CSP-HSORU
COLLABORATIVE RESEARCH INTO PHYSIOTHERAPY ORGANISATION

Research into the Organisation of Physiotherapy

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Summary

THIS PAPER is the first in a series of reports of current research by the Health Services Organisation Research Unit (HSORU), Brunel University. The research has been initiated by the Chartered Society of Physiotherapy and, although it has been undertaken within the NHS, we believe much of it is applicable elsewhere. The Society aims to promote an improved understanding of organisation among all physiotherapists. Critical comments from readers will be integrated as part of the research and are welcomed by the CSP Steering Group.

The research method, collaborative analysis of organisational problems, is briefly described and the value of organisational clarity for day-to-day running of departments and the development of services is emphasised. An outline of previous work between physiotherapists and researchers shows how relationships, both among physiotherapists and between doctors and physiotherapists, have changed as the profession has developed. The subsequent research on self-management and levels of work in physiotherapy is also described.

Introduction

The way in which physiotherapy services are organised can have far-reaching consequences for patient treatment and for the profession. Although most physiotherapists are aware of how organisational matters affect them, they see their main task to be treating patients. We feel that the organisation of services should concern every physiotherapist and is important in both private and public health services.

This paper will describe our research method and review the collaboration between physiotherapists and HSORU members since 1967. In subsequent papers, we will describe ways of thinking about organisation which have been used by physiotherapists and found to be helpful. These papers will be devoted to subjects such as: the physiotherapist as bureaucrat; levels of work and grading in physiotherapy; clinical autonomy and responsibility; the role of the Senior I physiotherapist; District physiotherapy; career progression and opportunities in physiotherapy; and the relation between education and clinical practice.

An Unusual Research Method

Since 1967, groups of physiotherapists have invited the HSORU to help with their organisational problems and hundreds have taken part in this work (Jaques, 1978). The research method used is somewhat unusual and calls for some explanation as it can be misunderstood (Rowbottom, 1977). The HSORU is university-based and undertakes applied research into Health Service organisation. We work on practical, everyday problems and thus gain scientific knowledge of organisations. We feel that research should be of practical use; and that research findings gain robustness and validity by being constantly tested in the real world.

We start with an organisational problem or sometimes the 'symptom' of an organisational problem. Our research depends on invitation from physiotherapists and others (the clients). They define the initial problem and we collaborate with them in helping to solve it; they continue to draw on our help only as long as they find it useful.

This method involves discussion between the researchers and physiotherapists, who jointly consider all the aspects of the problem. Confidentiality is maintained to enable full exploration of the issues, and the client has the right to decide when the time is right for wider circulation of the contents of the discussions which are often summarised in reports. The client retains full control of the content and pace of project development throughout the whole procedure, in the same way that patients should continue to 'own' their problems rather than accepting the passive role of 'patient'.

Involvement in real problems has given us an in-depth knowledge of the working of Health Service organisation. The clients have a pressing interest in solving their problem or improving the organisation for which they are responsible. They are concerned to explore all the dimen-

sions of the problem, and consider all the options, because they have to live with the solution and make it work. The clients' motivation to solve the problem and their detailed knowledge of the situation and what is practical, plus the long-term involvement of HSORU, all help towards achieving a satisfactory outcome.

Organisational Problems

It is surprising how many problems in the health service have organisational components or are due solely to bad organisation. Often problems can reflect, for example, resource constraints, difficult personalities, geography and government policy, but many can be solved to some extent by changing organisation and working arrangements; indeed this is a common way of dealing with problems, for example national re-organisation in 1974 and today.

Some problems are caused mainly by bad organisation. For example problems may appear to stem from personality clashes. However, on closer examination, they are found to involve organisational patterns and conflicting demands that would cause difficulties for any one, and put the most good natured person under stress. Unfortunately, it may often take a number of staff to leave the same post before it becomes apparent that there is an organisational problem.

Another example is 'lack of finance'. In the Health Service demand will always outstrip supply, and there will always be resource constraints. Good organisational design, however, can make the best use of existing resources and can show how much more can be done with comparatively little extra funding.

It is not always easy for physiotherapists to recognise a problem in their department or District as 'organisational' — they are not trained to do so. Consequently, when a physiotherapist has decided there is a problem and called upon HSORU for assistance, the first task is to decide whether the problem is organisational and whether the Unit can help. In most initial meetings the researchers and physiotherapists clarify and explore the problem through discussion. The researchers do not discuss or assist with interpersonal skills, resource allocation, policies, and so on, although these areas are important in the effective working of organisations.

The problem and related issues are clarified by teasing out the important elements and developing meaningful concepts. The work then moves on to creating various organisational solutions based on this analysis and looking at their advantages and disadvantages. The physiotherapists use these findings in the light of their understanding of their own situation. It may or may not be possible to implement new ideas on a particular site for various reasons. However without naming person or site the researchers can draw on the findings in discussions with other groups of physiotherapists.

To begin with most people find talking about their work in this way new and strange. Though people work intuitively, they do so in regular and often prescribed ways, and standing back and looking at these patterns independently of the particular personalities involved is difficult at first. However, although individual personalities are important in how work gets done, standing back for a moment to consider the arrangements for doing work can often throw new light on problems.

The following hypothetical discussion is with a Senior I physiotherapist when it was thought there were problems in the department.

Researcher: Could you say something about your work relation to the Superintendent?
Senior I: It's excellent — first class. We have a good understanding.
Researcher: What is this understanding about?
Senior I: Well, I'm completely free with patients — she doesn't interfere.
Researcher: What influence does she have over you?
Senior I: We discuss things very openly. It's a good relation. We don't use hierarchy here. Influence goes both ways.
Researcher: But you can't do anything you like. For instance, can you order any equipment you like?
Senior I: I've always got everything I asked for.
Researcher: Who do you ask?
Senior I: The Superintendent. She gets requests from three other Seniors.
Researcher: Supposing she didn't provide what you asked for?
Senior I: It's never happened — I don't know. I wouldn't ask for something she couldn't give me.

In this exchange the Senior I and researcher are discussing an everyday work matter (equipment). What is emerging through discussion is a particular social arrangement, that is the Superintendent possibly co-ordinates equipment requests. In this way the researcher and physiotherapist work towards defining the nature of the working relationship by exploring different aspects of the relationship. The conversation also reveals a familiar paradox. Often people as a group agree that a problem is present but as individuals they have a tendency to avoid facing it squarely or agreeing that it bears on them. Facing problems is unpleasant but the only basis for new solutions. In this case another solution might be for the Senior I to have a direct relation to the District Physiotherapist.

Early Work in Physiotherapy

The Unit's first involvement with physiotherapists was at a large teaching hospital in 1966 where the immediate problem was uncertainty as to who was in charge of the department of physiotherapy and occupational therapy. The formal 'head' was the then director of physical medicine, but it was clear that he shared some of the necessary work of running the department with the administration (house governor), the Superintendent Physiotherapist and Head Occupational Therapist. This problem was not merely 'academic'; no one was clear who was accountable for patient treatment or who was to make authoritative proposals for the development of services.

Exploration of this problem revealed many organisational relationships which needed to be clarified if practical questions, such as who should go to whom for what, were to be answered. The greatest difficulty at that time was that only two concepts were used to describe the organisational relationships between and among doctors, therapists and administrators. These concepts were 'managerial', assumed to mean that one person was sanctioned to control another; and 'collegial', meaning that action depended on those involved agreeing as equals. These concepts were obviously inadequate to describe the variety and subtleties of organisational relationships that existed, or were required: it was like trying to describe a rainbow with a vague idea of the concepts of black and white.

The main contribution made by HSORU was to explore and dissect the concept of authority, and elaborate a

language to describe the organisational relationships that all those involved thought were necessary to make the department work. It was agreed that doctors needed control over services provided to their patients; but this did not mean they had to *manage* therapists. Indeed they were unwilling to be involved in most managerial tasks.

Through collaborative discussions the Unit helped those involved to map out their relationships in a way which reflected the wished-for distribution of responsibility. A 'superior-subordinate' relationship was felt to prevail between the then director of physical medicine and the Superintendent Physiotherapist and Head Occupational Therapist, and between different grades of therapists (eg Superintendent and Senior Physiotherapists). This means that the superior could veto the appointment of a therapist, allocate resources and assign work, and appraise the quality of the work done. A 'prescribing relationship' was thought appropriate between clinicians and therapists working with their patients. It described the doctors' right to determine the priority of service, and to make comments on the general quality of the service, but precluded them from determining which physiotherapist should carry out a prescription, or from making direct judgments on any particular physiotherapist meeting their prescriptions.

By 1969, at the end of the first phase of the Unit's work with physiotherapists and others in the hospital group, some of the organisational relationships between doctors and therapists, and between senior therapists and other therapists, had been clarified. Some work had been done on the content of the relationship between administrators and senior therapists but this was only fully defined in the next phase of the Unit's work.

Self-Management

Collaboration with therapists in this hospital group started again in 1971 and continued until the 1974 NHS reorganisation. Problems were emerging due to the growth of physiotherapy towards full professional status and increasing claims for self-management by the remedial professions. The three main issues discussed in this phase were (1) definitions of the role of consultants in physical medicine, (2) distinction between the work of hospital and group Superintendents, and (3) the relationship of administrators to senior therapists.

The director of physical medicine found himself in an increasingly difficult situation: he occupied two conflicting roles. One role was that of clinician, requiring therapy for his patients, the other was that of manager of therapy services. He also found that other clinicians were by-passing him and prescribing therapy themselves. At the same time, therapists were questioning the appropriateness of a doctor managing their services, and asking whether it restricted the development of their profession.

The other main organisation difficulty at that time was the difference and relationships between group and hospital Superintendent roles. Discussions clarified the view that the difference between the roles was not enough to justify putting the group head into a managerial relationship with the hospital head. It was felt that there was not a sufficiently great difference in 'level of work', or enough 'organisational space' between the two roles for a 'superior-subordinate' relationship to be workable. It was clear, however, that the group head required some form of control over group activity, and an advisory relationship with hospital heads carried insufficient authority. But what kind of authority was appropriate?

It was not possible to address this question fully until after the 1974 reorganisation and the McMillan working party report (1973). However, progress was made in defining the administrators' relation to senior therapists as one of 'monitoring and co-ordination'. (We will omit the details of this for now.)

The analysis briefly presented above, and other work on the organisation of physiotherapy and occupational therapy, contributed to the comments made by the two professions on the reorganisation proposals. Therapists were concerned that the proposals would be implemented so as to make management by consultants in physical medicine (retitled rheumatology and rehabilitation) the rule, thereby denying therapists the right to manage their own affairs and negotiate directly with employing authorities, as well as restricting collaboration with other specialties.

Post-1974 Reorganisation Work

At the beginning of 1974, with the McMillan proposals for a District Therapist and the new NHS structure, the remedial professions had their first real chance to develop their own organisational structure. Collaboration between HSORU and the newly designated Area Health Authority centred on the therapists' concern that although the development of senior administrative posts in the therapies would provide greater self-management, it could depress the level at which clinical therapists worked. Observation of the developments in nursing since the 'Salmon' reorganisation had shown that this might occur. But the concern that a District therapy role over existing Superintendents and Heads would lower the level of clinical work, assumed a sense of what the existing and desirable levels of work were. Thus the starting question was: 'What is the NHS work that physiotherapy and occupational therapy structures are designed to provide?'

Through discussions with therapists it was possible to make explicit the expected level of professional work (ie patient treatment) in physiotherapy and occupational therapy. Further analysis clarified an exact meaning for different levels of work. From this therapists were able to determine the organisation that was required above and below those doing basic professional work as well as the appropriate relations between therapists and clinicians. The advantage of our particular research method in this process of organisational design was that it enabled therapists to make explicit their experience of different weights of responsibility, and allowed the construction of an organisational structure which reflected their actual experience and accommodated their intuitive sense of the difference between jobs.

The organisational structure which emerged from the social-analytic research process had three main levels*. The middle level, called Work Stratum 2, corresponded to the level of basic professional work, and was itself subdivided into three grading bands, which related to work of different weights of responsibility within basic professional work. Work Stratum 1 corresponded to the level of work done by helpers and students, and was also subdivided into grading bands. Work Stratum 3 corresponded to managerial work done by some Superintendents. It was found that some Work Stratum 2 therapists did not require a manager, but those who did were usually managed by Work Stratum 3 therapists.

Given their sense of the differences between Work Strata 1, 2 and 3, the therapists thought that there might be insufficient Work Stratum 4 work in the therapies at that

*The third paper in this series will describe the theory of work strata as developed and used in this study.

time to justify a separate post. It was thought that for the time being any District role should be co-ordinative work within Stratum 3. When the District Therapist role was first proposed it was assumed it would be a managerial role over existing Superintendents and Heads (McMillan Report, paragraph 42). But the research findings at that time pointed to a District Therapist who was chosen from existing Superintendents and Heads, with the authority to co-ordinate her colleagues but not to manage them. The most recent research work suggests this is not appropriate in all Districts and that a managerial relationship between District Physiotherapist and Superintendents may be called for in some of the new Districts. Grading of District Physiotherapist posts has also become an issue.

Another important outcome of this phase of research was a reformulation of the organisational relationship between doctors and therapists. Although earlier work had described this relationship as 'prescribing', various developments such as the appearance of new treatments and the increasing skills and standard of physiotherapy education had made this definition inappropriate and inaccurate. A new concept was needed to define the authority consultants required if they were to accept overall responsibility for their patients, and at the same time allow therapists self-management. Analysis led to the formulation of the concept of 'attachment with monitoring', which described a consultant's authority to participate in appointment to managerial therapy roles, but only to advise on the appointment to other roles. Recent work has led to further reconsideration of the relation between doctors and therapists.

Recent Work

Publication of work in 1977 led the Chartered Society of Physiotherapy to be concerned that matters affecting physiotherapy were taking place outside its ambit. The CSP believed that to get maximum value from the research the whole profession needed to be involved. Meetings in 1978-79 led to a new phase of collaboration which began early in 1980. The HSORU was asked to look into some of the organisational problems of 'high level' physiotherapy in general. Discussions with physiotherapists in all parts of the country led to a first report to the CSP. Work continues with physiotherapists in various Districts on problems of the present re-organisation of physiotherapy in one District. Working conferences are being mounted at Brunel and in the Regions for wider discussion of aspects of physiotherapy organisation.

Looking back over the history of the collaboration between HSORU and physiotherapists, one of the most interesting features is how changes in organisation both reflect and contribute to the development of the profession. Organisational change consolidates and institutionalises the gains of the profession, and provides a sound base and the right conditions for further developments in theory and service to patients. We will explore some of the organisational issues currently facing the profession in the coming papers which make up this series.

Suggestions for Further Discussion

Do you have any organisational problems? Why are they organisational? How are these normally dealt with? What was the point of the hypothetical dialogue? What have been the organisational changes where you work? What organisational changes will the NHS re-organisation produce? How have organisational relations with doctors changed?

REFERENCES

DHSS (1973). *The Remedial Professions* (McMillan Report). HMSO.

Jaques, E (ed) (1978). *Health Services*, London, Heinemann. Chapter 9 only is available from HSORU, £1.30 post free.

Rowbottom, R W (1977). *Social Analysis*, London, Heinemann.

Any questions, criticisms or comments concerning the papers in this series should be addressed to Steering Group (Brunel Project), CSP, 14 Bedford Row, London WC1R 4ED. All letters will be acknowledged and at an appropriate stage issues raised in them will be discussed in the Journal.