Continuing to manage professional identities

In last month’s feature, Celia Davies, Professor of Health Care at the Open University’s School of Health and Social Welfare, looked at professional identities and how they derive meaning from pairing: doctor and patient, manager and staff member, usually a dominant role with an ‘other’. Here, she continues to explore how this affects relationships and how new professional identities can be forged to meet current challenges.

Identity theory insists that we must not describe identities only in their own terms. We must understand their relational character and ask: ‘who exactly is seen as “other” in the process of constituting this identity?’ I suggest that there are at least three kinds of boundary maintaining processes of ‘othering’ at work in classic professional identity, as described in the last feature. Together they create the:

- Incompetent other
- Invisible other
- Unnecessary other

Consider first the question of the client, patient, or service user. Classic professional identity calls for an incompetent other, not active but reactive, not knowledgeable but ignorant, vulnerable, needy, grateful perhaps for an expert intervention that can mean the difference in extreme cases between life and death. User groups have challenged this.

**Activity 1**
A corollary of the classic professional identity is to think of the patient or client as incompetent other. This seems shocking, even offensive; professional training repeatedly stresses the importance of respecting the patient and providing patient centred care. Drawing from your own experience, can you see connections with the idea that being on the receiving end of professional advice means that you can end up feeling incompetent?

**Comment**
There are many ways in which those receiving care are put at a disadvantage: they are seen negatively as a burden, ‘dependent’ and needing help because of their dependency. One person described the shock of ‘trying to persuade social services that my mother was a human being’!

Writers on physical disability have been trying to create new kinds of relationship where people are respected and valued rather than being treated as other. Tom Shakespeare (2000) describes this well. Those who work alongside professionals, without formal qualifications, but often dealing face-to-face with patients, are often the invisible other. The impact they have on clients’ wellbeing is not regarded as important or worthy of recognition in the form of levels of training or reward. Nor does their experience readily translate into fast track routes into professional work.

What of those who manage professionals, or manage the contexts in which they work? The classic model of professional identity focuses on the one-to-one relationship with the client as at the heart of professional practice and sees all professionals as of equal competence. Its ideal is independent practice with a system of fees that helps preserve a sense of the professional as apart from the grubby business of commerce and industry, bureaucracy and politics.
Several have become the unnecessary: those without the commitment to a profession but who aim to make a profit, those who seem to seek power, and particularly those who are ‘mere administrators’. Managers, therefore, are a nuisance on whom you must put pressure to provide resources and facilities.

These features of the classic professional identity drew their coherence historically from a discourse of masculinity. They forged a place for the professions apart from the business and the land-owning classes, serving to produce status and prestige a different way (Davies 1996). As women take up more positions in professions, along with the diversity provided by different minority ethnic backgrounds and social classes, it becomes possible to question these norms.

Golden age professionals in the post-war years?
The mid-20th century welfare state brought the ‘golden age’ for professionals (Foster and Wilding 2000), giving them a state supported mandate to use their discretion in defining and meeting need.

The negative aspects of professional identity for others went unnoticed. Respect for the medical profession grew, as it made increasing strides in treating disease. ‘Support staff’ – who did detailed diagnostic and therapeutic work or helped care for and coordinate the overall experience for patients – got little attention. The manager, with the lowly title of hospital secretary, was a pale shadow of the doctor, someone who seemed always cautious, deferential and rule-bound. One 1960s hospital secretary explained how it felt to work with doctors: “Sometimes when I go home, I do wonder whether I should consult the worms before I cut the grass!”

The NHS has often been called a bureaucratic/professional alliance, but it was one in which the professional was the dominant partner.

Professions took a hard knock in the 1980s. The Conservative government elected in 1979 marked the beginning of the end for the golden age for many welfare professionals. The major changes included creating the purchaser/provider split, the emphasis on markets and the mixed economy of care and seeking to instate a new kind of manager, as an active entrepreneur, drawing inspiration from successful private business in emphasising how to get results (du Gay 1996).

Criticisms of professional practice and professional competence began to increase. This was not only an attack on professions, but also a move that challenged existing forms of management and questioned the role of politicians too.

Clarke and Newman (1997) emphasise that the new ideas worked by means of ‘vilification of the old and idealisation of the new’, where one identity sets its boundaries by disparaging others. Recent messages from Labour, less about managerialism and more about modernisation, reflect similar though not identical thinking (DoH 2000).

Legitimating managerialism

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<tr>
<th>Bureaucracy is:</th>
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<tr>
<td>rule bound</td>
<td>innovative</td>
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<td>inward looking</td>
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<td>compliance centred</td>
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<tr>
<th>Professionalism is:</th>
<th>Management is:</th>
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<tr>
<td>paternalist</td>
<td>customer centred</td>
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<td>mystique ridden</td>
<td>transparent</td>
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<td>standard oriented</td>
<td>results oriented</td>
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<td>self-regulating</td>
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<th>Politicians are:</th>
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<tr>
<td>dogmatic</td>
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<td>interfering</td>
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(Source: Clarke J, Newman J 1997)
In the new climate, professionals could no longer ignore management and devalue managers. They were being more actively managed, but they also found that they were becoming managers themselves.

**Activity 2**
What do Clarke and Newman mean when they talk of vilification of the old and idealisation of the new? The ideas in the table are probably familiar to anyone working in the last decade in the NHS. Can you see how the dynamic of ‘othering’ is at play just by reading the table?

**Comment**
Try reading from right to left and personalising it. ‘We the managers are innovative’, ‘the trouble with you others, the bureaucrats, is that you hide behind the rules.’ Reading each line in this way brings home the point that the idealising of the new is actually achieved by that process of demeaning and devaluing, in other words vilifying, the other.

Hybrid roles combining managerial and professional skills have now become more significant. Increasingly, roles are combined ones. The practising professional using therapeutic skills one-on-one, with no supervisory or budget responsibilities, is in a minority. Managers – classic professionalism’s unnecessary others – are not only becoming a necessary but also an integral part of an emerging new professionalism.

**Boundaries with colleagues**
What has happened to classic professionalism’s invisible others – colleagues without professional qualifications? The boundary between qualified and unqualified has certainly changed. Opportunities opened up for some without professional qualifications to build on their experience.

For example, home carers report a mixed picture of change. Not only are they now giving personal care – washing, dressing, help with mobility, feeding – they are often also engaged in activities that border on skilled nursing. They remain the least qualified staff, positioned at the bottom of the social care hierarchy, with variable and often minimal training, working in isolation for an hourly rate of pay that hovers around the statutory minimum (Clough 1998).

**Boundaries with adjacent professions**
Classic professional identity involves a vision of making a contribution to care as an autonomous and independent expert. This gives little room for valuing the contribution of other professions. Governments have grown ever more critical of what the White Paper Modernising Social Services called the Berlin Wall between the different professions in health and social care (DoH 2000). There is greater policy determination to ensure that integrated teams and shared training take place. Working effectively across professions and across agencies is a key challenge for today’s managers.

Consider these reactions:
For (nurse):
‘I think we need to overcome some of these, as I see it, ingrained traditional boundary things that are cocking up the way we all work … we’ve got to ask who are we working for, are we working for our own traditional boundaries, and maintaining the status quo, or are we trying to move forward and offer the best services to the clients really’.

Against (social worker):
‘You get a blurring of professional roles, which I think is dangerous. … Because at the end of the day social workers think they know what nurses and doctors do, but they don’t. Similarly nurses … think they know what social workers do, but they don’t. And it’s quite common to see where social workers have been meddling in medical matters, and nurses have been meddling in social care matters’.
Both (nurse):
‘I think I should concentrate on what I’m good at and allow the other person to do what they’re good at. And that way everybody will feel fulfilled in their roles on the team … There is some blurring, and that’s good … but also we need to be self-aware and know when to stop … and to clearly identify, well hang on I can’t do this anymore. I need to hand you over, or I need input from such a one’.  
(Source: Brown et al. 2000)

All this suggests that professional identity needs a more profound adjustment than merely adding in specific managerial skills at all levels. Today’s practitioner needs to be not someone with a sense of self as possessor of a clearly bounded expertise at all. Instead she or he needs to be someone who can value and connect with others, using the multiplicity of experiences of the client and team members to develop adaptive and creative solutions.

Activity 3
Are there some ground-rules for managers that can help to ensure that all members of the team fully contribute; where all are visible in their contributions, and none are regarded as incompetent or unnecessary others?

- Think of a situation where your own views were modified by hearing others. What made that possible?
- Using your own experiences, draw out some of the ground rules that allow a real dialogue to occur.
- Can you name situations of conflict where it would be useful to try out your ground-rules?

Comment
Someone who had been in a workshop where professionals, in this case in social care, from across a whole region met to discuss and challenge some recent changes, explained. ‘Groups took the part of health authorities, registered homes, we listened, then discussed things and challenged the changes as well – but rather than blaming or passing the buck, we endeavoured to find solutions and compromises. Our ground rules were very simple:

- Listen to what people have to say
- Do not interrupt
- State opinions briefly and concisely
- Do not be personal (derogatory).’

Several people discussing this made connections with familiar groupwork principles, seeing how ground rules could read across and how as managers they could structure meetings and intervene to facilitate more dialogue both within their teams and with service users.

Creating a climate where people can really hear the other and where they are prepared to change themselves, and are supported in this is a key part of what management is about.

REFERENCES

This material is drawn from materials from the Open University School of Health and Social Welfare course K303 Managing Care (Davies C. Workers, Professions and Identities. In Henderson J, Atkinson D. Managing Care in Context. London, Routledge. In press Dec 2002)

K303 is grounded in good practice for managing care services. The course is innovative in its use of multi-media, and students develop information technology skills of daily relevance to managers in handling and analysing data. Activities are designed with reference to Vocational Qualifications in Management at Level 4, including those for registered managers, and the course offers support in preparing for these awards.

For further information about this course, contact Betty Morris, Information Assistant on 01908 653743 or look at our web site at www.open.ac.uk/shsw.