CSP-HSORU
COLLABORATIVE RESEARCH INTO PHYSIOTHERAPY ORGANISATION

The Origin, Significance and Future of the District Physiotherapist Role

Physiotherapy Organisation: 6

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Can a profession recognise its own dilemmas, relate these to its aims, and translate this understanding into useful and purposeful action? The continued existence and requisite level of the District Physiotherapist role provides a challenging case. There seem good reasons not only for ensuring the continued existence of the District Physiotherapist role, but also for requiring it to be located at stratum IV. Mechanisms for carrying out such national tasks against potential pressures from within the profession are undeveloped.

An earlier paper in this series (Kinston *et al*, 1981b) reported recent research into the nature of the District Physiotherapist role. Widespread disagreement about the role had been evident in fieldwork and the research attempted to take account of these differences in a formulation which defined the core work of the role. This suggested that the role required 'the creation and maintenance of an overview of the physiotherapy system and the carrying out of integrative and co-ordinative activities so as to deal with potential fragmentation of the system as well as liaison with associated health and social systems'.

Such a definition left the expected level of the work undefined. Examples of Health Districts (HDs) which might require different levels of work were provided and it seemed that the role could be pitched from as low as stratum II in some HDs to stratum V in others. Kinston *et al* (1981a) give further explanation of levels of work in physiotherapy. Much of the disagreement as to the ideal level had stemmed from differences between District Management Teams (DMTs) and physiotherapists, and among physiotherapists themselves.

During our fieldwork, District Physiotherapists often suggested that their role could be phased out either as the profession matured or when the services in their Health District had been rationalised. Further routine analysis revealed that this was unlikely to be in the best interests of either physiotherapists or health care. Health services as a whole are in a continual state of flux under the impact of technological developments, population changes, resource fluctuations and administrative innovations. These produce new District-wide problems and service gaps which require appreciation and resolution.

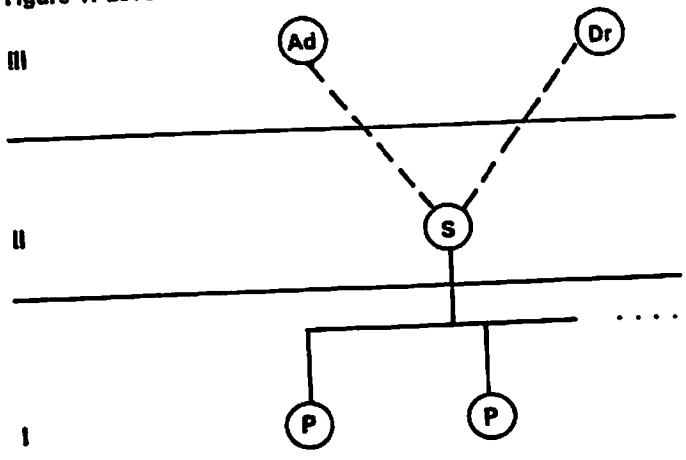
In this paper we wish to discuss some aspects of the origin of the District post and consider the differences between stratum III and IV District posts in relation to the possible future of the role. This paper also raises the problem of how a profession can decide its own direction.

Historical Origins

We will not attempt to provide a detailed or comprehensive account of events, but aim rather to show schematically the appearance of progressively higher levels of work in physiotherapy.

In the post-war period, physiotherapy services in hospitals and departments were run by Superintendents. The practice of physiotherapy was technical and physiotherapists were controlled, sometimes in an almost military fashion, by the Superintendent who worked within systems run by administrators and doctors (fig 1).

Figure 1: Levels of work in the 1950s



Guide to Diagrams

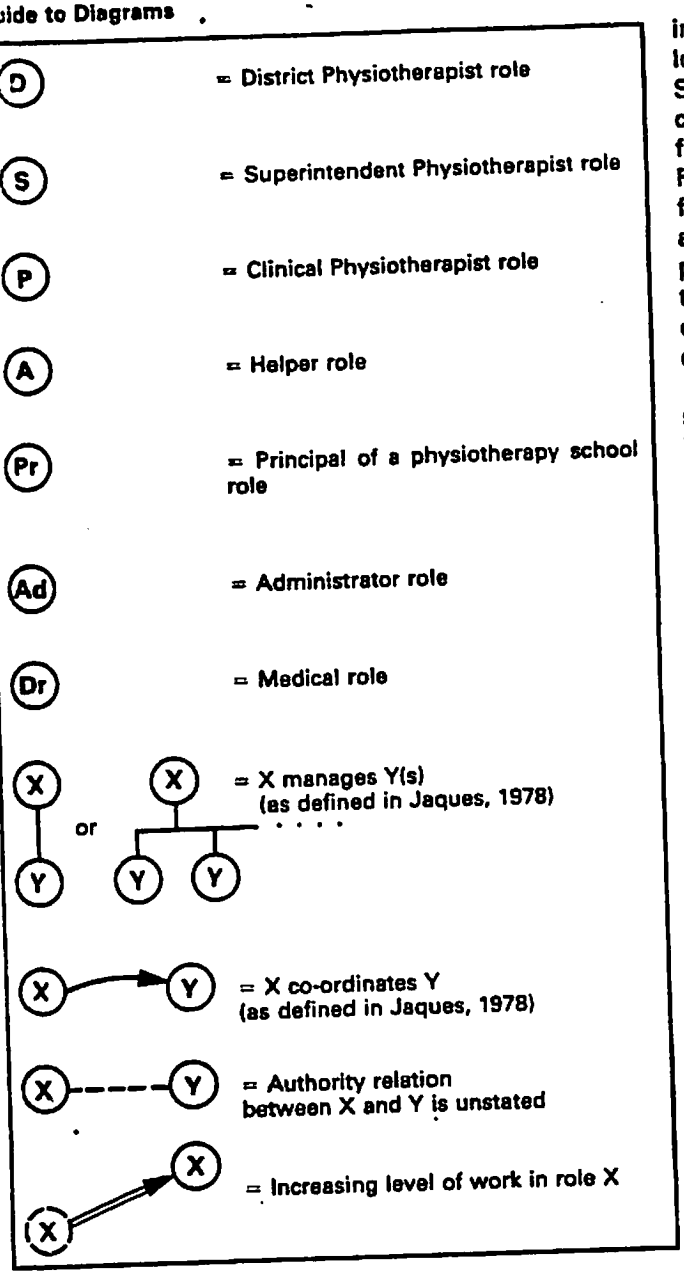
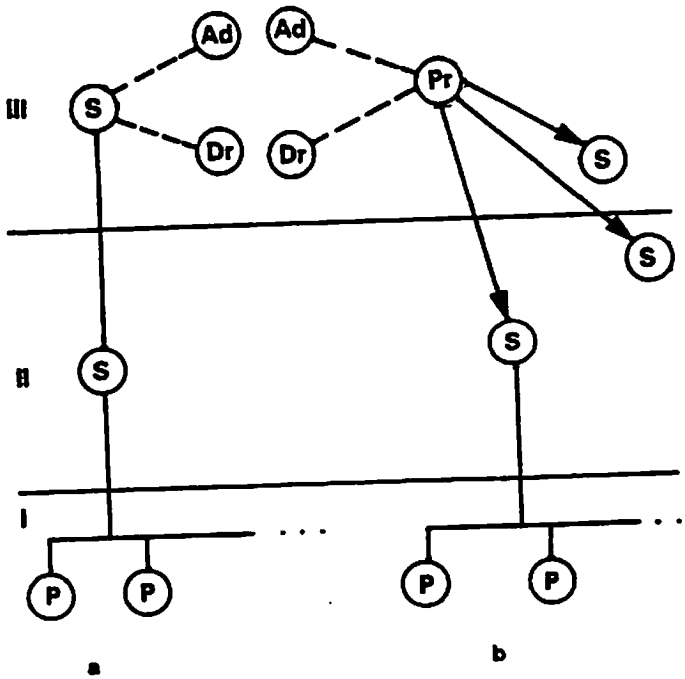


Fig 2: Levels of work in the late 1960s



As departments increased in size in response to increasing medical specialisation and social and technological advances in health services, the work expected of Superintendents rose (fig 2a). In the 1960s proprioceptive neuromuscular facilitation (PNF) was imported from the US and complex techniques such as those of Rood and Bobath were developing. There was a need for far more detailed assessment and on-going evaluation and modification of patient management than with the previous approach where doctors prescribed specific treatment modalities. Despite these changes in work and context, the level of work officially expected of the clinical physiotherapist did not change.

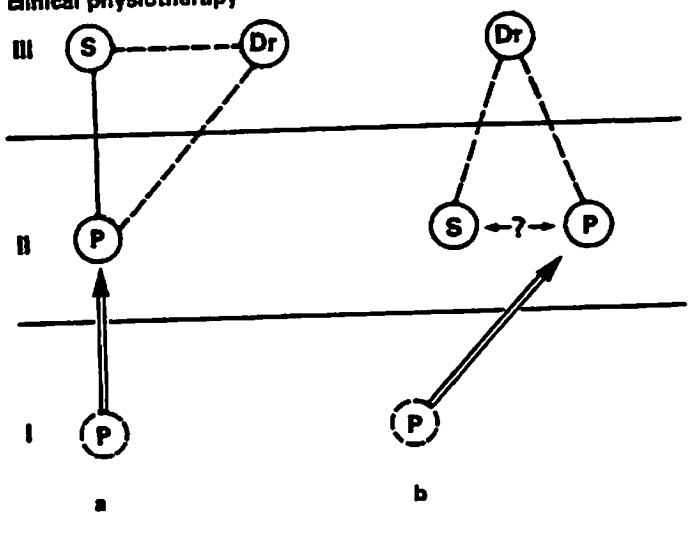
In the late '60s, amalgamation of hospital departments started and the Group Superintendent position was introduced. This post was sometimes held by the principal of a physiotherapy school; it carried co-ordinative responsibility (fig 2b).

The performance of physiotherapy at stratum I (application of a defined treatment on prescription) required that some one else should do the stratum II work of assessment and on-going evaluation. In the UK doctors were given this task. However, for reasons that are not totally clear, possibly because medical education does not include evaluation of physiotherapy, doctors were not exercising clinical judgment on indications or contra-indications for physiotherapy and were not making full and adequate assessments. This led to much treatment being ineffective. In addition, many patients who could not possibly benefit were being referred for physiotherapy by doctors whose own forms of treatment had been ineffective, a practice which still occurs (Bourne, 1978). These clinical problems were the natural concerns of clinical physiotherapists who, if of sufficiently high calibre, naturally found themselves doing assessment work at stratum II.

This caused few organisational problems if the Superintendent was working at stratum III (fig 3a). However, if she herself held a stratum II post her authority and relation to doctors was threatened by a junior correctly alleging insufficient assessment on the part of the doctor (fig 3b).

At this time, a frequent complaint was the acute shortage of staff. This problem became an excuse for every deficiency and led to short-term solutions by Superintendents, as well as by doctors and administrators, which strangled services. For example, it was used to justify increased control by doctors over their

Fig 3: Authority relations with development of stratum II clinical physiotherapy



physiotherapy staff, and to excuse cut-back and discontinuation of study leave. Selection procedures were sometimes a formality as there was a tendency for anyone who applied for a post to be accepted. Such an approach kept the service running but prevented development and generated poor morale and low standards. The Committee on the Remedial Professions (DHSS, 1972) noted the problems of pay and career prospects, but also emphasised the confusion over the professional role of therapists.

Of course, many physiotherapists had excellent personal relationships with doctors. The more able carried much responsibility for patients and were almost certainly working at upper stratum II. However, this social reality was not mirrored officially in agreed role and authority relationships. The importance of socially sanctioned organisation became apparent with the publication in 1972 of the Tunbridge Report on Rehabilitation.

This report was prepared by a sub-committee of the Standing Medical Advisory Committee and, therefore, was composed solely of doctors. Although this committee recognised the medical profession's failure to do the stratum II physiotherapy work and its failure to delegate the responsibility for this work to physiotherapists, it proposed that physiotherapists should be organised in departments of rehabilitation managed by a medical consultant (para 115) who would also be responsible for their education (para 122). Some members of the medical profession, for example geriatricians, psychiatrists and orthopaedic surgeons, opposed the suggestion, while the idea that physiotherapists were just technicians and that the future development and direction of physiotherapy should be limited by medical views of its contribution to rehabilitation appalled leading physiotherapists.

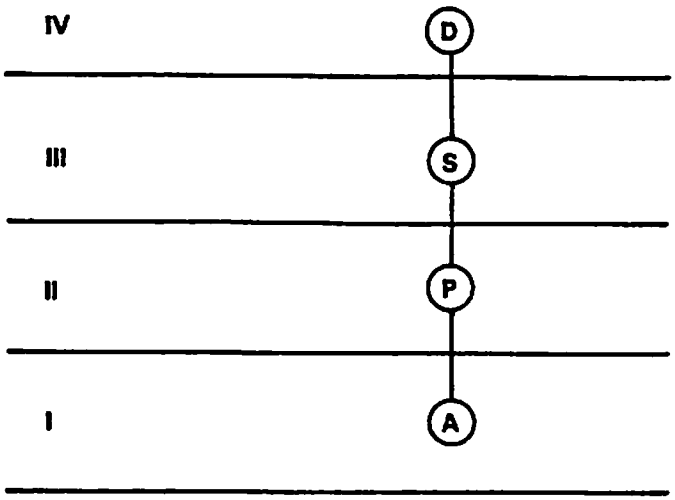
HSORU fieldwork found that arrangements in which physiotherapy depended as a profession on doctors were not working satisfactorily (Tolliday and Plouviez, 1976; Øvretveit *et al*, 1981); and informal reports throughout the NHS confirmed this as the general experience. It became apparent that if physiotherapy was to have a future of its own, then the work of devising and implementing long-term plans and relations to other professions had to be assigned and built in both at local and national levels of organisation.

It was no longer enough for Superintendents simply to look inwards towards their own department or group. If physiotherapy was to thrive, someone had to make high-level contact with, and look outward towards, other professions and other Districts. It was necessary to identify the gaps and argue the case, or, more bluntly, to persuade, exhort, negotiate and campaign for development of physiotherapy and its independent integration within the NHS. It seemed that a new level of work at stratum IV was being called for.

The work of getting appropriate information, marshalling arguments and convincing physiotherapists, doctors and administrators is time-consuming and demands substantial political and managerial ability. The recommendations in the McMillan Report (DHSS, 1973) for administrative high-level posts and the suggestion of an amalgamated remedial service were, therefore, not surprising.

A high-level District post seemed essential because of yet other developments. Clinical physiotherapists were consolidating their work level at stratum II and many

Fig 4: Ideal structure after 'McMillan Report'



helpers were employed under managerial control of physiotherapists to carry out a stratum I role. The work of the Superintendent moved into stratum III by definition, developing systems and ensuring day-to-day administrative control of the service on site. The McMillan structure was designed to allow the District Physiotherapist to get on with long-term work (fig 4).

In practice, of course, arrangements varied greatly and the District role was usually implemented in gradual stages — this process continues. In 1978, the McMillan structure was broadly confirmed by the DHSS sub-group on the Organisation of the Remedial Professions (DHSS, 1978). Its report noted that in some Districts a co-ordinative, rather than a managerial, District role might be preferable. The key omission in this, as in all reports, is an explicit specification of the expected level of work. Whether a role can carry appropriate managerial or co-ordinating authority with regard to another role depends on a number of factors. The respective levels of work in the District role and other physiotherapy roles are of prime importance in this case. If a District has developed in any significant fashion, it will have at least one and probably two or more Superintendents working at stratum III. These Superintendents cannot be managed by a District Physiotherapist at stratum III whose role must be confined to co-ordination (fig 5). A

Fig 5: Authority relations with a stratum III District Physiotherapist in a developed District

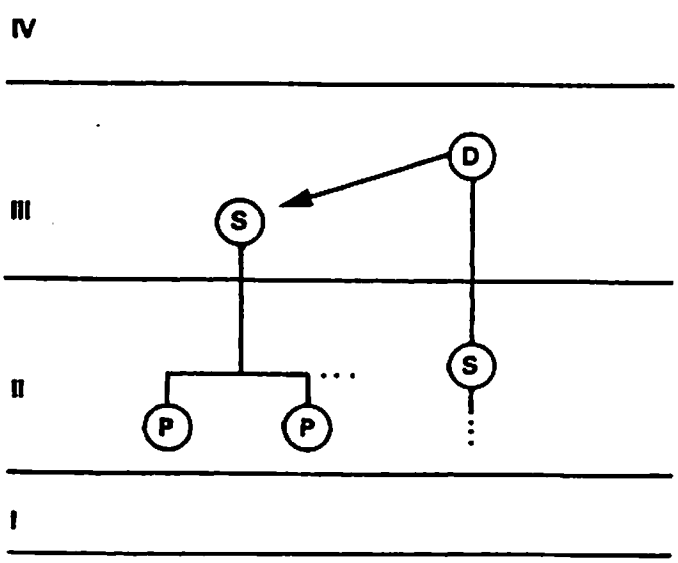
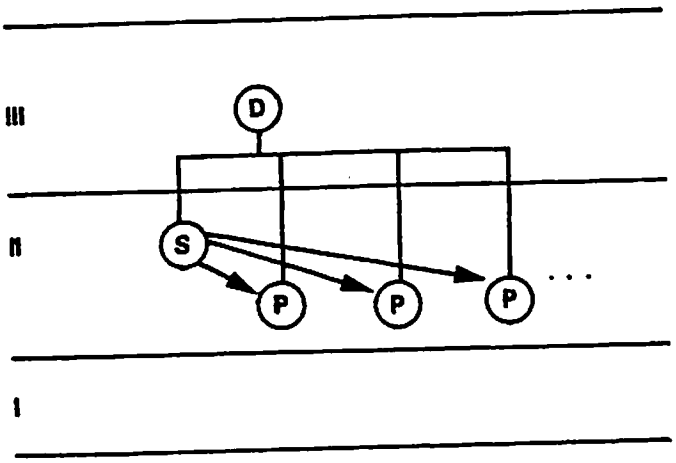


Fig 6: Authority relations with a stratum III District Physiotherapist in a less developed District



less developed District, which employs Superintendents only at stratum II, however, could be managed by a stratum III District role (fig 6).

Work at Stratum III and IV

In an earlier paper (Kinston *et al*, 1981b), we reported that our researches confirmed the value of the District Physiotherapist role, but that it seemed that in some Health Districts the role was more appropriately pitched at stratum III and in others at stratum IV. Examples of differences in the work were provided. During the research conferences, it was argued by some that all Districts needed a stratum IV role to generate needed development.

Development will occur at both levels but the style and character differs. At stratum III, development is encouraged and permitted in an incremental and systematic fashion, or as part of a project generated from outside the physiotherapy department. The physiotherapy service is expected to provide for the patients it has or will have in the immediate future as effectively and efficiently as possible, but in much the same way as it does at present. Most of the results of proposed changes can be clearly stated in advance and most changes take place within the already established physiotherapy system, for example a new scheme for rotating basic grades or a new specialist teaching course.

At stratum IV, development has the quality of innovation in that the currently accepted limits are not taken for granted and the end result of an initiative is less clearly known. Development is expected to extend into the unknown in a comprehensive fashion: new techniques, new categories of patients, new relations with other health workers, new forms of education. Such innovations affect other professional groups and contribute substantially to health policy in the District. Many such developments will, of course, be carried out and may be initiated by personnel in stratum III roles; the distinctive stratum IV task is to identify the gaps, to create the possibility for tackling the work involved, and to maintain its context over some years. For example, the development of a new form of service requires extensive preparation of the social environment, obtaining or redeploying resources, and possibly blocking a similar but less urgent development. This involves getting key personnel in the District enthusiastic, neutralising or converting those opposed, and appeasing those who are disappointed. The support of other physiotherapists can certainly not be taken for granted as any loss of prestige, facilities, work flexibility or personnel in existing departments will generate opposition or discontent. There are, of course, many practical tasks to be tackled at the same time, for example finance, equipment, personnel and rotas.

Irrespective of whether the role is pitched at stratum III or IV, a District Physiotherapist will need similar organisational tools. For example, it will be impossible for her to be a channel of communication between the DMT and physiotherapists if she does not have an easy access to the DMT, nor can she serve the DMT without details of agenda and minutes as well as a co-operative working relationship with the District administrator. Similarly, the DMT cannot arbitrate on professional matters and hence the District Physiotherapist requires right of access to the District Health Authority, a right which would be rarely exercised in a well-organised District. Authority relations to other physiotherapists are required at both levels though the exact details will vary from District to District. Holding a budget will occur at both levels, though the type of budget and its use will differ in relation to the work being done and the organisational structure of the District.

There seems to be a case for the maintenance of a stratum IV physiotherapy post on the grounds of development. Are there other pressures calling for a choice between the options of stratum III and IV roles in the country as a whole? To answer this, we must consider a new phenomenon, the appearance of high-level (stratum III) clinical physiotherapists.

The Future

How should the organisation of the future of the District role be tackled? Should the Chartered Society ask the DHSS what the NHS might want? Or should the initiative come from the DHSS or some group in the NHS, perhaps at Regional level? If the questions will not or cannot be answered at the present, this does not prevent us from considering some of the factors which should be taken into account by whoever is concerned for the future.

Escalation in Work Level

The appearance of the stratum III Superintendent was generated by the increasing number of stratum II clinicians, the medical profession's reluctance to take on managerial responsibilities, and grouping of hospitals. The appearance of the stratum IV District role was probably inevitable given NHS policy of providing comprehensive services; growth in physiotherapy knowledge; and stratum III Superintendent posts. Will this escalation in work level continue indefinitely? There is reason to believe that specialist clinicians are working at stratum III and there is pressure for a clinical role above Senior I (Øvretveit *et al*, 1982). How will this affect organisational structure? Will we see stratum V and then VI District roles? Will clinical work move into stratum IV and above? Will helpers move into stratum II?

One practical obstacle to unlimited development in the work is the limitation in personnel available. Even though the number of potential District posts is only about 200 (less than 1% of physiotherapists in the UK), it seems unlikely that this number of stratum IV staff is currently available.

High-level Clinicians

Another problem with unlimited development is that direct immediate patient care is the principal work output at stratum II. Work at stratum III and above deals with patients yet to be seen. For example, research benefits patients years later, if at all, and planning at stratum IV is geared to handling patients in the long-term future. Consultants, who are generally expected to work at stratum III, probably spend only about half their time in clinical work (Dunn and Atwood, 1978).

Clinical work in the NHS may reasonably be pitched at stratum II or stratum III but no higher. For financial reasons alone, the thousands of clinical posts needed for immediate patient care seem unlikely ever to be pitched above stratum III. There will, of course, be the occasional clinician of much higher ability, but we are considering the bulk of the professional roles as socially established. Given current recruitment and educational policies and practices, it is likely that there will be an important minority of clinical physiotherapists able and wishing to work eventually at stratum III. This poses a variety of organisational problems; here, however, we are concerned only with the issue of how the District role will be affected.

As the numbers of stratum III clinicians grow, under the guidance of their District Physiotherapist, they will become aware that the District Physiotherapist's responsibility for the overall service may conflict with their own wishes. For example, she may block their proposed development (in favour of another), reduce personnel for their services (to build up an unpopular field), impose administrative tasks (to help planning) and so on. As a result, it seems likely that the District post may come under criticism from clinicians in the future.

Self-management was the argument to justify the appearance of the District post — it may well be the self-same argument which sees its demise. Each stratum III clinician, it will be argued, is quite capable of self-management. The term 'self-management' will be wrenched from the context of the profession or service as a whole to the context of the individual or specialty. Possibly, the example of the doctors and the demise of the medical superintendent will be pointed to. Numerically, District Physiotherapists are highly vulnerable and would be unlikely to survive a sustained political attack within the CSP. Abandoning the District role would then be hailed by the CSP as further evidence of maturation of the profession.

The Need for a District Role

The current reorganisation has raised the possibility that District Physiotherapist posts might be abandoned or their authority reduced once again to an advisory status as a consequence of a general wish to move decision-making closer to patients (DHSS, 1980). The disadvantages of the loss of the District role may be easier to argue now when the role is being threatened from without rather than from within the profession. The work, which the profession has so carefully, determinedly and persuasively argued does exist and does justify the District role (Kinston *et al*, 1981b) will surely remain. How will it be done? How will development of popular specialties by stratum III clinicians be controlled and a balanced service provided? How will the gaps requiring resource shifts be closed? How will long-term planning occur? The medical model of committees and shared responsibility will probably be suggested, but doctors have failed to make a committee system work (2nd Cogwheel Report, 1972) for the same reasons that we found physiotherapists could not (Kinston *et al*, 1981b). The committee model seems to permit avoidance of executive responsibility and blocks implementation of painful decisions. It also multiplies the amount of administration for each clinician which was previously filtered out by the District Physiotherapist; and again, as with doctors, much would be neglected. District-wide development is not easily generated by part-timers elected for limited periods; and sustaining it for long periods against opposition is clearly impossible in such a structure. The fragmentation which the District role is fundamentally called upon to prevent would return, and the outlook of physiotherapy in Districts would be reduced from stratum IV to stratum III, to the detriment of patients.

This return to fragmentation is more likely if stratum III District roles are retained; post holders may not be able to exercise sufficient power and so may not seem to be assisting stratum III clinicians sufficiently. A stratum IV District Physiotherapist, however, should be of sufficiently high calibre to retain the support of such clinicians in the construction of a fair, comprehensive and balanced service. The current system of a mixture of stratum III and stratum IV District posts contains natural tendencies opposing the breakdown described above. Physiotherapists are drawn to different Districts according to reputation and recommendation. The more capable clinicians will apply to the more go-ahead Districts run at stratum IV and will tend to be appointed there. The stratum III District physiotherapists will prefer to work with able, hard-working stratum II clinicians rather than with research-oriented specialists who expect to spend time travelling and teaching.

Would it not be reasonable to retain this mix? In the short-term there is probably no alternative. In the long-term, it seems that such inequity is against the spirit of the NHS, as embodied for example in RAWP (DHSS, 1976). There is, however, a more practical case for aiming for stratum IV capability throughout: a stratum IV view will be an important factor in the relationship of physiotherapy to the rest of the health service and the social environment. This needs some elaboration.

Differences in Style and Thought

Work at stratum III involves dealing with and developing systems over which the role occupant has control. Jaques (1976) refers to it as the level of 'direct command'. Individuals who work most comfortably at this level have an inward-looking focus. The environment is expected to supply whatever is necessary for the system, and if it cannot be coerced to provide, it is adapted to perhaps with frustration and disappointment.

Work at stratum IV calls for modification of the environment. The stratum IV task is to deal with systems over which the post holder does not have control. It will never be possible for an NHS physiotherapist to have coercive control over the DMT, medical profession, physiotherapy education system and similar social groups. If physiotherapy services are to flourish in their particular environment, a level of work which is outward-looking must be assigned and the role must be filled by a person who can do this with ease. At this level, it is taken for granted that success does not come from being in the right or applying a norm, but from carefully worked out strategies to get the co-operation of key individuals and

groups. This requires a willingness to stand back from day-to-day problems (by delegating responsibility for handling them) and an ability to talk to other groups in their language and understand their problems.

Each work stratum has its own subtle style of language reflecting the view of the world necessary to get the work at that level focused upon and completed satisfactorily. All significant long-term decisions in a District will be taken, by definition, at level IV or above. If other groups such as administrators, doctors and nurses have people of the appropriate calibre in post, then they will not listen sympathetically unless discussion with them uses the language of an overall vision of the District, and the intermeshing of physiotherapy policies and plans with policies and plans of other groups and the District as a whole. For example, appeals to CSP policies or DHSS norms may weaken rather than strengthen a case for more staff. Extrapolation of this sort is a characteristic approach at level III. The stratum IV listener is aware, however, that neither the CSP nor DHSS appreciate the problems he sees in his particular District.

Stratum V District Role

In a very few 'super-Districts' there may be a place for a stratum V District post possibly with the stratum IV function delegated to two or more subordinates. In such a District, the very definition of physiotherapy and physiotherapy services would be changing. There seems little realistic possibility that this could be a general arrangement and these centres of excellence would function as a national and international resource.

Conclusion

At the moment the physiotherapy profession is fighting for retention of District posts. The struggle seems likely to be successful. There are, however, structural forces both within and outside the profession that could lead to the loss of this integrating mechanism. These must be taken into account now within the service and in pre- and post-registration training otherwise District Physiotherapists will become a politically vulnerable group.

Successful retention of the role is most likely if it is pitched at stratum IV. At this level, the holder can best enhance both clinical development and service commitments. The role will, therefore, be useful to and valued by high-level clinical physiotherapists as well as by senior administrators and others in the associated social system.

In this paper we have been assuming both that a stratum IV role will be filled by someone of the appropriate calibre, and that they will indeed be expected to work at the level assigned and given the tools and assistance to do so by the DHA and their fellow physiotherapists. These are large assumptions. An organisation wall-chart, the budget and personnel ritual, travel to and from London are no substitute for doing stratum IV work. It is not realistic to expect someone whose natural ability at a given point in their career is in stratum III to function at stratum IV. One further onerous task for District Physiotherapists must, therefore, be emphasised: namely, staff appraisal and counselling. Young physiotherapists, by being helped regularly to look at their work and into themselves, can determine their own personal career paths and can work to excel and provide an up-to-date expert contribution to physiotherapy at stratum II, III or IV. If the profession fails to do this, and, in particular, if the profession cannot create an ethos which values work at all levels, it will be rightly accused of producing a stultifying hierarchical bureaucracy. A major purpose of the CSP-HSORU research is to help avoid such an outcome.

If the strategic significance and implications of the stratum IV District Physiotherapist role are recognised, some concerted national action may be necessary to make it a reality. This sounds like at least a ten-year task but how and to whom is it to be assigned? We will return to this issue in a later paper.

Suggestions for Further Reading

Part 3 of Jaques *A General Theory of Bureaucracy*, (1976) provides more details about the differences between work at levels III and IV.

Suggestions for Further Discussion

What would be the differences for your District if physiotherapy services were run at stratum III or stratum IV? How will the occasional clinician capable of stratum IV or V work fit into Districts run at stratum III or IV? Are there other ways of dealing with fragmentation of services within your District? How might the national work referred to in this paper be organised? Assuming the District Physiotherapist role is worth retaining, how could the profession ensure this?

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