly relevant as community-led approaches are emerging as a way forward for healthcare internationally. For these to work as intended, communities and patients, in addition to medical and other professionals, need to be regarded as system owners and architects of the system. Arguably this underpins the success of Nuka, Alaska, which as Nyswander (1956) says, started *where the people are*. COR practitioners have insights, theories and tools, developed over decades, that can help to address these issues. Those seeking more information about the methodology and practice of COR are advised to refer initially to the discipline's three most seminal text's Ritchie et al, (1994), Midgley & Ochoa-Arias (2004), and Johnson (2012). Also see Midgley (2000) for a more philosophical perspective linked into a discussion of methodology and practice.

5.9 Is professional identity a crucial element in resistance to change in primary health care?

Having considered the relevant aspects of the organisational change field and reflected upon the interplay between professional identity and resistance to organisational changes, the question which remains is - does the evidence lead us to conclude that the issue here is one of professional identity and not something else? After all, as was determined above, the majority of organisational change programmes fail (Burnes & Jackson 2011) and so logically it seem safe to assume that these failures cannot purely be as a result of professional identity. This would indicate that there may be some other reason why organisational changes within the primary healthcare sector in Scotland are being

resisted. While there may be other contributing factors which this research has not uncovered, the evidence generated here has strongly concluded that professional identity plays an important role in the generation of resistance to organisational change and as such cannot be ignored.

The established academic literature also concludes that identity and professional identity is important, especially within the medical profession. Social identity theory states that individuals seek a positive social identity, Tajfel and Turner (1979) consider this to come in part from group membership of an in-group. When this need is not met, or if the in-group is challenged, then this can be constituted as creating a social identity threat. For high-status groups, such as the medical profession, this threat can arise when there is the potential for a change in the status quo (Scheepers & Ellemers 2005). Within the medical profession, the identity of the profession is likely to be stronger than any other identity, such as team, department or employer (Callan et al. 2007). This strong focus, which is undiluted by other identities, can exacerbate any threat the professional perceives. Previous research (Morrison 2009) has highlighted that when a high-status group feels threatened they will try and maintain their dominant, high-status identity by emphasising their social dominance against others. In other words, they will try and employ identity management strategies in situations where they uncover possible identity threats. To counter this response to an organisational change, the change management process must accommodate and diffuse this reaction.

The grounded theory being formed as a result of the consideration of the data and published academic literature is that:

Primary Healthcare workers, and in particular General Practitioners, when faced with an organisational change to their established way of working have a tendency to attempt to resist the change, especially if they consider (consciously or unconsciously) this change to be a threat to their professional identity. This tendency must be considered and addressed within any top-down organisational change within the arena of primary health care.

5.10 The Nuka trial

The Nuka trial, conducted within Fife in 2012 was discussed in the introduction to this thesis (section 1.4.2). The Nuka trial is an example of a failed organisational change and was the prompt to the research here. This trail also provides an example of an organisational change which did not meet the requirements of the grounded theory identified above and did not take the professional identity of those involved into account.

Interim research, six weeks into the pilot, showed that the Nuka trial was succeeding. It was seen as succeeding not only by the people who championed it but also by the staff and patients involved in it. However, it failed to grow into the transformative basis of health and social care in Tayriver because of critical failures to manage boundaries and associated identities. Everyone who took part in the trial, or was affected by the changes necessary to accommodate the trial, had social identities, and for the professionals involved a professional identity. These identities were challenged by the trial and no consideration was given to mitigating potential threats or challenges to those identities. Social and professional identities are not immutable but any given community, group or profession may be highly resistant to change, even if that change be highly beneficial if identity is threatened.

5.10.1 Learning points

The failure of the pilot showed that not all the GP partners were willing to accept radical changes to the way they worked. During the interviews there were comments made about the GPs not being willing to fully work as team members, they wanted their autonomy and the respect they felt they had earned via years of training. This suggests that medical education will have to adjust and attitudes will have to be changed before doctors will accept organisational or structural changes which are currently seen as threatening to their autonomy and by extension their professional identity. The professional identity of a doctor has to change to allow, for instance, full team working. The identity has to be changed to one in which being a team member is seen as desirable and a positive value, where it is seen that being a good team player is part of being a ‘good doctor’.

As one member of the NHS Management team who created the pilot commented:

> One of the things about a relational model like Nuka is you are required to recruit people with the right attitudes and it's the right attitudes intrinsically em so the Alaskans are very careful about who they recruit as not everyone is going to work well in that model and I can see that a lot of the GPs that are coming through have chosen general practice because of the paternalistic model em so a lot of these people weren't the right kind of people to function in a Nuka model.

The attitude of the GPs was also shown to be important, as was the need to accept that changes were required, that they, the GPs, need to make changes and that theirs was a pivotal role in creating and sustaining the changes. All too often, as was seen in the interviews, GPs blame others for the issues they have – they say that if Social Care was better, or if secondary care helped more, or if we had more resources or more doctors – then they would be fine but that isn't going to change the fundamental issue that the demands now being placed on them have changed and their role has not changed to keep up with that.

As this research has shown, GPs are very good at accepting changes so long as they are not directly affected by them. This, arguably, is because they are protecting their professional status, their professional identity and this must be considered in the change process. One way to do this is would be by allowing GPs to take the lead and allowing them to protect their identity.

However, it must be remembered that the Alaskans have been developing and extending their system for more than twenty years now – this was not a quick fix they implemented to solve their problems. The Alaskans started the process of redesigning their health system with extensive consultation with the people they served. They did not rush into a new system, nor did they attempt quick fixes to solve local problems or borrow ideas wholesale from other models – they created their own tailor made model in response to what they were told was required by patients and healthcare staff. As Jacobs et al. (2013) point out there are cultural differences between countries which mean that a system cannot be lifted wholesale and be implement unchanged, what works in one country will not necessarily work in another.

This research has shown that if potential threats to identity and, specifically professional identity, had been considered in the planning stage then the Nuka trial would have had a

much better chance of succeeding in transforming the care provided by one GP practice in Fife.

5.10.2 Could a Nuka-type system be implemented in Scotland?

In Scotland, the NHS Boards are currently tackling the issue of integrating health and social services. They are attempting to bring together two very different organisations with different cultures and blend them together to provide seamless healthcare for patients. The Alaskans have demonstrated there are distinct advantages in bringing primary, community and mental healthcare services into one organisation – they have improved patient care, reduced waiting times, reduced costs and provided a better service for both staff and patients. Of course, to do this they had to change the roles of doctors and nurses – they had to change the way they worked, how they envisaged their roles, in other words, their professional identity. The system was redesigned to incorporate all healthcare staff into one organisation and structure. Primary healthcare staff had to develop close partnerships among each other and also with hospital specialists. Each member of staff holds a clearly defined role supported by a common management philosophy and with shared budgets and costs. Could NHS Scotland do that? Basically, tear up the current system and start again? Possibly, but it must be remembered that it took the Alaskans nearly 30 years to achieve their successful system, so this would long-term project not a quick solution to the current problems.

The Nuka Health Care system is a philosophy; it has an intention and a mission which provide it with guidance and consistency (Hussey & Gottlieb 2014). It is a total system, enriched by all the sum of all its parts. Could it work in Scotland? If implemented on a practice by practice basis, if the staff all bought into the philosophy and were willing to change their working practices to accommodate that philosophy, then possibly. However, it would require a cultural shift on the part of many healthcare staff, especially GPs. As discussed earlier, the education of doctors would have to change, inter-professional team working would have to be fully embraced, boundaries held by the different healthcare professionals would need to change and new institutional logics would have to be created. There would have to be a shift in balance in the medical ethos – from control to partnership and from expert to coach or facilitator. In short, professional identities, especially those of GPs, would have to accommodate and embrace these changes.

However, the system could be implemented and implementation is exactly what is being attempted in another Nuka style trial, being conducted at the time of writing.

5.10.3 2015 /2016– Another attempt to introduce Nuka

Three years after the failed attempt to introduce the Nuka model into Fife a GP practice in another Scottish region contacted the Nuka Implementation team and expressed an interest in taking the idea further. Interviews were conducted with two members of staff at this practice and they provided information about the background to the changes introduced.

This practice, which we shall call Shoredge (a pseudonym) had talked with the practice manager from the Fife practice (Woodside) years before and were now at a point where they felt they required a major overhaul of the way their practice operated if they were to successfully continue to operate as a practice. Demographic changes had resulted in a growing demand for GP appointments and the practice was finding it increasingly challenging to provide sufficient clinical capacity to meet the demand. Despite previous attempts to solve the problem using 'lean' approaches and appointment rescheduling, the demand remained unmanageable.

After discussion with a nearby practice, the decision was made to merge the two practices together creating the largest practice in the area with over 14,000 patients on their list. Their aim was to facilitate the transformation of their primary health care delivery. They wanted to ensure patients were seen in the right place, at the right time, by the right people. They believed that a different approach was needed to improve access, health and well-being and to ensure the practice was sustainable. The practice wanted to take the Nuka ideal of providing service excellence and operational sustainability and involve patients and staff in the design of the new system.

Their aspiration was to provide the following:

- Patients are empowered to self-manage
- Patients experience is positive
- Health and wellbeing outcomes are improved
- Waiting times are improved

- Patient flow is leaner
- Relationship- continuity is optimised
- Surgery resources are used effectively
- Appointments are used appropriately
- Operational performance is improved
- Partnerships tailor services to need
- Impact on out of hours service is reduced
- Impact of secondary care is reduced
- Staff experience is positive
- The service model is sustainable.

To achieve their aim the following model was created and implemented in phases. Six small, co-located, integrated teams were created with a defined population of around 2,400 patients. In phase one, teams contained 1.5 GPs, a nurse, a healthcare assistant, an administrator and named community nurse. It is planned that in phase two a behavioural psychologist will be added to the team and a case manager role will be developed. This model is a bio-psych-social model of healthcare which aims to address all the patients' health and wellbeing issues in one visit to the surgery. It is a holistic model which looks at the whole person rather than a medical model focussed only on the presenting health problem. The provision of care and support planning aims to promote patients self-management of issues where possible.

By summer of 2015, the practice had managed to create interest and 'buy-in' from patients, complete the design of their model including creating care and support plans and created 6 small sub-teams. The practice went 'live' with their new structure in September 2015. They are committed to building on the system as required and refining it to suit their purpose and situation.

The practice in January 2016 started the process of initiating a formal evaluation of their programme, with the aim of assessing the implementation of phase one and their progress so far. It is too early in the evaluation period for them to share any of their results. However, anecdotal evidence from the staff, gathered during interviews, suggests that the new structure is working. So the question which must be asked is why would this experience

appear to be a success (albeit that it is early days in the implementation process) when the first trial was abandoned as unworkable? It could be that the practice involved in this trial was an amalgamation of two separate practices which joined together. They were free to 're-write the rules', create an office culture which was amenable to the change. Coupled with this is the fact that the GPs developed the system themselves and were open to the idea of changing the way they worked – they themselves established the new guidelines and rules. This was not a system or change which was imposed on them. The fact that by amalgamating two practices they created one large practice may also be a factor. Goldberg (2012) suggests that the size of a practice is important as bigger practices have more resources with which they can promote innovation. Also, the practice involved here are not approaching this as a trial run of a new system – they were fully committed to making changes to the way they work and intend to continue to adjust the changes, as they feel necessary until they have a workable solution to the issues they had identified. The GPs in this practice were committed to introducing a small team working environment, to improve their working day and to improve the service they offered. These GPs have also partly been inspired by work being done in London at Bromley by Bow Centre. The experience of the Bromley by Bow Centre is discussed below.

5.10.4 Nuka inspired changes elsewhere

The ideas behind the Alaskan redesign of their health care system have been considered with interest by many other health care service providers in countries other than Britain. As mentioned above the Kings Fund in the UK have published reports on the viability of the Nuka system. In America, several areas have attempted to replicate Nuka. One of these is the Cherokee Indian Hospital, where in 2015 a new hospital designed around the principals of Nuka was opened. This hospital was designed around the patient's needs; it has been arranged so that people who attend for treatment see a medical team, consisting of a doctor, nurse, dietician, psychologist and pharmacist, rather than having a disjointed visit to each speciality individually. This team work collaboratively and are based in a shared workspace – the doctors are no longer separated off in their own offices. The CEO of the hospital states that:

> The Nuka system of care is based on the premise that patients get healthy when they have a healthy partnership and relationship with their team…

However, as with the introduction of the Nuka model in Alaska, this was no quick transformation – the hospital state that it took 'years of research to arrive at the model and figure out how that approach should translate into physical building plans'

Within the UK there has also been interest in the Nuka model in Wales. In 2014 Cymri NHS published a paper called Redesigning Healthcare: Learning from the Nuka system of care to inform the system of healthcare in NHS Wales. This paper was based on a series of seminars with representatives from Alaska. The Welsh concluded that if nothing else then they could take insights from the Nuka system into how they might rebalance NHS Wales so that they focus on ways to improve outcomes and the patient experience. The Welsh feel that despite making some progress towards the aim of putting patients first their healthcare system is 'still arranged around the needs of the organisations, clinicians and Welsh Government' (Hussey & Gottlieb 2014, p.17). The same can be said of the Scottish NHS. However, moving the focus toward the needs of the people requires changes to the organisation and to the professional culture of the NHS be it in Wales, Scotland or England. In Alaska cultural changes were tackled by ensuring that any clinicians who were hired had, what the Nuka management team considered to be, the appropriate attitude required for working in a team based environment.

In London, a team at Bromley by Bow Centre have set up a model designed to respond to their particular social and economic conditions. Here, a small independent charity built a health centre which was owned by patients. They created a holistic model initially aimed at supporting vulnerable adults, young people and families, groups who are often hard to reach through conventional services, and aimed to make it easy for these people to access support and integrated services including medical care. Their model was co-created with their users and grew up over an extended period of time – like in Alaska there was extensive consultation involved and there were no quick fixes introduced. Now, almost 20 years after the centre was opened it actively supports the whole community – the vulnerable, families, young and old people, working with over 2,000 people a month. The model was started small and grew to meet the needs of those involved. This model works collaboratively with the local community and offers a wide-ranging holistic programme. Its ethos is that relationships are crucial and it appears to be very much a UK version of the social prescribing seen in the Alaskan model.

In Scotland, in September 2015, the First Minister announced that over the next two years ten health centres across the country would be testing out different ways of delivering healthcare. Two of these test sites would trial a way of working in which GPs and other health professionals work in multidisciplinary teams so that patients see the right professional quickly. As part of this, an extra years training will be given to a small number of GPs to allow them to train in the new skills required to take on this new role and to work across primary and acute care. This small scale trial appears to cover some of the basics of the Nuka system – multidisciplinary team working with the patient's requirements at the heart of the system. The fact that GPs need to be trained to work in a new way backs up the idea expressed in chapter 5 that professional identity and medical education need to accommodate new working practices.

5.10.5 What can we learn from Nuka?

There are many lessons which the UK NHS can take from the knowledge built up by the Alaskans. The Nuka system of healthcare took more than 20 years to develop into the successful system we see today, and we must be aware that the NHS needs a similar journey, there are no quick fixes. However, there are several learning points which we can take from the Nuka systems which could be incorporated into the NHS fairly easily.

1. Care should be provided on a personal, longitudinal holistic basis delivered by small teams (rather than by an individual GP who can call on other professions as required, as is currently the case)

2. The development of multi-disciplinary teams with an appropriate skill mix. These skills should include doctors, nursing care, pharmacists, behaviourists (covering behaviour change and managing chronic conditions) and administrative support.

3. The teams should not only have a skill mix but the spread of skills should be balanced and seen as equal in value.

4. Teams should focus on early intervention and meeting the needs of those with acute illness and chronic conditions.

5. The use of metrics to monitor service provision and clinical standards show be more widely used

It is also worth noting that in Alaska all GPs are salaried, they are not independent contractors in the same way as in the UK. However, the trend to salaried GPs is becoming more and more prevalent in Scotland – younger GPs don't want to take on the commitment of being a partner, being tied to one location or all the managerial aspects of running a practice. Being salaried allows a GP more security and flexibility to work wherever, and whenever they wish. It also reduces their autonomy in some ways – not in how they practice medicine but in the flexibility they have from being self-employed.

5.10.6 Nuka and professional identity

At the beginning of this chapter, it was said that the Nuka trial in Fife has provided the ideal example to consider whether or not the professional identity of the GPs involved in the trail had any bearing on the failure of the project. Using the theory developed within this research it would seem reasonable to suggest that it did, and, consequently the GPs blocked the organisational change. Interviewees confirmed that the GPs didn't like the idea of losing their autonomy, of working as an equal member of the team, of potentially losing status. The GPs didn't want to change the way they worked, they were happy to make small adjustments which they could accept as being beneficial to the patients but didn't want to make substantial changes to the way they worked. GPs, despite the current difficulties (increasing demands, lack of time and so on) basically like their jobs, as was shown by the questionnaires, and so they don't want to change the way they work. They would like to be freed from some of the pressures and stress they are experiencing, but fundamentally they don't want to change the way they work. They don't want organisational changes. They perceive organisational changes as being a threat to the way they work, to the role they perform and thus their professional identity.

There has been discussion about doctors taking on more leadership type roles, as part of organisational changes, especially in a Nuka style system. However, doctors are not trained to be leaders; it is not part of their professional identity. From the start of their training medical students are separated off from other university students, even other healthcare professionals, placed within medical schools, and socialised into their new profession. They are trained to make quick, autonomous decisions; they are used to taking

control of situations and they are not used to being questioned or challenged by others. Doctors are not socialised into the NHS in the same way they are socialised into medicine. Medical education needs to recognise the wider NHS and the context of the role medicine (Nicol & Cowpe 2016).

Despite this lack of leadership education, GPs are expected to be the managers of small businesses. The skills they need are not skills which those doctors are taught. Leaders, or managers, are expected to consult and engage with others, to seek out and consider opinions from others and to be seen as more equal (Nicol & Cowpe 2016). Doctors are not taught these skills and so don't see them as something a good doctor would do, they don't see these skills as important and they don't see these skills as forming part of their professional identity.

The professional identity of doctors would have to be fundamentally changed if the current system of healthcare were to be adapted to follow a Nuka style model of healthcare. Indeed this happened to some extent in Alaska where a large proportion of doctors left the area when Nuka was first introduced – they just didn't want to work in a different kind of system.

However, as the second pilot of Nuka has shown, GPs can accept the changes but it has to be on their 'terms' with their support and with them leading the way. They have to be able to create the kind of system they want to follow, and build it from the ground up, employing staff (including GPs) that are open to the ethos of the practice they are trying to build. This is something which has to happen on a practice by practice basis, when they are ready to implement it, not as a political directive.

5.10.7 NHS conference 2015

At the NHS Scotland Conference in 2015, several examples of innovative projects were presented. Projects ranged from individual practices exploring new sustainable ways to work which suit their specific patient population to practices seeking to embed an integrated and collaborative approach to locality planning within their defined area. Many of these practices see the general practice as being at the heart of a multidisciplinary team which includes a Nurse, Health Visitor, a GP and social work. A practice in Glasgow has found that by attaching a social worker to their practice they are freeing up GP time to deliver healthcare and helping patients with complex and additional help needs.

These pockets of innovation show that some GPs recognise that there is a need for change, and they are proactively seeking solutions to their local problems. These projects have all been developed from the bottom up, a grass roots approach by enthusiastic GPs: GPs who were eager to balance a medical and social model of care, not purely deliver a standard medical model as they recognised this was no longer meeting their or their patient's needs. However, there was also talk about not knowing what other practices were doing, that innovation was not being shared.

As with most change management programmes, once a critical mass of people are willing to make the change, then it becomes easier to implement. With GPs, that critical mass must also be achieved, not only at national or regional level but at the practice level. As demonstrated by the Nuka pilot, only one GP in the practice was really behind the pilot and without the support of his partners, the pilot failed.

One GP suggested that if QoF points were awarded for innovation then more practices may be willing to take risks and try different ways of working without fearing that they were jeopardising their incomes. A quote from one of the presenting GPs was: 'we would like to do things but there are barriers'. A lot of the speakers recognised that change had to be taken slowly – as demonstrated by the Nuka model which took more than 20 years - and that if things were going to change they had to start at the ground, probably as a reaction to how bad things really were getting at 'the coal face'.

5.11 Longer term solutions

Professional identity within the medical profession, as discussed in chapter 4, is socially learned; it comes from education, from peer modelling and from fitting in with the ideas the profession and society consider relevant to the role. Medical education plays a large part in underpinning the socialisation of medics. This socialisation process needs to take into account the changing face of medicine. New recruits have to absorb the attitude that working as a fully functioning team member is a desirable identity trait for doctors as opposed to being socialised into the understanding that doctors are autocratic and senior to all other health service roles. There have been efforts made at multi-agency education (Langendyk et al. 2015; Burford 2012; Monrouxe 2010; Wackerhausen 2009; Beech & Huxham 2003) involving doctors sharing training with nurses, physiotherapist and pharmacists. The aim of multi-agency education is to install a collaborative inter-professional identity as required by modern multi-professional healthcare teams. Inter-professional learning has so far not been successful to any great extent, despite being

accepted by the students involved there is little evidence that long-term attitudes are changing (Langendyk et al. 2015). This was certainly evidenced within the data gathered here. While the GPs accepted they needed to work in tandem with other professionals, in reality, they were only prepared to do it on their terms; they wouldn't accept other professionals as their equals. Notwithstanding the vested interests of educators to maintain professional boundaries, inter-professional education is required to construct professional identities, which allow for the collaborative relationships required to deliver comprehensive patient care in the 21st Century. What it means to be a doctor is changing in response to economics, policies, societal requirements and the multidisciplinary model of care. Therefore, it follows that the education process also needs to change.

As discussed earlier, General Practitioners (GPs) in the UK are independent contractors who run small businesses. This arrangement provides GPs with autonomy over how and when they work. Changing the business model to one in which GPs are employed by Health Boards, in the same way hospital doctors are, so they become in effect salaried GPs, will change the working dynamics between GPs and the Health Boards. It would also help to diminish burn out and provide a health service which is responsive to organisational change and can be changed to be fit for purpose in the 21st Century.

5.12 The integration agenda

Having established that organisational change within the primary healthcare sector is necessary and that the consideration of professional identity is important, the discussion must now turn to the future and how this knowledge may be taken forward. The biggest current change within NHS Scotland is the Integration Agenda, a large-scale organisational change and so the ideal circumstance against which to consider this knowledge.

An important consideration within many Scottish Health Boards at present (2015/2016) is the Integration of Health and Social Care Teams to create a more streamlined health service. This is a radical change within the Health Service in Scotland and the research contained in this thesis is being put to practical use within Fife NHS as it plans how to carry out this integration. To date (late 2015) the Integrated Social Work and Care agenda has been characterised by uncertainty, delays and it has failed to pay more than a passing 'nod' to the relevance of professional identity. However, the leaders of the change

programme have now, as a result of the dissemination of this research, recognised professional identity must be addressed as part of the change programme. They have also accepted that the professional identity of the groups concerned is completely different and that the different groups have different cultures and working practices and this will ultimately cause issues within the change process. This understanding has led to them taking the decision to ensure that the change model which is implemented ensures that the multiple professional identities and the barriers and resistance to change which may ensue are taken into account and controlled for.

There has been previous research carried out around the topic of inter-team and intra-professional team working. So far this research has produced mixed messages. Finn et al (2010) found that emphasising inter-professional teamwork actually let to the reinforcement of hierarchical barriers. Meanwhile, Kreindler et al. (2012) recommend an emphasis on group identity rather than individual professional identity for promoting active and successful group working. However, neither of these pieces of research investigated the subject of identity as a cause of resistance. Having looked at ontological security and the theories of faultlines it would appear to undoubtedly deserve consideration. If professional identity is not addressed then the resulting barriers and the resistance that is initiated to attempt to block the change could result in the failure, or limited success, of the Integration agenda.

At the beginning of this section the Integration Agenda was said to be radical, and it is recognised that radical changes tend to effect more than just those being directly changed. Changes to the boundaries of the clinicians will also effect non-clinicians, the management team, patients and ultimately the NHS itself. This is evidenced by Midgley's (1992) research on boundaries and their many layers. As mentioned above, changes can have unintended consequences. These are all issues which those proposing the changes need to be aware of. In actuality, when faced with radical organisational changes, the resultant changes may not be as radical as they are initially proposed to be, they may well be 'watered down', as a result of the maintenance of profession identity by the affected groups. The management team may have taken a decision that ultimately preserving the status quo is preferable.

5.13 Conclusion

This chapter has discussed analysis developed from the research conducted into why GPs in Fife were blocking what to the Health Board appeared to be a potentially useful organisational change. Discussion in this chapter centred on establishing the existing theories and recognised scholarly literature. This led to consideration of how the findings from this research support or extend these existing theories and discussions. It has been shown that this research underpins the notion that professional identity must be considered when an organisational change is being considered in order to minimise resistance to that change; this is a currently under-researched topic within organisational change. It has highlighted that suggested changes must be seen to incorporate professional values such as autonomy, expertise and so on which will allow the profession to sustain its established role.

This research also highlighted that medical education must consider what it is teaching student doctors in order to allow their professional identity to adjust to conditions in the 21st Century. The premise of the traditional independent GP practices, essentially small business units, must also be considered and questioned as to whether or not this is the best system to provide quality patient centred healthcare in our changing social and economic environment.

The following chapter is the concluding chapter. It seeks to summarise the work that been discussed in the previous chapters and consider the thesis as a whole. The key findings and contributions will be discussed as well as the limitations of the research. The difficulties of using a grounded theory methodology will be considered and the credibility of the methodology will be discussed. The chapter will conclude with recommendations for future research.

Chapter 6 Conclusion

6.1 Chapter overview

The aim of this research was to answer a question posed by NHS Fife as to why they were unable to persuade the General Practitioners, within their area, to run a pilot project trialling a new way to structure and organise their practices. From this starting point, the research evolved into seeking answers as to whether or not professional identity was playing a part in the rejection of structural organisational changes in the primary healthcare environment.

The research had two main aims - firstly, from the co-founders point of view, this research aimed to discover to what extent professional identity affected the willingness of those within Primary Healthcare units, in Fife, to accept fundamental changes in their working practices. Secondly, from an academic viewpoint, the aim was to draw more general conclusions from the specific case of Fife. Specifically, seeking to answer the question of what is the relationship of professional identity to processes of change?

Given the contemporary challenges in the field of healthcare, not just in Scotland and the rest of the UK but worldwide, and the widely discussed need to reform the current primary healthcare system, this is a topic of interest to many. The knowledge detailed here will also be of benefit to policy makers and anyone attempting to introduce organisational changes within a professional group.

As mentioned above, this research contributes to not only knowledge about the Scottish and UK Primary Healthcare System, but also to an international body of studies showing that the same issues are affecting family healthcare organisations in many different countries (Beaulieu et al. 2008).

The thesis combined two main academic areas, that of organisational development and of professional identity. The key findings and contribution to these areas of knowledge will be considered below. The research has also produced practical implications for the funders and these will also be discussed. As with any research, there are limitations to the research and these will be reflected upon. The methodology used, that of grounded theory, will also be considered and it will be evaluated against the criteria or credibility, originality, resonance and usefulness. The quantitative element of the research will also be evaluated. The chapter will conclude by offering recommendations for future research.

6.2 Academic contribution

The evidence generated here has strongly concluded that professional identity plays an important role in the generation of resistance to organisational change. That is not to say that there may not be other contributing factors, but it has been shown that professional identity is an important factor and as such cannot be ignored.

This leads to the fact that the key academic contribution made by this research project is to show that, when implementing an organisation change with groups who have a strong professional identity (in this case healthcare workers within a primary healthcare setting) the change programme must take that identity into consideration. Not doing this risks the professionals resisting and blocking the proposed change. This will contribute to the potential failure of the implementation of that change. To date, this knowledge has been taken forward for use within another Scottish Primary healthcare area wishing to learn from Nuka.

The relationship between COR and the work of health and social care professionals, managers and other workers is also discussed and further details about this can be found in Walsh, Kittler and Mahal (2018). It was argued that Midgley et al, (2007) see the identities of COR practitioners as an often-missed influence on the way boundaries are determined. Midgley et al (2007) suggest 12 indicative strategies for systems practitioners to address issues raised by their own ascribed identities. These strategies were used to highlighting a number of more general failures of systemic reflection on identity in the NUKA trial in Scotland.

This thesis also extends the work of two established pieces of work – those of Leverman et al (1998) and Schilling et al. (2012) as was discussed in section 1.5 of the Introductory chapter.

6.3 Methodological contribution

This research makes a methodological contribution by extending the discussion around the usage of a mixed method grounded theory methodological appraoch. Until recently grounded theory was considered to be primarily a qualitative method, however recent literature has questioned this assumption (Walsh 2015, Walsh 2015a, Walsh 2015b). Although using a mixed method paradigm in both qualitative and quantitative spheres has

become well established over the 'last 20 years or so' (Walsh, 2015a, p.534) this is not the case within the area of grounded theory (Creswell 2013). Although Walsh (2015 p. 584) considers a mixed methods grounded theory study to be 'groundbreaking' and has herself used a mixed methodology within a classic grounded theory project, others disagree with her (Walsh, 2015, b). This topic was discussed in depth in chapter 3. This thesis contributes to the debate by showing that a mixed method grounded theory study can be used legitimately and usefully within an academic study. Using a mixed method study can strengthen the end results and contribute to establishing a systematic, valid theory. Although this research was primarily qualitative, building in a quantitative element did help to validate the findings from the interviews and strengthen the overall research.

6.4 Practical contribution

This research has looked at a small group of primary healthcare professionals, but the implications are relevant for anyone who is required to implement a multi-system change within a healthcare environment or within an environment where the staff involved have a strong professional identity. Wherever a traditional linear, step orientated model is used there will in all likelihood be a degree of resistance from staff. This resistance and the blocking of the change will ultimately contribute to the already high rate of failure of organisational changes. The resistance will be generated by a perceived threat to the individual's, or group's, professional identity. To neutralise, or at least reduce, this risk, the idea that professional identity may generate resistance must be considered from the start of a project and it must be re-considered in a cyclical process at all stages of the project lifecycle. The organisational change programme plan must contain steps to identify and defuse resistance before it derails the successful implementation of the change. This is not currently an element of change models and training.

The research done in this thesis has demonstrated that change in itself and adapting to that change can be stressful. That stress can lead to increased resistance to changes and increased inertia to accepting any changes, despite acknowledging that change may be required and may be beneficial.

Thus introducing a major structural change in general practice at a time when there is already a degree of turbulence is unhelpful. Stress needs to be reduced and people need to be calm and open to change. Therefore, conversely, the very time when a radical

change is required is actually the worst possible time to try and implement it. Going by this reasoning, the failure of the Nuka trial in Fife could be partly attributed to timing, partly to the fact that it didn't come as innovation from the grassroots and partly to the fact that there was not a critical mass of the GP partners on board at the time.

6.5 Impact for funders

This project was partly funded by a regional Health Board within Scotland. They wished to understand why they were having difficulty in running a pilot study to test a new model of working. They also wanted to find out why there was so little interest shown in a project they considered to be beneficial to those working in GP practice, and which they thought might ease a lot of the organisational issues being experienced by those GP practices. It was vitally important for them to find answers to these questions prior to tackling their next large change programme; the creation of H&SCI Partnerships (Health & Social Care Integration) between primary care and social work departments. This integration change, the result of government policy, was intended to merge two sectors of the primary healthcare system, two sectors with not only strong cultural differences but also different professional bodies. If this new Health and Social Care Partnerships are to succeed the Health Board Implementation group will need to work with GPs and their staff to create new forms of Community services, a more 'joined up and seamless' provision of primary healthcare. GPs, their co-operation and acceptance of this, are integral to this development. The findings of this research are feeding into the action planning process and are helping to inform the policy makers and planners in Fife NHS. This research has helped shape the change implementation plan by showing that the best way to engage GPs in creating a new model for the future of integrated community services is by considering professional identity and by planning for, and around, the resistance that identity may create. To date (February 2016) four meetings have been held with the Steering Group responsible for the H&SCI integration in Fife NHS. The stated aim of these meetings has been to help the Steering Group to create a local change model which takes into consideration the professional identity of those within the primary healthcare team, from the start of the planning process.

6.6 Evaluating a grounded theory

This research used a Constructivist grounded theory (CGT) approach, as advocated by Charmaz (2006). As was detailed in Chapter 3, when discussing how to evaluate a good Constructivist grounded theory Charmaz suggests the following criteria are used – credibility, originality, resonance, usefulness (Charmaz 2006, p182). Therefore, it seems reasonable to use these criteria for evaluation of the grounded theory part of this study.

The following four sections of this chapter will demonstrate that this research was conducted in such a way as to meet the requirements for a successfully and methodologically correct grounded theory study as promoted by Charmaz.

6.6.1 Credibility

The criterion of credibility is about the links between the data and the theory, the links between the analysis and the main argument of the study. To establish the credibility of the data within this research, firstly some of the limitations associated with the data are considered. The data collection method of interviewing has many limitations, as discussed in chapter 3; the interviewees are self-selected and interviews have the potential to contain a degree of interview bias. This may be particularly evident in a research project conducted at the request of an employer, as in this research, despite guarantees of confidentiality. To guard against this affect, efforts were made to ensure the interviewer did not influence or direct the responses in any way. The grounded theory ideal of using a constant comparative approach to data analysis also helped guard against this bias by checking response against response. Potentially, the credibility of the research could have been further increased by augmenting the duration of the data collection period (to guard against results being affected by a specific event). However, there was a limitation of time which was a result of restraints arising from the co-funders requirement to have the results feed into a specific planning process.

Credibility can also be established via recognition that the research data achieved data saturation. The in-depth nature of the interviews also provides evidence that the topic has been fully explored, as does the logical links between the data gathered and the resultant argument.

Credibility can be further evidenced by the consistency of the methods used, by the adherence to the grounded theory methodology, and the interviews and analysis being conducted by only one researcher. The inclusion of verbatim accounts of the interviews also helps to enhance the credibility by confirming the interpretation is grounded in the data. Linking the analysis with the established literature also facilitated the development of the data and subsequently gave credibility to the final argument.

6.6.2 Originality

Charmaz asks if the research offers new insights into the area of research and whether or not it challenges or extends existing ideas. This research, as was discussed above and in chapter 1, extends the research on organisational change on professional identity and builds on the work of Leverment, Ackers and Preston (1998) and Schilling, Werr, Gand and Sardas (2012). It suggests that a new model of organisational change must be developed which includes professional identity. This Researcher is unaware of any other research which suggests this.

6.6.3 Resonance

Resonance means whether or not the grounded theory produced is relevant. This can be demonstrated here by that fact that the interviewees agreed that the analysis offered insights into their everyday professional and working lives. To ensure this, the later interviews were used to discuss some tentative ideas from the ongoing and concurrent data analysis. The fact that the findings have been accepted by the co-funding body is further evidence that the findings are relevant and have resonance within the field.

During a post research discussion with the Practice Manager from the failed Nuka trial, she agreed that there was a definite element of professional identity causing issues within the trial and concurred that a perceived threat to professional identity was probably behind the trial being terminated early. This agreement further strengths the resonance of the research.

6.6.4 Usefulness

The usefulness of the research has been demonstrated by the inclusion of the ideas generated here within the organisational planning being carried out by the research co-funders. The research has implications for not only other area of health care, both within the UK and Internationally, but to other professional sectors as well. The problems being experienced within the primary healthcare area under research are, as discussed in chapter 1, widespread, and as was demonstrated are being experienced internationally. The learning points from this research can also be transferred to any organisational change involving any professionals with a strong sense of identity; this research is not applicable to only health care professionals.

6.7 Evaluating the quantitative element

Creswell (2013) recommends that each strand or phase of a mixed method study is evaluated separately; using the most relevant validity, or credibility, measure for that strand. Having considered the validity of the grounded theory strand of the study we will now consider the validity of the questionnaires, the quantitative element. Given that the questionnaire was used to test, validate and further question the results found in the interview data, this form of triangulation helps to establish the validity of the questionnaire findings. Seeking examples which did not support the overall view was a form of disconfirming evidence (Creswell & Miller 2000), a valid technique for testing validity. Also throughout the research, there was an ongoing dialogue with a participant from the original Nuka project, in which both the interview and questionnaire findings were discussed in detail, which adds further credibility to the both to the quantitative and qualitative streams of the research. As with the quantitative interviews, being able to spend more time in the field might have helped to solidify the results and enhance the validity and credibility of the findings but, due to time constraints, this was not possible. However, possibly for both streams of the research, the fact that the Researcher kept a detailed research log, which can provide an audit trail of what was done, when and why helps to strengthen the quality of the research. According to Creswell and Miller (2000) keeping detailed research notes is one of the most important things that a researcher can do.

6.8 Reflection on using a grounded theory methodology

This section of the chapter reflects on this researcher's experience of conducting a large-scale research project, for the first time, and on the learning points from that journey. It also aims to highlight the issues that were generated by using a grounded theory and specifically the method of Constructivist grounded theory.

Many students at Masters or PhD level are attracted to the grounded theory methodology as it appears to be prescriptive, the steps to follow in a grounded theory project are listed in multiple textbooks (e.g. Strauss & Corbin 1990; Charmaz 2006; Urquhart 2013) and journal articles (e.g.Dunne 2011; Montgomery & Bailey 2007; Birks et al. 2009; Evans 2013; O'Reilly et al. 2012). However, even with all these helpful lists and articles, the experience here was that this was not a straightforward exercise. Possibly the fact that there are a vast number of articles explaining different aspects of the process should have indicated that the process is not as straightforward as it initially appeared to be. In hindsight, it is evident that flexibility is important and this methodology is not about slavishly following prescribed steps but creatively adapting the steps to fit the specific data and situation. This flexibility is ultimately what is appealing, but to an inexperienced researcher, it is a double-edged sword. A more prescriptive methodology would have been easier and potentially less time-consuming.

The issue of literature, when to read it and when to incorporate it into the project, has been covered in chapter 2 so will not be replayed in detail here. Suffice to say that a lack of detailed knowledge of the literature in the area was a hindrance when coding. I followed Charmaz's (2006) guideline to keep the naming of codes grounded in the data and not to use the literature to create codes and categories and consequently the labels for the categories initially appeared to be very naïve and clumsy, and without substance. Ease of coding is something which very much develops with experience. However, not turning to the literature, in any depth, until analysis had started did help to ensure that the interview questions were not influenced by the existing literature, which helped to ensure the data was grounded in the experiences of the interview participants. However, finding multiple genres within the literature, for example, sociology, psychology and organisational development, did cause some confusion as this is not a scenario covered by Charmaz or any of the other texts consulted. For instance, the topic of professional identity can be approached from different academic and philosophical angles and that resulted in uncertainty at times.

As mentioned above, lack of experience in coding proved to be problematic, despite clear guidelines from Charmaz (2006). These guidelines were extrapolated into this work as far as possible. A central guideline of Constructivist grounded theory is that coding should be interpretive rather than objectivist. In other words, a code is not just a term but should convey the meaning and the experience of the interviewee, not just a bald description of the data. The formation of codes and categories was therefore quite a slow, tentative, time-consuming process. A more traditional descriptive form of coding would have been easier and quicker.

The initial decision to use unstructured interviews, in hindsight, posed certain difficulties. The interviews started with a broad 'tell me about' question, as advocated by Charmaz (ibid). The intention was then to use the answer from that question to shape the next question. This proved to be harder than anticipated as for a novice interviewer it is not easy to listen fully while considering what the interviewee is saying and also formulating successive questions. This was initially highlighted by difficulties in the pilot interviews which resulted in the production of an aide-memoire or loose topic guide for subsequent interviews, so moving away from the purely unstructured interviews which had been originally intended.

As discussed above this methodology provides the researcher with a degree of flexibility. It is a way of thinking about data rather than a method which must be technically followed. However, having said that, a grounded theory study does still have to follow certain central requirements, as discussed in chapter 3, which this research does.

Where the inexperience of this Researcher came to the fore in this project was in the ability to code and analyse in a more grounded, less descriptive way. With hindsight, more use could have been made of pure grounded theory coding and analysis methods. Memo writing should have been started sooner and used to a greater degree than it was to explore the underlying themes of the data. It could be argued that this deficiency has, to some extent, resulted in more of a mixed method study using a grounded theory method than a truly grounded theory thesis. However, as Urquhart (2013, p.136) explains 'GMT *[Grounded Method Theory]* is generally used in two ways – either as a stand alone method of qualitative data analysis or as a way of building theory', (the italics are my insertion). This research started with the aim of building a comprehensive theory but settled, as a result of inexperience and project constraints, on using grounded theory as an analysis method and creating a practical application (for use by the co-funders) rather than a full

grounded theory. Birks and Mills (2009) consider employing grounded theory methods with other research methods to be a legitimate use of the methods, they call such a methodology a modified grounded theory. Using Urquhart (2013) and Birks and Mills (2009) criteria, despite this research not producing a full grounded theory it is still a credible piece of research using a grounded theory method.

The project was partly constrained by the requirements of the co-funders, as often is the case in research funded by non-academic bodies. They had an area they wished to explore and they wanted a concrete answer to their problem by a specific point in time. This controlled the research from the start. Given the nature of the research, recruiting participants was a severe hindrance, despite (or possibly because of) the co-funders willingness to assist in recruitment. The inclusion of the quantitative stream of the research was also at the request of the co-funders (as discussed in chapter 3) and while this was initially seen as a hindrance ultimately it proved to be beneficial to the research.

6.9 Reflection upon the overall research experience

This research project has proved to be both rewarding and challenging. To have contributed knowledge to the design of a large-scale organisational change within Fife NHS (the Integration Agenda) has been immensely rewarding. This has been a true example of the impact primary research can have within a professional or industrial environment. However, the experience of this research has also been extremely challenging and frustrating at times. One consequence of being part-funded by a public body is that they, rightly, expect to have their wishes and requirements considered. A lack of internal agreement after it became obvious that the research wouldn't be evaluating the Nuka trail resulted in many months delay in the start of the research while other potential topics were considered. The loss of many months work has had repercussions on the amount of time available to complete the PhD component of the research. Added to this there were recruitment difficulties among a group of professionals who are notoriously hard to access, which also served to slow down the pace of the research.

As part-funding for the project was coming from a specific Health Board they wished the sample to be from their area. Although this was the case with all of the interviewees, a wider sample frame was used for the questionnaires in an attempt to increase the response rate and to allow for consideration of a geographical bias. If the interviews had

likewise been from a larger geographical area then the response rate might have been higher.

The limited number of interviewees and respondents to the questionnaires resulted in a limitation of the quantity of the data which could be collected. However, the interviewees who did consent to be interviewed were very generous with their time and although the quantity of the data was limited the quality, being rich in detail, was unaffected. Fortunately, as this was a grounded theory methodology the limited number of interviewees was in itself not detrimental to the final result. The methodology is considered ideally suited for research which has limited data. This also was an exploratory piece of research and so again the limited data was not considered too much of a hindrance.

If the project had managed to procure more interview data then the research may have looked different. More data may have allowed for greater saturation of the categories or indeed more categories, although this point is open to argument as the categories which were produced were considered to be saturated fairly quickly. More data within the questionnaires would have allowed for statistical analysis of the results which would have been interesting and may have produced some additional findings.

To develop this research further a greater sample size would be required, ideally covering multiple health board area's across Scotland, England and Wales. Although the devolvement of the NHS to the Scottish Government has resulted in substantial differences between the way NHS Scotland and NHS England and Wales are managed, they still face the same fundamental issues and the need to consider the resistance generated as a result of professional identity is required by both

The co-funders of this research provided no firm guidance as to what they hoped to achieve from the research thus placing the full responsibility for the design of the project onto the Researcher. While this was quite stressful it also proved to be a great learning experience as all the research decisions were ultimately the responsibility of the Researcher.

One of the biggest challenges within this research was accommodating the co-funders' request to include a quantitative stream in the research. This meant that the methodology of the research had to be changed after nearly 2 years of research. This is an example of working out with an academic arena and although challenging proved to be excellent learning experience of the need to be flexible and meet the requirements of the funders.

6.10 Limitations

As discussed in Chapter 3, some of the limitations associated with this study are related to criticisms of mixed methodology and grounded theory research in general. Specific limitations related to the methods used here have been described in detail in the relevant sections in chapter 3 (section 3.4, 3.8 and 3.17). The purpose of this section is to consider the limitations of the methods in the context of this thesis.

The first limitation has to be that of the Researcher. The Researcher was new to the usage of a grounded theory methodology and this was a limitation as a considerable length of time and resources were spent on learning how to use the method, especially the coding and analysis aspects of it.

Another limitation which is apparent comes from the selection process of both the questionnaire and the interviews – they were both self-selected, which introduces a selection bias. The other main selection bias was that accessing nurses and receptionists proved hardest as they don't control their own diaries. Practice Managers were the easiest group to access as they run their own diaries and don't have clinical sessions. Several of the GPs who agreed to be interviewed were part-time and were able to be interviewed around their clinical sessions. The selection process did not control for individual or group differences, such as gender, age or profession. This was a proactive decision made based on the limited number of individuals who agreed to be interviewed and as a way of not limiting the number of completed questionnaires.

The findings in this research are based on the views, experiences and discussions held with interviewees and those who answered the questionnaire. The interviewees were all based in one area. This was unavoidable as the co-funders of this research were interested in hearing the views of those of concern to them. However, the questionnaire had a wider base to try and increase the generalisability of the findings. The relatively small sample size for the interviews (n=14) may be seen as a limitation and lead to criticism that the results are not representative. However, given that data saturation was reached it is unlikely that an increased sample size would have been useful and a small sample size, as discussed in chapter 3, is acceptable for a project like this. Part of the decision process to use a grounded theory methodology was that it was suitable for a small scale project, and would be able to provide insight from a relatively small number of interviews. Furthermore, the aim of this research was to produce insight and

understanding on a specific issue, not to produce results of a statistical nature about the prevalence of perspectives.

There is also a potential limitation as a result of respondent's bias, respondents saying what they believe you want to hear in other words. Attempts were made to reduce this by explaining the confidential nature of the research and by reassuring respondents that it was their views and experiences that were of interest and there was no wrong or right answer to a question.

This research studied reactions to the idea of change at a single point in time. However, as others have claimed (Piderit 2000), change is an ongoing process and reactions to changes may evolve over time. Reactions to changes may follow a natural progression from resistance to acceptance, and so any research into attitudes may be affected by the timing of external issues.

6.11 Recommendations of future research

This section of the chapter considers how this study has opened up possibilities for future research. Unfortunately, a PhD research project does not provide the scope or resources to raise this theory to a more generalizable level. Yet the enormous demand in healthcare internationally for generalizable knowledge does create academic opportunities including building on the grounded theory produced through a primarily qualitative exploration with a primarily quantitative approach aimed at testing discrete hypotheses (this coupling of qualitative exploration with quantitative hypothesis testing was discussed previously in section 3.13). After developing appropriate instrumentation this could help to produce a Change Model specifically for use within a professional environment to reduce the very high failure rate of change programmes in the future – this would be highly attractive to NHS and other health system managers. Indeed increasing the number and nature of participants and generating more data by *either* or *a combination of* qualitative exploration and quantitative designs is needed to expand the breadth and depth of understanding of the way professional identity influences or is influenced by attempts to change and develop health and social care.

Other projects could assess to what extent professional identity is associated with barriers to change in health systems around the world. This could potentially highlight new insights

into the issue of professional identity resulting in barriers and resistance to organisational changes.

Projects can be designed that will focus on particular problems, such as the need for health systems strengthening in developing countries (House of Commons International Development Committee 2014) or on systems reform in richer countries like the US and the UK (for instance by focusing on the severe challenges of integration of health and social care in the United Kingdom). Other aspects of these domains can be explored – professional identity and gender (given the gendered nature of health and social care), professional identity and culture (given the high proportions of overseas healthcare workers in many health systems, e.g. in the UK around 20% of the workforce is expatriate[4]); professional identity and leadership (given the emphasis on leadership in healthcare,see Brookes & Grint 2010). These are large, international and substantial domains for further inquiry with both academic (by developing new knowledge) and practical implications (by application of this evidence in the planning and implementation of health and social care).

The leadership aspect of professional identity appears especially appealing at the time of writing because of the increasing emphasis on leadership improvement as argued by Howieson et al (2013). According to Brookes and Grint (2010), the need for "clumsy solutions" (to use Grint's 2008 language) to tackle "wicked problems" (Grint uses Rittel and Webber 1973 famous term) is necessary in the New Public Leadership of public sector services. Indeed from Grint's (2008) viewpoint leadership in the face of wicked problems itself is characterised by the need for clumsy solutions drawing on three perspectives, the individualist, the egalitarian and the hierarchist. However, what is overlooked, despite the contribution to this book from the eminent Walshe and Chambers (2010) around leadership in healthcare, is the vital perspective of professional identity.

Again, missing from Grint's (2008) own eminent contribution is consideration as to how professional identity defines or influences any of these perspectives or how professional identity might amplify or act as a barrier to a synthesis of these perspectives in leading the creation of so-called "clumsy solutions". Grint is also silent as to how this leadership theory can be operationalised. Community Operational Research may provide a practical way of achieving this so it is useful to consider the possibility of a synthesis building on the

[4] https://www.kingsfund.org.uk/projects/verdict/what-do-we-know-about-impact-immigration-nhs

discussion of professional identity and systemic boundaries in Community Operational Research (Walsh, Kittler and Mahal, 2018).

It is clear then, as discussed earlier, this research is based on an issue which is becoming apparent for many health and social care providers around Britain and the world. Research looking at the problems and solutions in other countries would be interesting and instructive for both policy makers and change managers in the UK.

6.12 Concluding remarks

This thesis has explored the reasons why healthcare professionals within the primary sector were resisting and blocking changes, changes which others thought were the perfect solution to the problems intrinsic to the sector. It was established that those wishing to implement the organisational changes had not taken the professional identity of the actors involved into account. This was further confirmed by the literature which showed that professional identity is not something considered as part of the established change models. Research from the area of identity confirmed that a strong professional identity is felt to be fundamental to many within the healthcare profession, especially doctors and General Practitioners. The data gathered here confirmed this. Further research, as identified above, should be undertaken to confirm and refine the issues presented here.

In conclusion, this research has established that unless professional identity and the effect it can have on those facing organisational change is considered and incorporated into the change process at all stages, then the change will be more likely to fail. This knowledge advances the academic understanding of the change process and yields significant benefits to those practising in the field.

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Appendices

Appendix 1 Research flyer

Research Study

The experiences of Primary Health Care Professionals

We would like to talk to a number of Doctors, Practice Nurses, Practice Managers and others working within a Primary Health Care setting, about their experiences of work related-changes. We are interested in understanding how people experience change in their working environment and the impact changes have on their working relationships, practices and process.

In recent years there has been a lot of effort spent on understanding "patient experience" but we still have a very limited understanding of the work experiences of those employed in Primary Health Care. This study aims to help fill this gap.

We would like to talk to people, at their convenience, for around an hour and then again in nine months to a years' time. The hour need not be all at once, it could be in half hour chunks. We would like to talk to you this autumn and again in nine months to a years' time.

If you have any questions or would be interested in taking part please contact Dawn Mahal on 07779940167 or email dawn.mahal@stir.ac.uk

Dawn Mahal
Research Student
Stirling Management School
University of Stirling

September 2014

Appendix 2: Consent form

Consent form

The experiences of Primary Health Care Professionals

1. I confirm that I have received an explanation about the study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason. ☐

3. I agree to take part in the above study. ☐

4. I agree to the interview being audio recorded ☐

5. I agree to the use of anonymised quotes in publications ☐

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

Dawn Mahal

PhD Research Student
Department of Management, Work and Organisation
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Appendix 3: Interview topic guide

FIRST QUESTION - How long have you been a [position]

SECOND QUESTION - Tell me about being a [position] – not your day to day tasks but what it's like to do your job

IDEAS FOR PROMPTS

- Has your role changed since you started
- Is your job what you expected *in what way / way not*
- Characteristics of a typical XXXX
- What are your biggest professional challenges *how could they be fixed*
- Do you see your job as being restricted to your working hours or is it more to you *does it spill over into your home life, has this changed over time*
- Is there tension between your professional values and what is required of you at work

THIRD QUESTION - I've heard it said that the NHS is said to be in a constant state of change – tell me about that

IDEAS FOR PROMPTS

- Tell me about a change *who or what imposed the change*
- What come first the implementation of the change or the accepting the need for change then implementing it
- Who decides the change is needed or ok? Does the change affect you
- Models of care are changing *how do you feel about that, threat or opportunity*
- Inter professional collaboration *is that happening here, how does it make you feel*
- If a big change came in tomorrow – a change in your day to day working practice – what would your gut reaction be to that *worry, excitement, fear….*
- Main problem in the practice today and how to fix it

Wind up – questions, contact again

Anyone you can point me to for interviews?

Appendix 4: Questionnaire (paper version)

Hello,

I am a PhD student researching attitudes towards structural changes within Primary Healthcare.

It is widely agreed that the primary health care sector currently faces a number of ongoing challenges, for instance an aging population, growing numbers of patients with multiple long-term conditions and increasing expectations from the public. Within this context I am interested in finding out how those working in Primary Healthcare feel about the possibility of changes to the way in which they currently work. These results will help me form a picture of how staff feel about their current roles, how they see them changing and what concerns they have. The final result will form a section of my PhD research.

I would be immensely grateful if you could complete the very short survey on the other side of this sheet or paste the internet link below into your web browser.
https://www.surveymonkey.com/s/YF78XJQ

All responses will be held in the strictest of confidence. The responses will not be traced back to any respondent and no individual response will be attributed to anyone. The responses will be amalgamated to create an overall result. The responses will be securely held for the duration of my study and then will be destroyed.

If you have any questions or would like more information about my research please email me at Dawn.Mahal@stir.ac.uk. I am happy to send a copy of the results to anyone who would like them, please just email me.

Thank you

Dawn Mahal

Dawn Mahal
PhD Researcher
University of Stirling Management School

February 2015

Please circle the responses you wish to give

1. My role meets the expectations I had when I completed my training:

   Agree Disagree

2. I feel a threat to my ability to help my patients:

Strongly agree Agree Neither agree or disagree Disagree Strongly disagree

3. I feel we are facing radical changes within Primary Healthcare:

   Yes No I've never really thought about it

   If you answered 'Yes', what is the single biggest change you think will happen in the NHS in the next 10 years?

4. I feel threatened by the possibility of changes to the way I work:

   Yes No

5. Over the next 12 months are you expecting to have to fight against changes to the way you work?

   Yes No

6. What is your biggest current concern?

7. What is your role within primary healthcare? Please circle

   GP Practice Nurse Practice Manager other – please state your job title

Thank you very much for taking the time to answer my questions

Appendix 5: Coding table

All initial codes from the interview data

bureaucracy	arrogance	resisting
administration time	disconnected	work life balance
contract	image	recruiting issues
disjointed demands	generational	key person
business	attitude	chronic management
burning out	respectability	facilitation
coping	controlling	common goal
getting harder	leadership	Fife attitude
pressurised	paternalism	Hospital at Home
changing	juggling	Jack of all trades
financial carrot	blocking partnership	Nuka
financial management	nurses taking over	patient care
best practice	overloading	small business
business	common goal	controlling
not health related	patient care	pressure
disconnected	facilitation	generational
good practice	GP attitude	GP control
team working	unrealistic	non GP partners
profitability	recruiting issues	resisting
identity	expectations	profitability
practice management programme	GPs not interested	

Codes which were added after the questionnaires

privatising	unrealistic demands	recruiting crisis

Codes which were removed as they were considered to not be relevant as they only had one or two mentions. Despite being removed from the coding table they were not discarded in case they appeared to be relevant at a later date.

codes which were removed	reason
practice management programme	did not appear relevant
recruiting issues	not a reason for resisting change
Fife attitude	relevance
Hospital at Home	Out with scope
key person	relevance
chronic management	relevance
facilitation	relevance
Jack of all trades	refers to practice managers
juggling	in the context of practice managers
financial carrot	relevance
disjointed demands	similar to other codes