CSP-HSORU
COLLABORATIVE RESEARCH INTO PHYSIOTHERAPY ORGANISATION

# Organisational Problems of High-level Clinical Physiotherapists

## Physiotherapy Organisation: 5

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*This paper puts forward for discussion a number of the organisational problems associated with the Senior I grade in the NHS. These include: lack of further clinical career opportunities; poor definition of the grade; inadequate formal recognition of professional ability and achievements; uncertainty about the amount of research, teaching and administrative work expected; unclear accountability and authority in relation to other physiotherapists; and confusion as to the extent of clinical autonomy. There are no clear and easy solutions to these problems which require debate among all physiotherapists. Any action or inaction will have implications for the development of the profession. The Chartered Society of Physiotherapy is arranging Regional workshops for Senior Physiotherapists and HSORU researchers to come to a clearer understanding of the problems and to look for possible solutions.*

A NUMBER of problems and issues facing the physiotherapy profession have become most apparent in the difficulties and uncertainties encountered in the grade of Senior I physiotherapist. As the top clinical practitioner grade it is a focus of aspiration for many physiotherapists, and is an important organisational mechanism which helps develop the profession.

Different people see different problems, depending on their vantage point. Among those concerned about the Senior I grade are: Senior Is in post, Superintendents and District Physiotherapists, junior physiotherapists, the CSP and the DHSS. This paper will outline different views even though the problems may be felt most strongly by Senior Is in post. This is because solutions will work well only if they are acceptable and felt to be fair to all concerned.

### The Problem

Some Senior Is think there is lack of recognition of their skills and expertise and the work they do. After four years in the grade a Senior I reaches the top of the incremental pay scale with no further promotion possible in clinical physiotherapy. Extending the pay scale alone would not solve the problem unless it is believed that financial recognition should be purely for years in post.

Alternatively, Senior Is could be rewarded on the basis of skill and expertise which could be assessed in various ways. A Senior I would then be eligible for a higher grade or pay increment on passing the assessment, and the qualification would also confer higher professional status. Unfortunately, this might lead to two Senior Is with the higher qualification undertaking work bearing different amounts of responsibility but being paid the same. If it is agreed that pay should be for work done, physiotherapists need to decide how they want differences in clinical physiotherapy work to be assessed. There is a need to decide exactly what future high-level clinical physiotherapy work should be, and how and where to draw the line between high-level clinical physiotherapy work and other clinical physiotherapy work.

The results of lack of recognition and promotion prospects in clinical physiotherapy are well known. If a Senior I wants to further her career she is faced with the choice of leaving the NHS to start private practice; moving away from clinical practice to teaching and administration; or even emigrating. Often it is the most capable and skilled clinical practitioners who make such a move. Alternatively, some Senior Is remain in posts in

which the expression of their developing abilities is increasingly restricted. In the latter case organisational strains begin to show.

There is no clear answer to this difficult problem which other professions have experienced but have failed to resolve satisfactorily. Usually the problem is ignored or avoided until it reaches a crisis point. In physiotherapy the development of specialties may have provided a temporary and partial solution.

The advantages and disadvantages of the development of specialties need to be examined by all physiotherapists because of the implications for the future of the profession and organisation. The level of work in a specialty can be higher or lower than in general physiotherapy. It has to be decided whether to define the top clinical grade in such a way as to encourage only the development of specialties, or in a way which would support the development of high-level 'generalist' clinicians, or whether two or more types of top clinical grades are necessary. These are policy decisions for the profession but, whatever is decided, organisational problems must be solved to make it work. In some Districts, developing specialties already affect the flexibility which Superintendent and District Physiotherapists need to provide an overall District service. If this trend continues, new forms of organisation will be necessary.

Before tackling these issues it is helpful to consider how the grade of Senior I is defined, the purpose of grades, and how grades relate to levels of work and organisational structure.

**Ambiguity of the Grade**

The Halsbury Report (1975) originally proposed the grade of Senior I with the intention of providing 'a suitable career opportunity for staff who want to remain in clinical work by according recognition to those who, in the opinion of the employing authority, undertake highly skilled and specialised work' (paragraph 88).

The present Whitley Council (DHSS, 1981) description of the grade is: 'A physiotherapist who is mainly undertaking highly skilled and specialised work beyond that covered in the training syllabus; examples of such work might be research and development work in the special difficulties of physically disabled children or the elderly [and so on]; or, either working single-handed or responsible for one other qualified officer or assistant and mainly undertaking duties requiring the exercise of a particular expertise or ability; or, acting as deputy to a Superintendent physiotherapist' (paragraph 2084).

We have found that the Senior I grade is used to cover a wide variation of levels of work. The following two examples show how the description can be interpreted at two hypothetical extremes:

1. At a lower level of responsibility a physiotherapist graded Senior I would provide unsupervised physiotherapy treatment to any cases that are allocated by the hospital Superintendent.
2. At a higher level of responsibility, a physiotherapist graded Senior I would carry out expert physiotherapy but, in addition, run a specialist unit. This could involve administering two or more geographically distinct units and community services, allocating and supervising staff and students, initiating research and developing the specialty and services. These Senior Is develop a different authority relation to their hospital Superintendents.

**Grading Work**

*Recognition of Work to be Done*

One of the main purposes of grades is to specify pay, but to do this fairly the grade must be related to the work done. This will be difficult if the grade is not clearly defined.

In terms of the level of work descriptions we have been using (Kinston, Øvretveit and Teager, 1981), example 1 above is characteristic of stratum II work: an expert assessment and response to given cases. Example 2 could well be stratum III work, requiring the maintenance and development of a specific service on an annual basis. It appears then that the Senior I grade may be interpreted to cover both top stratum II and stratum III clinical work which carry very different levels of responsibility.

It is possible at present to apply the Senior I grade to work at two qualitatively different levels. This is because a judgment over grading need be concerned only with whether the work is 'highly skilled and specialised'; or mainly requires 'the exercise of a particular expertise or ability'; or involves deputising for a Superintendent (Whitley Council definition, DHSS, 1981). In addition, if it is accepted that grading should be for work presently undertaken, then the grade should not be abused to reward staff for long service, to gain a pay rise, or to recruit staff.

There seems to be a need to recognise the different levels of work required in clinical physiotherapy and to tie grades more closely to the work to be done. Physiotherapists need to decide whether and how they want differences in level of work to be judged and related to grades, and whether they wish the Whitley Council to use definitions which relate more closely to the responsibilities they carry.

*Recognition of Personal Ability to do Work*

A clear distinction needs to be made between the work to be done and the person who does it. Some Senior Is think that there is a need for professional recognition of personal skills, abilities and past achievements in clinical physiotherapy. Better definitions of clinical grades would not provide recognition of professional ability because the grade would be a description of the work and not the person. There appears to be a need for a professional 'marker' which provides a generally accepted social recognition of personal ability. This could take the form of a post-registration course completion and test, peer merit award, or a combination of both. Achieving the professional marker would not in itself lead to a higher grading, because the grade would be tied to the work. However, if the work required the skills or abilities judged by the marker, the marker could make the physiotherapist eligible for work which is more highly graded.

*Type of Work and the Senior I Grade*

The Whitley Council definitions do not specify how much administrative, teaching or research work should be included in roles graded as Senior I. If the grade were to be more clearly defined it might be necessary to describe the grade so as to include or exclude particular types of work. This would depend on whether the profession wanted the top clinical grade to take a particular direction, or how much it should be open to the District Physiotherapist and the physiotherapist in post to decide the work content. These decisions would have organisational implications.

*Authority and Accountability Relationships Between Physiotherapy Roles*

Whatever the decisions over the content of the grade, authority and accountability relationships should be based on and designed to facilitate the work that is to be done. Because of the wide variety of work presently carried out by physiotherapists graded Senior I, it is not always appropriate that they be organised in the same way.

*Present Organisational Relationships Between Physiotherapy Roles*

At present some Senior Is are unclear about to whom, how and for what they are accountable. Traditionally, all Senior Is have been managed by Superintendents, but in some cases this arrangement has led to problems. Work stratum theory (Kinston, Øvretveit and Teager, 1981) provides an understanding of this organisational phenomenon. It is shown above that Senior Is can be carrying out top stratum II or stratum III work. Research has found that a one-stratum distance is necessary between a manager and subordinate for a full managerial relationship to be workable. Thus a Superintendent working at stratum III can manage a Senior working at stratum II. However, a capable Senior may, over time, develop her specialty, assume greater responsibility, and re-define the work in the role. When both Superintendent and Senior are working at stratum III each will find that a managerial relationship no longer feels right, but will be unsure about the most appropriate relationship in the circumstances.

An example of the difficulty that can arise involves the work of ensuring an overall physiotherapy coverage. A Senior who has built up a specialist service might feel a primary allegiance to that specialty. However, staff will still have to be moved to cover the work that has to be done, and the Superintendent may be unsure about her own authority to make and implement these decisions. New forms of organisation will be necessary to ensure the work is done, for example management of stratum III Seniors by a stratum IV District Physiotherapist.

**Clinical Autonomy**

The issue of clinical autonomy arises in two main areas: Senior Is' relationships to doctors (inter-professional) and Senior Is' relationships to senior and junior physiotherapists (intra-professional). Important clinical decisions in physiotherapy are about type, frequency, priority and termination of treatment, as well as when to refer to another remedial therapist for treatment. A major issue is, who should be responsible for making these decisions? Is it appropriate that a top-level clinical physiotherapist should be solely responsible for making all or some of these decisions? What responsibility should a doctor carry during physiotherapy treatment, and what corresponding influence should he have over the treatment?

The DHSS recommendations to doctors (HS/77/33) provided referral guidance, but for a number of reasons, Senior Is are not always clear about which treatment decisions they are solely responsible for, or authorised to make. Usually the issue of clinical autonomy is resolved in each individual situation according to the personalities involved.

The profession needs to choose whether or not to formulate a clear policy about those aspects of treatment for which physiotherapists should assume full responsibility, at which stage of their careers they should assume these responsibilities, and who is to be held responsible for their treatments until they reach this stage. Each decision has different organisational implications.

There are differences of opinion within the profession about whether these issues should be clarified. Some physiotherapists think they gain more freedom through informal arrangements with doctors. Another view is that unambiguous and agreed guide lines would provide individual physiotherapists with authoritative professional support to make and enforce treatment decisions. This would ensure that treatment depended less on the personal confidence and forcefulness of the individual physiotherapist, and more on the body of physiotherapy knowledge brought to bear on the case.

**Conclusion**

Some of the problems associated with the grade of Senior I are typical of problems found in complex organisations. Once grades are no longer tied closely to the level of work which is done, they can be used for a number of different purposes to solve short-term difficulties. This will eventually lead to the type of problems we see in the grade of Senior I.

One of the reasons why this issue has not been tackled is that there is nobody with a clear responsibility or authority to monitor the situation and put forward proposals. The difficult task of considering all aspects of the problem and taking a dispassionate view of the implications of possible solutions rests with physiotherapists themselves. Later papers in this series will report solutions derived from our continuing collaborative research with physiotherapists.

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