CSP-HSORU
COLLABORATIVE RESEARCH INTO
PHYSIOTHERAPY ORGANISATION

The Physiotherapist as a Bureaucrat

WARREN KINSTON BSc MB BS MRCPsych
Senior Research Fellow

JOHN ØVRETVEIT BSc
Research Fellow

Health Services Organisation Research Unit, Brunel Institute of Organisation and Social Studies, Brunel University, Uxbridge, Middlesex

An organisation is made up of linked roles which are filled by people. Terms used to describe an organisation, or the people, must be defined clearly and understood by those in the organisation if it is to function satisfactorily. Any interaction of practitioners to serve patients, private or public, requires some form of organisation. In the UK, the National Health Service is a very large bureaucracy which includes a physiotherapy section. Physiotherapists should be aware that they participate in the creation of their own roles and organisational structures. These ought to depend on the work to be done, but are often distorted by pressures for prestige or short-term political considerations. Many organisational arrangements are informal. Formalisation may be optional or essential; it is often used to contain and channel the exercise of social or personal power.

THE FIRST article in this series described the involvement of the Brunel Health Services Organisation Research Unit (HSORU) with the physiotherapy profession. It outlined the method used by the researchers, gave examples of work completed prior to the present collaboration with the Chartered Society of Physiotherapy (CSP) and invited collaboration from readers (Øvretveit *et al*, 1981).

This paper introduces some concepts and ideas of social structure which are basic to the HSORU research approach and necessary for understanding later papers. Some of these ideas, for example role and authority, were used in the initial paper without clarification. However, it is important that terms should be clearly defined and agreed upon. This may be difficult when these same terms are used colloquially in a variety of ways. The vocabulary of organisational theory is complex and controversial and only the crucial distinctions are highlighted here.

It is common for social and psychological contexts to be confused since the same word is often used in both contexts; for example, *autonomy*, *authority* and *responsibility* can be properties of both persons (psychological) and of roles (social), depending on the nature and purpose of the discussion. Unless this is clear, debate can become a meaningless exercise. A senior registrar in medicine aged 35 years and with a higher degree can certainly have clinical autonomy so far as personal ability is concerned but so far as institutional status is concerned, he cannot.

Role and Office

Organisations are social structures deliberately created and maintained to get work done (Etzioni, 1964). They are built up from roles. These roles stand in relation to each other and it is the quality and strength of the links between them, as well as the roles themselves, which give the institution its character. People have expectations or requirements of the holder or occupant of the role and these can be specifically defined or described; thus, a role can be defined in terms of expectations. Roles are crucial to effective working relationships. Role behaviour is distinguishable from behaviour which is a function of a particular person. Role may also be defined as the limits of social expectation, for example the 'mother' role consists of behaviour which is the very least expected of a mother — it is not a definition or prescription of the way every, or indeed any, mother does or should act. Similarly, we may distinguish between the role of 'physiotherapist', common to all physiotherapists, and actions of individual physiotherapists within that role. Naturally, there are always debates about how particular roles should be defined. For the present purpose, it is important to note that explicit role definition is possible, and often socially necessary (Litterer, 1965).

Physiotherapists occupy two main employment roles in the UK: first, the role of NHS employee which includes making physiotherapy skills available to the public; and second, the role of private practitioner which includes contracting an individual's skills directly to individual patients. It will not be surprising that organisational differences arise; catering for the needs of 55 million people is not the same as providing treatment in a local practice.

It is easier to reach agreement about the necessary attributes of a role than the attributes of a person. Mismatching the psychological qualities of physiotherapists with the social attributes of their roles is a cause of stress and potential confusion. Physiotherapists are not trained in the analysis of social structure but, since they work within the largest bureaucracy in the UK, some understanding of roles and their relationships may be useful.

The most immediately obvious difference in the nature of the two roles is the degree to which the holder may define the role. Private practitioners may decide the sort of patient they will treat, the treatments they will provide,

when and where they will work, the colleagues they will associate with, and so on. Should they stop work, move away or die, the practice with its associated role players will disappear (unless sold), though the demand or need for services may remain. Most significantly, there is no defined ceiling on earnings; pay will depend on what the market will bear and on the skill and effort put into the work.

In a public body like the NHS, however, the role is also an 'office' (as in 'the office of President'). It exists independently of the person who fills it and may remain empty for years unchanged. The principal characteristic of an office is that it is created by someone other than the holder. Therefore, there is more potential for a mismatch between what an individual wishes or understands his role to be, and the official view of what it should be. Could the NHS allow its posts (offices) to be defined by the holders? To some degree it must, but it would be unlikely that local or *national* needs would be fairly and comprehensively met if all physiotherapists were allowed to operate totally according to their own wishes. The organisational work is to define NHS roles (offices) to balance the needs of the patients, the needs of other relevant health care workers, the needs of the profession and the needs of the individual physiotherapist. This is not easy, nor is it clear how such a continuous and sometimes thankless task should be undertaken.

Bureaucracy

The NHS, then, is a system of offices, ie a bureaucracy. If a bureaucrat is a person working in a bureaucracy, then an NHS physiotherapist is a bureaucrat. The bureaucracy is not separate from the treatment of patients; the treatment of patients is an expression of bureaucratic functioning. These papers are concerned with the physiotherapy bureaucracy within the NHS, and helping it function more satisfactorily. *Bureaucracy* and *bureaucratic* have become terms of abuse; perhaps *large-scale complex organisation* would sound less noxious. However, a change in terminology is unlikely to alter the issues and problems.

The widespread development of bureaucracy is a comparatively recent phenomenon (Weber, 1947). Before this century, it existed only in the Civil Service, the Church and the Armed Forces. Now, the majority of employment is within some form of organisation. This proliferation of bureaucracy occurred spontaneously and it is not surprising that there are troubles. Organisations are created by people to get work done, typically very large amounts of work (Jaques, 1976). Given the aims and work of the NHS, it was inevitable it should be a bureaucracy; as it happens, it is the largest single employer in the UK.

In so far as a bureaucracy obstructs work, it can be said to be functioning pathologically. Such malfunction may be inherent and inevitable, but criticisms of bureaucracy often sidestep the difficult task of putting things right or offering acceptable alternatives (Jaques, 1976). People working in a bureaucracy usually know whether the organisational structure is obstructing or facilitating their work and, from our experience, can usually contribute to better organisational arrangements given the opportunity (Rowbottom, 1977).

Physiotherapists have traditionally looked to the medical profession for guidance. However, it is unlikely that satisfactory solutions to organisational problems of physiotherapy will be obtained from outside the profession. Most other groups in the NHS have their own organisational problems, and emulation of their arrangements seems unwise. The final responsibility and decisions about physiotherapy organisation rest partly with the DHSS and partly with the local health authorities. These bodies are instruments of government. For reasons outlined in the following section, it is likely that such bodies would be responsive to guidance from the profession.

The Work to be Done

Organisational structure should be based on the work to be done, otherwise it will fail to facilitate the work. Surprisingly, perhaps, it is often difficult to describe work; especially for the person involved. It is difficult to be explicit because the aspects relevant to organisation, work responsibilities, are not as evident as activities or tasks. An office, or role, embodies a description of work to be done but is outside the desires or idiosyncrasies of a particular person. It should be rooted in the needs of the situation.

Role descriptions and statements of work to be done help combat one of the most pervasive and baffling ills of bureaucracy: the elevation of status over work. The preoccupation with career progression and the accompanying prestige, rights, privileges, rank and pay can result in the creation of structures which prevent, inhibit, discourage or interfere with work. For example, the introduction of the 'Salmon' scheme in nursing led to serious deterioration in ward sister work and professional discontent in higher posts (Jaques, 1978). The physiotherapy profession is certainly not immune to this phenomenon and examples will be discussed in later papers.

Structure should facilitate functioning in role, and enable work to be done with increased efficiency and effectiveness. It should also minimise mismatches between individual abilities and desires and the work to be done. If these mismatches become too great, physiotherapists will avoid working in the NHS or be unable to fill needed posts. The educational service can play a major part in this area by recruiting people of the right calibre, and by providing them with realistic expectations and appropriate training. This would require close liaison with the clinical services and, inevitably, would have to take governmental policy into account.

Formal and Informal Organisation

Writers in organisation theory sometimes distinguish between formal (ie explicitly specified) and informal organisation, for example personal networks (Katz and Kahn, 1968). This series of papers is primarily concerned with formal organisation. This is not to decry, devalue or minimise psychological, political or other factors in the working of an organisation; it is simply to state the field of concern. Informal organisation often relies on a substructure of formal organisation and examples of this will be provided. In other cases, a new arrangement may begin informally and, when it is well established, those involved argue that matters cannot be left to chance and personal idiosyncrasy, and so formal enactments are made. A current example is the relation between educational and clinical services for clinical teaching of student physiotherapists; this is unformalised — should it remain so?

The formalisation of structure, like decisions within that structure, is a matter for the profession and other relevant bodies. The HSORU does not intervene in, nor advise on, political, administrative, or clinical choices. Any choice has its own organisational implications and the examination of these is the research task. Such clarification may contribute helpfully to rational debate within the profession; other non-organisational implications will be raised in such debates.

Enactable Features of Organisation

It is pedantic and time-consuming to make all aspects of organisation explicit. However, if certain matters are not defined and public, confusion and disorganisation result. It seems essential, for example, that work is divided up and that work content of roles is determined; in physiotherapy we may ask whether there should be superintendents, and if so, what should they be doing. In addition most employees require authority for decisions to be clear, for example who can and should order equipment when needed. Relationships between roles, for example how a Senior I and a Superintendent should relate to each other, and accountability are also important but often get less attention until matters go wrong. The pay structure is always a matter for enactment, for example grading of District Physiotherapists has recently been an issue. Finally, various rules and procedures may have to be laid down, such as the way clinical autonomy is defined and when and how it is assigned.

Often informal political activity, in other words individual or group power, rather than structure is emphasised as the determining factor of organisational life (Haywood and Alaszewski, 1980). This may be so, but power need not be seen as bad or in opposition to constructive action. Power drives the organisation; without the ability of individuals and the determination of groups, nothing would happen. The purpose of structure is to provide realistic and acceptable limits and to channel power constructively. Poor structure often fails to give powerful groups or people socially defined responsibility and can generate discontent, discord and work disruption. The frustration of some capable physiotherapists in the UK Senior I grade can be understood in this way (Øvretveit, in press).

Conclusion

Future articles in this series will be concerned with the matters raised above. The issues are, or ought to be, the concern of all physiotherapists who work or plan to work in the NHS. After all, they will have to live with the problems and find their own solutions.

It is not clear who carries the responsibility for the organisational matters of detecting problems, finding solutions and deciding on changes. The DHSS is formally responsible for organisation but much of this is delegated locally. The CSP certainly has an interest and a responsibility to speak for the profession as a whole on organisation. These bodies carry social responsibility. Many physiotherapists may feel personal concern for the future of the profession. These papers, and the HSORU conferences and discussions, may serve as a vehicle for their participation and critical contribution.

Suggestions for Further Reading

From the perspective of this series of papers, E Jaques, *A General Theory of Bureaucracy* (parts 1 and 2) will prove the most congenial and informative text. A short readable introduction by Weber to his main theories is provided in *Basic Concepts of Sociology* (transl H P Sechter, Peter Owen, London, 1962). An outline of the broad field of organisation is provided in paperback by C Handy, *Understanding Organisation* (Penguin, Harmondsworth, 1976).

We are unaware of a suitable general introduction to the organisation of health services. For a criticism of the research contribution of HSORU see P Draper and T Smart 'Social Science and Health Policy in the United Kingdom: Some contributions of the social sciences to the bureaucratisation of the National Health Service.' *International Journal of Health Services*, 1974, 4, 453-470. The history and structure of the NHS is described in detail in R Levitt's *The Reorganised National Health Service* (Croom Helm, London, 1978) which is a useful reference.

Suggestions for Further Discussion

Is your work helped or hindered by the NHS bureaucracy? To what extent can you create your own role? Is the responsibility you carry matched by the authority of your role? What is the administrative content of your role? Does your group use any informal arrangements which might be better formalised (or vice versa)? Who are you accountable to for what? What has all this got to do with you?

> 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.

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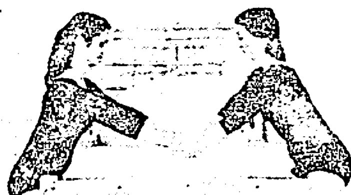

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