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Implementing change in physiotherapy: professions, contexts and interventions

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Implementing change in physiotherapy: professions, contexts and interventions

Abstract

Purpose - This paper reports findings from qualitative interviews with physiotherapists to demonstrate why even minor changes to clinical work resulting from the introduction of new interventions, are often difficult to implement. We illustrate how some of the obstacles to implementing change were managed by physiotherapists.

Design/methodology/approach - A total of 32 qualitative interviews with participating physiotherapists were conducted, 12 interviews prior to the introduction of the new system, and 20 afterwards. The interviews were coded and analysed thematically.

Findings - The findings reveal a number of perceived limitations of current management of low back pain and identify key themes around convergence with the new approach, such as, willingness by physiotherapists' to adopt the new approach, the perception of benefits to adopting the new approach as well as some difficulty in adjusting to it. We refer to the positive and negative elements as 'soft' and 'hard' disruption. The adoption of the new approach is explored with reference to the 'situated' dimensions of physiotherapy practice and Normalisation Process Theory.

Research limitations/implications - The study raises the need to conduct future observational research to support the interview findings.

Originality/value - The study describes the 'situated' components of physiotherapy work, which have received limited research attention. The value of the study lies less in its ability to specifically explain why physiotherapists adopted or rejected the new system, but in describing the conditions and consequences of change that might be translated to other professions, contexts and interventions.

Implementing change in physiotherapy: professions, contexts and interventions

Introduction

The last few years have witnessed dramatic growth in the number of implementation initiatives in UK healthcare reflected in the emergence of a large volume of publications and funded research. However, despite this effort, little is known about the process of implementation and how change is sustained in clinical settings (Grol and Grimshaw, 2003; Parmelli *et al.* 2011). Pay for performance programmes in the UK (Roland 2004; Harrison and Checkland, 2009) are one example of governments' attempts to close the translational gap, by aligning incentive structures with desired performance outcomes (Checkland *et al.* 2008). However, the emphasis on external levers of change may overlook the 'internal', less overt, and 'situated' drivers (Davies *et al.* 2004; McDonald *et al.* 2007), and knowledge about how such initiatives can be sustainably implemented remains incomplete. The implementation literature suggests that external drivers (e.g. clinical guidelines) alone are unlikely to be successful in bringing about radical change to the content of clinical work (Baus, 2004). Addressing the different layers of implementation, at the level of health professionals and organisations is needed to sustainably implement new interventions or services. However, tensions may arise between these different levers of change. For instance, wider policy promoting the use of guidelines to inform clinical decision-making may conflict with local priorities, designed to deal with the immediate, situated, taken for granted aspects of clinical work. The alignment of evidence-based interventions with such priorities may therefore be central to their adoption. However, healthcare professionals may not simply apply abstract, disembodied evidence rigidly to their own context, but engage in the active interpretation and reconstruction of its local validity and usefulness ('situated knowledge') (Wood *et al.* 1999; Lave and Wenger, 1991). This perspective assumes that translation is

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3 neither natural nor inevitable but involves the ‘testing out’ of a new approach in daily
4
5 practice (Doolan *et al.* 2003; Berg, 1999; Sanders *et al.* 2011). Research to date, however, has
6
7 not fully examined this 'situated' component of implementation. An initial review of the
8
9 literature is followed by a description of the methods, by the study findings, and finally a
10
11 discussion of their relevance to physiotherapy.
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14 15 16 *Changing health professional behaviour*

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18 The term 'barriers to change' has widely been used to explain the difficulties of introducing
19
20 innovations in healthcare (Checkland *et al.* 2007; Ferlie *et al.* 2000). This concept, however,
21
22 makes a number of assumptions; that ‘barriers’ are generally undesirable and change is
23
24 necessarily advantageous. However, what might be a ‘barrier’ to implementing a new service
25
26 or intervention might at the same time be integral to existing clinical work, and therefore its
27
28 complete removal may be counterintuitive. Checkland *et al.* (2007), following Weick (1995),
29
30 claim that health professionals engage in 'sense-making' to assign meaning to their role.
31
32
33 Armstrong and Ogden (2006), for example, found that GPs engaged in a process of
34
35 evaluation and experimentation to ‘try out’ new medications and their impact on routines
36
37 before introducing alterations to their work. Looked at in this way, innovations that ‘make
38
39 sense’ or add meaning are more likely to succeed by virtue of the positive impact that they
40
41 have on clinical routines. The introduction of new innovations in health care may also
42
43 demand a proactive response so that professionals engage in, what might be called, ‘transition
44
45 work’. They must play an active part in bringing about change, and they are less likely to do
46
47 so in the absence of a key motive. Consequently, clinicians may need to become convinced of
48
49 the benefits of a new approach at a deeper level, not just what is ‘practical’ or ‘relevant’, but
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51 what may be professionally desirable.
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3 Behaviour change may stem from the acquisition of new skills and not only from coercive
4 external levers such as clinical guidelines (Nancarrow and Borthwick, 2005). Modifications
5 to existing behaviour through enhanced skills and competencies may encourage broader re-
6 stratification (Harrison and Dowswell, 2002; May *et al.* 2004) in line with wider policy that
7 views healthcare work as part of an ongoing professionalism agenda (General Medical
8 Council 2006). More recently such trends have been evidenced in policy promoting new
9 values in medicine that take into account the shifting demography of populations and social
10 attitudes (Tomorrow's Doctors, 2003). Others view them as the inevitable
11 'reprofessionalisation' of National Health Service (NHS) occupations, a process where
12 groups attempt to increase their status through the acquisition of new skills (Sanders and
13 Harrison, 2008; Haug, 1973, 1976; Lupton, 1997) or in response to policy such as the NHS's
14 recent programme of modernisation (e.g. NHS Modernisation Agency) (Green *et al.* 2011).

31 *Theoretical stance*

32 This paper adopts the underlying theoretical orientation that innovations in healthcare can
33 transform the workplace, though such transformation can only be achieved through an
34 analysis of the 'situated' dimensions of change (Allen, 2009; Berg *et al.* 2002).

35 Clinical work is often routinized, involvintg 'taken for granted' practices, and subjected to
36 the demands of the health care organisation; in essence a type of labour that is highly
37 'situated'. By 'situated', we refer both to the physical organisation of work (e.g. how care is
38 structured and delivered across the clinical setting), and the social relationships formed
39 during the course of routine clinical practice with patients and clinical colleagues (e.g.
40 physiotherapist-patient interactions, and division of labour between colleagues); previously
41 defined as 'practical' and 'relational' coherence (Sanders *et al.* 2011). 'Situated' is derived
42 from the idea of 'situated learning', originally developed by Lave and Wenger (1991), who

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2
3 view any social process as involving active learning. This way of approaching learning is
4
5 something more than simply 'learning by doing' or experiential learning. As Tennant (1997)
6
7 has pointed out, Lave and Wenger's concept of situatedness involves people being full
8
9 participants in the world and in generating meaning. Lave and Wenger (1991: 108-9) state
10
11 that 'the purpose is not to learn *from* talk as a substitute for legitimate peripheral participation;
12
13 it is to learn *to* talk as a key to legitimate peripheral participation'. This orientation has the
14
15 definite advantage of drawing attention to the need to understand knowledge and how
16
17 learning is operationalised in context. Situated learning depends on the claim that it makes no
18
19 sense to talk of knowledge that is decontextualized, abstract or general. It has to make local
20
21 and practical sense. In this way, organisations are intrinsically 'learning communities'.
22
23 Organisations oriented to individual accreditation (e.g. performance review) may deny the
24
25 importance of relationships in the workplace because of pressures on *individuals* to meet
26
27 centrally-determined targets. This approach to learning and organisational change is
28
29 challenging and profoundly problematic. It highlights just how far formal frameworks for
30
31 improving clinical practice have drifted away from a proper appreciation of situated learning
32
33 as a route to improved performance and clinical care.
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41 This paper reports **why disruptions to clinical routines caused by the introduction of a**
42
43 **new intervention make even minor changes to clinical work difficult to implement. The**
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45 **paper illustrates how some of these obstacles to implementation were managed in the**
46
47 **context of routine physiotherapy.**
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51 **Methods**

52 *Context*

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3 Interviews with clinicians were conducted, which were nested within a larger quality
4 improvement study. The larger study aimed to evaluate the clinical and cost-effectiveness of
5 a subgrouping and targeted treatment system. The larger study had three phases: 1)
6 observation of current clinical practice and patient outcomes; 2) introduction of, and support
7 to use, the new system; and 3) observation of clinical practice and patient outcomes,
8 following the introduction of the new system and for 12 months thereafter. **The purpose of
9 this larger study was to investigate whether a ‘targeted’ evidence-based approach to the
10 management of low back pain led to improved outcomes in patients compared to usual
11 primary care. Usual primary care often involves the use of the clinicians’ judgement
12 and experience, whilst the new intervention adopts a more systematic approach to
13 patient care which has been previously shown to produce superior outcomes. A key
14 component of the new approach to care is the classification of patients into low, medium
15 and high risk groups, the latter of which have been shown to benefit from a more
16 specialised and intensive clinical intervention that includes the management of patients’
17 biopsychosocial ‘obstacles’ to recovery as well as the physical symptoms.** The study was
18 located in 5 GP practices and associated physiotherapy services within one Primary Care
19 Trust in the UK. The practices ranged in population size (4,000 to 24,000) and composition
20 (four to twelve GPs and a variety of primary care services). General practices were selected
21 in order to ensure a breadth of practice settings (urban/semi-rural/rural) and size
22 (small/medium/large). Taken together they cover a broad range of English general practices.
23 In keeping with the national picture, these practices accessed various physiotherapy treatment
24 pathways, referring back pain patients to physiotherapy colleagues working within the GP
25 practice or referring patients to physiotherapists based at other primary care treatment sites.
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56 *The intervention and physiotherapist training*
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3 Features of the multicomponent, quality improvement intervention with physiotherapists
4 included a stepped knowledge and skills-based training and clinical mentoring programme.
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6
7 All the study physiotherapists attended an initial three-day training course. This included the
8 use of a validated 9-item subgrouping tool which identifies whether back pain patients are at
9 low, medium or high risk of poor outcome, a review of best physiotherapy practice for
10 patients with low back pain, and guidance on how best to manage patients at low and medium
11 risk of poor outcome. The stratified care approach has been shown to be clinically superior to
12 best current practice with cost savings to the health service (Hill *et al.* 2011). These patients
13 have predominantly physical obstacles to recovery such as limited physical function, leg pain
14 and pain in other body regions. Nine physiotherapists (**from a total of 26 from the 5 study**
15 **practices**) undergoing this initial training then went on to attend a further 6 days of training
16 aimed at the assessment and management of patients at high risk of a poor outcome. These
17 additional 6 days of training focused on identifying and managing patients with physical and
18 psychosocial ‘obstacles’ to recovery. The training programme for physiotherapists treating
19 patients at high risk of poor outcome was delivered using a range of methods, including role
20 play, case discussion, audio and video training materials and simulated patients.
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40 Following the training, **all** the physiotherapists participated in two hours per month of group-
41 based clinical mentoring for a 12 month period. This was intended to consolidate the
42 physiotherapists’ skills and confidence in delivering the stratified treatment system, through
43 discussion of patient cases. The physiotherapists who received the 3 days training and the
44 physiotherapists who received the 9 days (3 plus 6 days) were mentored separately and by
45 different facilitators as they had received different training and were managing different
46 groups of patients. Mentors were also available by email and telephone to provide support
47 (see Sowden *et al.* for more detail). In addition to the mentoring, the physiotherapists
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3 received individual feedback following observation of their clinical practice. The
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5 physiotherapists who received the 9 days training also received feedback on two occasions,
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7 following observation and video recording of a consultation between them and a simulated
8
9 patient (actor).
10

11 12 13 14 *Interviews*

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16 A total of 26 physiotherapists participated in the larger back pain study. There were equal
17
18 proportions in each of the 5 participating practices, covering different geographical locations
19
20 within the county of Cheshire, England. All 26 physiotherapists were approached and invited
21
22 for an interview by letter. We were interested in capturing everyone's views, and we therefore
23
24 did not employ any exclusion criteria. Those who refused did not provide a reason. A total of
25
26 32 qualitative interviews with physiotherapists **undergoing both the 3 day and the 9 day**
27
28 **training**, were conducted; 12 interviews prior to the introduction of the new system, and 20
29
30 following introduction of the new system (including most of the original 12 respondents).
31
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34 **Among the 12 physiotherapists interviewed prior to the introduction of the new system**
35
36 **5 attended the 9-day course and 7 the 3-day course only. As the new system was**
37
38 **introduced shortly after the training, the interviews had to be completed in a short time**
39
40 **scale, in which case we could not interview all of the physiotherapists. By the time of the**
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42 **second round of interviews some of our original respondents could not be interviewed**
43
44 **due to refusal to participate or were no longer working at the practice. It was therefore**
45
46 **necessary to interview additional respondents in the second round as certain questions**
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48 **still had not been explored in enough depth.** Interviews were conducted in 2008. The
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50 respondents represented a diverse mix in terms of age, experience, seniority and length of
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52 service in physiotherapy.
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3 Whilst focus groups are likely to yield useful insights as they encourage discussion amongst
4 participants, there is a risk that individual perspectives will be lost within a group discussion
5 and we therefore opted to conduct interviews rather than focus groups. We wanted to
6 interview a greater number of physiotherapists following the introduction of the stratified
7 care system, to fully explore the effect of the 'situated' components of physiotherapy practice
8 on acceptability and use. We also sought to examine their experiences in sufficient detail to
9 enable us to reach thematic 'saturation'. We reached such a stage after 20 interviews. A grand
10 total of 32 qualitative semi-structured interviews were finally conducted either face to face or
11 via telephone. Telephone interviews were conducted in the same way as face to face
12 interviews using a topic guide, and were audio recorded and fully transcribed. The telephone
13 interviews were on balance slightly shorter but covered the same topics as face to face
14 interviews, and the main issues were examined in similar detail. The baseline interviews
15 enquired about physiotherapists' clinical routines to identify the practical difficulties they
16 faced managing patients with low back pain. This included questions about how chronic and
17 acute patients responded to treatment, their perceptions of patient's obstacles to recovery, and
18 the psychosocial problems affecting patients with low back pain. The purpose was to
19 understand the situated context of back pain care. The subsequent interviews focused on the
20 new system (e.g. the subgrouping tool and matched treatment pathways) and the social
21 context of adoption or resistance to the new approach for managing patients. Questions dealt
22 with therapists' reactions to using the tool and to adopting the matched treatment pathways,
23 the impact these had on their practice, the perceived benefits for patients, the health care
24 system and for them as members of the physiotherapy profession, and the impact of using the
25 new tool and treatment pathways on interactions with other therapists, patients and
26 established clinical routines. The interviews were conducted using a topic guide, which
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3 adopted the form of a conversation and respondents were encouraged to freely express their
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5 views.
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8 9 *Analysis*

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11 The interviews with physiotherapists form one part of a larger study that included interviews
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13 with GPs (see Sanders *et al.* 2011). This paper reports findings from the physiotherapist
14
15 interviews only. The analysis presented here is concerned with **explaining why disruptions**
16
17 **to clinical routines caused by the introduction of a new intervention make even minor**
18
19 **changes to clinical work difficult to implement.** All interviews were fully transcribed and
20
21 coded using the N-Vivo data management system, and subsequently analysed thematically.
22
23 The data were coded independently by three of the authors and a coding scheme was agreed.
24
25 The data were analysed drawing upon patterns and connections in the data, broadly based on
26
27 the constant comparative method in qualitative data analysis (Strauss and Corbin, 1990).
28
29 Emergent insights from the interviews were summarised during the course of fieldwork and
30
31 tested in subsequent interviews to inform theory development. The broader framework for the
32
33 analysis was shaped by the original aims of the qualitative study; to explore physiotherapists'
34
35 experiences of using a new intervention in clinical practice. The subsequent analysis involved
36
37 identifying common responses related to the advantages and challenges of introducing the
38
39 new intervention for physiotherapists during their clinical work with patients and colleagues.
40
41 The key themes were structured as 'incoherence in back pain care', 'soft disruption' and 'hard
42
43 disruption'. Team meetings were held regularly during the course of the fieldwork and
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45 continued subsequently, to ensure the data were analysed robustly as well as to cross-validate
46
47 the findings. The quotes are illustrative of the main themes. Favourable ethical opinion was
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49 obtained from a Local NHS Research Ethics Committee.
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Results

This section is divided into the following themes: ‘Incoherence in back pain care; ‘Soft disruption’; and ‘Hard disruption’. We refer to ‘Normalisation Process Theory’ to help interpret the findings. The first theme provides the context for understanding respondents’ evaluations of current management of back pain patients; a vital first step in establishing meaning of the subsequent adoption of an intervention (‘coherence’).

The subsequent two themes ‘soft and hard’ disruptions demonstrate how physiotherapists responded to the intervention following its introduction.

‘Incoherence’ in back pain care

Physiotherapists claimed that low back pain frequently led to social and psychological difficulties for patients which physiotherapy services were not well equipped to manage. They described deficiencies in their current management of low back pain, largely related to a perceived lack of time and skills to effectively address the patient’s back pain related psychosocial issues or to manage more psychosocially complex patients. Psychosocial influences were thought by some to fall outside of the current traditional practice of physiotherapists who defined their role primarily in relation to the physical management of musculoskeletal problems, but which they recognised as important. The discourse of patient-centeredness was clearly important in the management of patients, but lacked clarity in definition or how it should be performed in practice:

“We are mainly taught the physical approach, physical therapy and we have no tools to address the other issues that I have just been talking about. That is where I feel I don’t think I have much to offer other than lend a listening ear and a bit of advice if I can, but I have no way of knowing whether that advice is appropriate”. [P5]

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5 Physiotherapists described low back pain as a ‘heart sink’ health problem, indicating a need
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7 for further training. They were uncertain about how to approach patients’ psychosocial issues,
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9 and wanted guidance on the appropriate way to engage with patients with low back pain in
10
11 ways that recognise that it is a complex condition:
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16 *“I think that really we are not very well equipped to give the right message across to these*
17
18 *patients... I don’t think we have enough training and background to maybe to know exactly*
19
20 *what to say to these people, to be positive but to be realistic. I think we need more input with*
21
22 *that kind of thing, the right things to say and the wrong things to say, would help”. [P8]*
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27 Some physiotherapists however claimed that many practitioners were reluctant to change
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29 established ways of working:
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34 *“I think that there is too much old practice, too much of the people saying ‘oh well I was*
35
36 *taught to do this when I trained’ ... That kind of philosophy needs to change, definitely”.*
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38 *[P10]*
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43 Physiotherapists reported that patients were often given diverse and conflicting advice by
44
45 different health professionals:
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49 *“...obviously the GP is the first person the patient sees, if they could be better educated with*
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51 *regards to back pain and then that filtered down and everyone trying to do a fairly similar*
52
53 *thing, not similar for every single problem but approaching problems in similar ways”. [P6]*
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3 Therapists also thought that the management of low back pain was often less than ideal, with
4
5 GPs perhaps too quick to certify patients as sick:
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10 *“Yeah, the sort of patients who don't seem to respond to what I do... the GPs never want to*
11 *really see them they just sign them off with sick notes and give them anti-depressants and*
12 *things like that, but I feel that there is a little bit more that we could do perhaps as*
13 *physiotherapists to help with these patients as well as their physical problems”. [P1]*
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21 Some thought that ultimate responsibility for the management of patients with back pain
22
23 should reside with physiotherapists, who they felt have the necessary skills for the task and
24
25 by implication are better suited to provide care:
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30 *“I am probably not a good one to ask that, because, I think everyone should be referred [to*
31 *physiotherapy]. That may sound wrong, but I don't know why people expect the GP's to know*
32 *what we do, in so much detail. They don't know what is available. I think it is perfectly valid*
33 *for them to send anybody to us and for us to make that decision”. [P8]*
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41 Thus at least one of their suggested solutions to the problem of poor care coordination was to
42
43 take on greater and more overall responsibility for patients with back pain, with GPs
44
45 assuming a minor referral role. The issues highlighted in the interviews identified a number
46
47 of limitations in current back pain care. May and Finch (2009) claim that the adoption and
48
49 subsequent implementation of new approaches in healthcare requires a certain level of
50
51 ‘coherence’ of the desired practice change, that is, a ‘fit’ between the recognised limitations
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53 of the current approach and the potential of a new approach to better address them. Looked at
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3 in a different way, the above responses reflect wider shifts in physiotherapists' approach to
4 care, promoting a patient-centred perspective and a flexibility to deal with complexity.
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8 9 **'Soft' disruption**

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11 Physiotherapists rationalised the new approach to back pain care in a way that made sense to,
12 **and could be integrated in**, their clinical work. **New changes to practice were viewed in a**
13 **'positive' way, coined here as 'soft' disruption.** The new system enabled them to modify
14 their current practice for the perceived benefit of patients, reported previously by Butler
15 (1997) in relation to the idea of 'performativity'; the 'embedding' of new working
16 **approaches within established routines** through their habitual use:
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27 *"I think since doing the extra, the other six days, my way of thinking and my practice has*
28 *definitely started to change. And like I say, I noticed that with the neck patient, whereas*
29 *before I would've just gone through my normal assessment. I'm actually thinking a bit more,*
30 *listening a bit more, picking up things that maybe I wouldn't have picked up, or maybe*
31 *would've bypassed before, delving a bit deeper". [P13]*
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41 **This finding might be interpreted using the Normalisation Process Theory (NPT), as a**
42 **process by which physiotherapists began to engage in what May et al (2009) call**
43 **'reflexive monitoring', or evaluation of how a new practice encroaches on existing work.**
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47 Therapists **also** claimed that patients were willing to disclose more information as a result of
48 their newly acquired communication skills:
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3 “They’re far more open, they tell me a lot more. Loads more... and you learn far more about
4 the patient themselves and the lives they lead and how it’s impacting on them, you know how
5 the problem is impacting on their lives”. [P1]
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11 They accepted the logic of patient-centred practice and the challenge that a new approach
12 offered to their otherwise routine work. The emphasis on more systematic identification of
13 key psychosocial problems in back pain appeared to make sense to a number of respondents:
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20 “It fits with my way of thinking quite well. It doesn’t quite so easily fit with what I have been
21 doing. It is a new way of doing things. It challenges the old model of sort of closed
22 questioning”. [P14]
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29 The training and mentoring programme was felt not only to improve the physiotherapists’
30 assessment of patients but to also equip them with new skills and confidence to manage
31 patients with complex psychosocial problems. The above and subsequent quotations suggest
32 that adoption of the new approach to care involved ongoing evaluation, encouraging critical
33 reflection about current practice (**‘reflexive monitoring’**). This led to reflection on the old
34 and new approach in order to identify the more beneficial approach for patients and for their
35 own working practices:
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47 “I was very much directed to manual therapy and hands-on, and listening to people, because
48 I think I’m a quite good listener, and I do listen, so I was picking up certain things. But again,
49 I didn’t know how to act on it, and I didn’t feel confident to act on it. So it’s given me perhaps
50 a bit more confidence to address these issues”. [P5]
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3 Therapists also claimed that their self-confidence improved as a result of the training and
4 mentoring programme, with several positive consequences for patient management. They
5 were more confident about adopting the new system, one consequence of which was the
6 earlier discharge of patients, particularly those deemed to be unsuitable for long-term
7 physiotherapy intervention:
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16 *“I think, well, I think that as a result of my increased confidence that I’m discharging sooner*
17 *because I’m discharging knowing that I’ve done everything I need to do, I’m not going to get*
18 *this one hundred per cent better if they’ve got lots of degenerative changes...”.* [P7]
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25 They also talked about how they felt they had greater confidence to discuss and manage the
26 psychological and social consequences of back pain:
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32 *“And I think now I’ve got more confidence in how to deal with some of the things they’re*
33 *saying to me. Before if I’d done that and I wasn’t confident I think I would’ve reverted back”.*
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35 [P1]
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41 Therapists were able to deal confidently with a wider range of issues presented by patients
42 because they had acquired effective skills. These additional skills provided them with the
43 confidence to deal with more complex health problems previously described as 'acts of work
44 and courage', considered central to the role of 'leadership professions' such as clinicians in
45 their ability to deal with uncertainty and complexity (Iles *et al.* 2005). The training and
46 mentoring programme led to a number of other unintended benefits to physiotherapy practice,
47 adding further credibility to the new system and the new role of our respondents. They
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3 musculoskeletal problems such as knee or shoulder pain, not solely back problems; and
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5 consequently added further support to its efficiency and physiotherapists' ability to manage a
6
7 broader range of musculoskeletal conditions:
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11 *“And it’s really interesting in that it’s not just with back pain patients either; it’s actually*
12 *transferable across any patient. Neck pain, shoulder pains, any chronic pain patient or even*
13 *a patient who’s in an acute episode of something, it makes you think differently to what those*
14 *patients are telling you”.* [P1]
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23 Patient care became more efficient whilst altering therapists’ overall clinical strategy towards
24
25 a patient-centred perspective. Adoption of the new approach was not simply the consequence
26
27 of acquiring more skills and knowledge. It also involved a long process of learning and
28
29 evaluation of how the new approach ‘fitted’ within existing clinical routines, and ultimately
30
31 whether it led to significant benefits. Others valued the subgrouping tool due to the ease with
32
33 which it quickly classifies patients into low, medium and high risk subgroups. This **has**
34
35 implications for wider physiotherapy services, potentially facilitating faster access to the
36
37 appropriate treatment, and in changing physiotherapy appointment frequency or duration.
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39 Overall, it was perceived to enhance the efficiency of the service:
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45 *“We may be seeing them over a longer period of time, but we’re not seeing them as often. So*
46 *that’s working better for us from a case load point of view”.* [P2]
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52 In this example **current** care was greatly enhanced by the new system. In other words, this
53
54 different way of working was perceived to be beneficial in terms of using appointment time
55
56 efficiently and more effectively managing clinical case loads. The recognition of the impact
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3 of the new approach on efficiency was important with regard to an altogether different
4
5 problem; therapists perceived that some patients, in the past, had been difficult to discharge
6
7 from physiotherapy and became over dependent on their physiotherapist for emotional
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9 support:
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14 *“They came to us and they got stuck with us because we either became the emotional crutch*
15
16 *and then couldn't discharge them”*. [P11]
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20 Some found the increased focus on identifying and addressing psychosocial ‘obstacles’ to
21
22 recovery intellectually more stimulating and emotionally more rewarding than existing
23
24 working practices, thus increasing their engagement with patients and their job satisfaction:
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29 *“People, at the moment, are very stressed and I find that you know I find that totally*
30
31 *interesting. The social side of it, of people's lives and their problems and things like that and*
32
33 *seeing if you can problem solve with that... I find that more interesting than dishing out a*
34
35 *sheet of exercises”*. [P18]
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40 Others claimed that **patients also benefitted as the intervention** enabled them to accept
41
42 ownership of their back problem and for finding solutions, which in turn enhanced patient's
43
44 willingness to put things into practice:
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49 *“Just get them (patients) to think about how they're going to overcome obstacles and how*
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51 *they feel they're going to, so it's their ownership of it. And that's a completely, completely*
52
53 *alien way of thinking about it. So it's hanging back, giving them permission to think about it”*.
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56 [P11]
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5 Nordgren (2010) found that the term ‘consumer’ is replacing ‘patient’, resulting in a
6
7 transformation of patient subjectivity from a passive recipient to active participant of
8
9 healthcare. This shift, in relation to physiotherapy, is apparent in the above quote, and the
10
11 language of patient engagement does frequently appear in the responses of our
12
13 physiotherapists.
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18 The benefits of the new system were therefore two-fold: an evidence-based approach to the
19
20 management of patients with more complex psychosocial issues preventing physiotherapists
21
22 from being ‘pulled-into’ a dependency relationship with challenging patients, and an
23
24 opportunity to work with patients in a more collaborative and professionally rewarding
25
26 manner. Both elements were important for the future sustainability of the new practice. This
27
28 discourse might be viewed as a response to the broader managerial rhetoric around
29
30 accountability and efficiency in the NHS (Harrison, 2002):
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36 *“It made me reflect on things and it’s helped me see, identify some habits that I probably*
37
38 *have got into over the years that I need to look at changing. Nothing minor, nothing major,*
39
40 *but you know, little things that you just do because you do them”. [P9]*
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45 Here, the therapist is questioning some of the situated elements of back pain care that have
46
47 become routinized with time, and now required critical evaluation. Some claimed that the
48
49 new system had a considerable impact on daily work, making it virtually unthinkable to
50
51 revert back to the previous way of working (Giddens 1984; May *et.al.* 2007). These data
52
53 illustrate an important activity of professions, namely their engagement in a dynamic process
54
55 of appraisal and adaptation (Nancarrow and Borthwick, 2005). **The intervention led to**
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3 **critical questioning of certain ‘taken for granted’ (‘situated’) aspects of patient care,**
4
5 **and the belief that the intervention offered additional benefits to physiotherapists. The**
6
7 **process involved the testing out (experimentation) of the different elements of the new**
8
9 **approach to back pain care, and ultimately to physiotherapists’ engagement with the**
10
11 **new approach, or ‘cognitive participation’.**

16 **‘Hard’ disruption**

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18 The implementation process, however, was not altogether straightforward. The success of any
19
20 intervention will ultimately depend on the response of the users. This demanded an awareness
21
22 of patients’ expectations and assumed an ability to negotiate treatment:
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27 *“And I think one of the things I’ve got is sometimes you have to buy brownie points with*
28
29 *patients...I’ve only had one patient who just, you know, well “what are you doing?”, you*
30
31 *know, “when are you going to treat me?” She just didn’t get her head round the discussion”.*

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34 [P1]

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38 **The challenge from patients came in the form of expectations about the specific nature**
39
40 **of physiotherapy work, as involving active management, rather than solely the provision**
41
42 **of guidance or discussion about patients’ psychosocial problems. Such practices, key**
43
44 **components of the new intervention, were called into question by patients and therapists**
45
46 **had to develop ways of responding to them; a task that they could not easily undertake.**
47
48 **According to the NPT, the problem here was the difficulty of engaging individuals**
49
50 **(cognitive participation), in this case the patients. Although the therapists were**
51
52 **convinced of the new approach, their client group was not so easily persuaded.**
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3 Therapists also raised concerns about the potential deskilling effects of the new care system
4 with its emphasis on ‘working with’ patients rather than ‘doing things to them’. Changing to a
5 more patient-focused paradigm according to some physiotherapists seemed to affect patients'
6 expectations and those of the practitioner. At the same time, physiotherapists felt compelled
7 as a result of the training, to alter their approach to patient care. These changes caused
8 tensions for both parties and required considerable effort to redefine roles and expectations.
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18 *“Physios, when they’re first asked to do this sort of work... will often feel quite de-skilled by*
19 *it. Because physios are trained to do things and if they’re sitting and talking, as it feels like,*
20 *they’re not doing something. And that’s a bit of an issue from some sort of previous work that*
21 *I’ve been involved in and that’s quite challenging I think, you know, people sitting talking to*
22 *patients, rather than doing things to them, that’s a sort of struggle for them at first”.* [P9]
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32 This difficulty was reflected in the below quotation that a physiotherapist’s role should not
33 extend to the management of ‘psychosocial’ problems in patients with musculoskeletal
34 disorders. **The essence of physiotherapy work according to patients required active**
35 **physical intervention, and physiotherapists felt compelled to meet patient demand by**
36 **providing ‘hands on’ therapy at least in combination with guidance and advice. Clearly,**
37 **this did not sit well with the ‘psychosocial’ components of the new intervention which**
38 **does not deal directly with patients’ immediate pain problem. Consequently, there**
39 **seemed to be a mismatch between existing routines and some of the requirements of the**
40 **new approach (‘psychosocial’ intervention). In relation to the NPT the problem of**
41 **implementing the intervention resided in a critical failure of the intervention to match**
42 **patient expectations, and hence its workability in everyday clinical work (‘collective**
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3 **action’); hence the capacity of the intervention to facilitate agreement between**
4
5 **physiotherapists and patients about the purpose of *physiotherapy*.**
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10 *“I don’t know how in depth I’ll be able to go with the psychosocial bit because still, it’s the*
11 *time factor, because you know there are all these other patients that still have to be treated,*
12 *but also I still feel at times that I’m asking things that are not really my province to be*
13 *dealing with as a physio perhaps”. [P16]*
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20 **In addition, the psychosocial elements of the intervention also required the investment**
21 **of additional time and did not sit comfortably with physiotherapists’ expectations of**
22 **their role which did not extend much beyond the physical aspects of care. Others blamed**
23 **the system for encouraging GPs to refer inappropriately, and for the referral of patients with**
24 **‘complex’ conditions to specialist physiotherapists.**
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34 *“One of the patients complained to the GP that I was like “a blue-arsed fly” ... because I*
35 *cannot physically see as many people as I do and assess people in this way. And now, because*
36 *I was getting swamped with people coming up to physio to make appointments...”. [P16]*
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43 *“I mean if I wasn’t comfortable with it, I wouldn’t have been doing it (working in current*
44 *role) for fourteen years. So that’s what, I mean I can understand how other people on the*
45 *course are thinking well how is this going to fit with what I already do? And what time*
46 *issues? And how will, if I take longer with my patients then what do other people in the*
47 *department think? And there’s a waiting list and all that kind of, all the politics of it”. [P9]*
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3 Clinical work is quite sensitive to change, as even small alterations to routines may have
4
5 significant ‘knock on’ effects. Any change to this balance may lead to disruption. The
6
7 normalisation process theory (May et al 2007) refers to the importance of establishing
8
9 coherence between existing routines and the introduction of new interventions, to ensure a
10
11 smooth transition. Therapists in this study voiced some concerns about how a change in
12
13 working patterns would impact on their own and their colleagues’ roles. The benefits were
14
15 clear, although the practical concerns still left some feeling uneasy about the workability of
16
17 the new system. In summary, the introduction of the new approach and the establishment of
18
19 ‘coherence’ was an ongoing challenge for our therapists requiring frequent reassessment, re-
20
21 evaluation and negotiation of roles and responsibilities. This resonates with an earlier point
22
23 that organisations are essentially ‘learning environments’ where change leads to evaluation,
24
25 negotiation and critical reflection on the part of the participants. In essence, our therapists
26
27 engaged in such evaluation (**‘reflexive monitoring’**), and finally concluded that **on balance**
28
29 the change had **largely** positive benefits; in the following example the advantages were
30
31 related to maintaining supportive relationships with GPs.
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39 *“I think the GPs have been surprised from what I hear from other clinicians having taken on*
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41 *the same training, about what we’re able to do and I think that will help better working*
42
43 *relationships with GPs and Physios. Erm, and I think that probably will improve our*
44
45 *relationships with GPs in primary care if they can see that we’re wanting to help patients in*
46
47 *return to work, any medication issues and I think that will help”. [P1]*
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50 51 52 **Discussion**

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54 Physiotherapists recognised a need for change in their management of back pain on a number
55
56 of different levels. For instance, back pain care requires a more overarching approach that is
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2
3 inclusive of patients' psychosocial problems. The limitations of addressing only the
4
5 biomedical, mechanical or 'anatomical' aspects of low back pain were obvious to therapists,
6
7 and signalled a need to develop a more patient-focused approach to care. In particular they
8
9 expressed a desire to work more collaboratively with patients, in terms of decision making,
10
11 goal setting and activity planning. This is in keeping with Breen *et al.* (2004), who identified
12
13 a lack of capacity in primary care to deal with the multidimensional needs of back pain
14
15 patients, as well as citing poor access to specialist opinion. Also, the recommendations given
16
17 to patients by health care professionals, including physiotherapists and GPs, were perceived
18
19 as inconsistent.
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25 The new approach, on the other hand, helped physiotherapists overcome many of these
26
27 limitations, and led to the creation of new routines of which the specific benefits were, firstly,
28
29 more *effective* management of patients. As a result of paying greater attention to psychosocial
30
31 'obstacles' to recovery the physiotherapists felt that their clinical practice was more effective
32
33 and that they were better able to help the more complex, distressed pain patients, who they
34
35 had previously felt they had little to offer. Once learnt, they also found that they were
36
37 applying their new knowledge and skills to other musculoskeletal conditions, beyond back
38
39 pain, **and** were more in tune with prevailing policy that promotes self-management (Kennedy
40
41 *et al.* 2007), and development of skills for negotiated interactions with patients (Blakeman *et*
42
43 *al.* 2006).
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50 Secondly, the physiotherapists could utilise appointment durations and frequency more
51
52 effectively and discharge patients sooner, thus improving the *efficiency* of their practice,
53
54 reported previously as a discursive strategy used by specialist nurses to present themselves as
55
56 positively contributing to the organisation of the NHS (Sanders and Harrison, 2008).
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5 Thirdly, in addition to the perceived benefits for patients and the health care system itself, the
6
7 physiotherapists **claimed** that there were benefits to them both personally and professionally.
8
9 As a result of the tool, the training and their acceptance of this new overall approach to the
10
11 management of low back pain, they found their work more interesting and rewarding and also
12
13 felt that their standing as a profession, in the eyes of GPs, was enhanced. GPs appeared to
14
15 welcome this ‘vertical boundary’ change (Nancarrow and Borthwick, 2005). The addition of
16
17 evidence-based cognitive behavioural skills (e.g. training in managing the more distressed
18
19 and disabled patients with back pain) to their professional repertoire was seen to enhance
20
21 their status vis-à-vis general practitioners. GPs taking part in the same study stated (*see* paper
22
23 reporting GP findings – Sanders *et al.* 2011) that they had greater confidence in
24
25 physiotherapists’ ability to deal more effectively with patients’ low back pain related
26
27 psychosocial issues. Unlike the community pharmacists in a different study (MacDonald *et*
28
29 *al.* 2010), our respondents indicated that GPs, with whom they liaised closely, were positive
30
31 about physiotherapists’ enhanced skills, leading to more effective patient care (May, 2004).
32
33 Occupational work boundaries were therefore clearly delineated, freeing physiotherapists to
34
35 command a more dominant position in the care of back pain patients. Evetts (2003) argues
36
37 that the ideology of ‘professionalism’ appeals to occupational groups as it represents having
38
39 exclusive ownership of an area of expertise and knowledge. **All of these issues point to what**
40
41 **we coin ‘soft disruption’, which describes the process by which the introduction of new**
42
43 **interventions might be viewed in a ‘favourable’ light and, as shown here, seen to**
44
45 **enhance routine care. The situated (taken for granted) elements of physiotherapy work**
46
47 **were not radically disrupted by the new approach, and were generally perceived to**
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49 **enhance routine care.**
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3 However, the introduction of the new approach was not without problems. In as much as
4 participating physiotherapists appeared to embrace the new system, the more fundamental
5 challenge came from patients and the expectation that physiotherapy involved more
6 traditional hands-on treatment. **One difficulty of introducing the new approach was the**
7 **effect of a change in perception of patients as *consumers* rather than simply patients**
8 **(Nordgren 2010).** In response, physiotherapists negotiated with patients as a means of
9 'selling' the new approach. Some claimed that they did not have the necessary training or
10 skills to deliver the high risk intervention, with its increased focus on psychosocial factors.
11 Others expressed concerns that their practice had become overburdened with additional
12 referrals from general practice, and that conflicts could arise between therapists. For instance,
13 the pressure to refer 'challenging' (high risk) patients to more 'qualified' therapists could
14 lead to 'tension' **between therapists receiving extended training and those who received**
15 **only basic training. All of these difficulties represent a mismatch between the new**
16 **approach and the 'taken for granted' routines and established practices in**
17 **physiotherapy work. We coin these more substantive difficulties 'hard' disruption,**
18 **which may be more awkward to resolve due to their deep rootedness in daily clinical**
19 **practice.** However, it is important to stress that the **perceived benefits** of the new approach
20 outweighed the difficulties. Nevertheless, all of these factors point towards the centrality of
21 the situated dimensions of physiotherapy practice, and the need to recognise and address the
22 implications for routine work of any new intervention introduced into clinical settings (Allen
23 2009; Berg 1999).

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52 According to the Normalisation Process Theory the implementation of a new approach to
53 care is operationalised through four mechanisms: coherence (establishing meaning), cognitive
54 participation (engagement of individuals); collective action (interaction with existing
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3 practices); and, reflexive monitoring (reflection and understanding of an intervention) (May
4 et al. 2009b; May et al. 2003). Our therapists clearly sought to establish coherence of the new
5 approach by rationalising the benefits and limitations of the new system. They clearly
6 engaged in the new approach to back pain care during their interactions with patients.
7
8 However, not all patients were convinced of the importance of the ‘non-mechanical’
9 components of back pain treatment, and therapists had to work hard to ‘sell’ the new
10 approach. Finally, the training and mentoring programme frequently led to active reflection
11 about current back pain care and the advantages that a new system could bring. The potential
12 ‘disruption’ to their clinical (‘situated’) routines was managed by the active ‘trying out’ of the
13 new system with patients and through discussions with colleagues about its benefits and
14 limitations. Any disruption to existing physiotherapy work was viewed as an opportunity to
15 enhance clinical care rather than a threat to existing routines (‘soft’ disruption). Clearly, the
16 implementation of the new approach moved well beyond the initial stages of coherence and
17 cognitive participation; therapists understood its relevance and meaning within their daily
18 work. They moved to the subsequent stage of ‘normalisation’ of the new stratified care
19 approach by using it as a ‘benchmark’ for reflecting critically upon their daily work with
20 patients. **The contribution of the new approach to back pain care was by and large**
21 **positive. We might conclude from our findings that the perceived degree of disruption to**
22 **taken for granted (situated) practices due to the introduction of a new intervention in**
23 **healthcare will influence its uptake. It is important to note, however, that disruptions to**
24 **normal routines are likely to be viewed differently by different occupations, and any**
25 **evaluation needs to consider the *perceived* impact of new interventions on the clinical**
26 **practices of professionals. The GPs in our study (see Sanders et al. 2011) viewed the**
27 **intervention very differently to the physiotherapists.**
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3 There were broader implications for physiotherapists, however, and in order to fully
4 understand implementation we also need to examine the professional context in which it is
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There were broader implications for physiotherapists, however, and in order to fully understand implementation we also need to examine the professional context in which it is operationalised.

Broader implications for physiotherapy

Our findings are significant for understanding the ongoing development and *reprofessionalisation* of occupations in the NHS, a subject that has received limited research coverage (Lupton, 1997). In order to **appreciate** the drivers and obstacles to implementation, it is important to examine the role of specific professions. In contrast to nurses working in primary care (Salhani and Coulter, 2009), physiotherapists exercise considerable discretion over the content and scope of their work (Svensson, 1996; Allen, 1997). The new stratified care system in turn appeared to enhance existing clinical work in the following ways. It encouraged critical reflection on the appropriateness of established physiotherapy concepts, and on the notion of ‘what it meant to be a physiotherapist’ in view of the challenge of managing complex physical and psychosocial problems (McKinlay, 1977). It was within this context that physiotherapists perceived the new system as an opportunity to extend their skills.

In summary, the new system was perceived as offering an opportunity to extend their knowledge and skills with physiotherapists’ responses to change symbolising a type of ‘thoughtful obedience’ rather than resistance; careful consideration of the new approach leading to its subsequent adoption (Mintzberg, 1973). Nevertheless, all of these factors seemed to indicate a ‘strategic’ preoccupation with enhancing skills rather than perceiving change as a threat to physiotherapy work.

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References

Allen, D, (1997). The nursing-medical boundary: a negotiated order? *Sociology of Health and Illness*, Vol. 19 No. 4, pp. 498-520.

Allen, D, (2009). From boundary concept to boundary object: the practice and politics of care pathway development, *Social Science and Medicine*, Vol. 69, pp. 354-61.

Armstrong, D. and Ogden, J. (2006), The role of etiquette and experimentation in explaining how doctors change behaviour: a qualitative study, *Sociology of Health and Illness*, Vol. 28 No. 7, pp. 951-68.

Baus A. (2004), Literature review: barriers to the successful implementation of healthcare information systems. West Virginia University Department of Community Medicine. Office of Health Services Research.

Berg, M., Horstman, K., Plass, S. and van Heusden, M. (2002), Guidelines, professionals and the production of objectivity: standardisation and the professionalism of insurance medicine, *Sociology of Health and Illness*, Vol. 22 No.6, pp. 765-791.

1
2
3
4
5 Berg, M. (1999), Patient care information systems and health care work: a sociotechnical
6 approach. *International Journal of Medical Informatics*, Vol. 55 No. 2, pp. 87-101.
7
8

9
10
11 Blakeman, T., Macdonald, W., Bower, P. and Gatley C. (2006), A qualitative study of GP's
12 attitudes to self-management of chronic disease, *British Journal of General Practice*, Vol. 56
13 No. 527, pp. 407-414.
14
15
16

17
18
19
20 Breen, A., Carr, E., Mann., E. and Crossen-White., H. (2004), Acute back pain management
21 in primary care: a qualitative pilot study of the feasibility of a nurse-led service in general
22 practice, *Journal of Nursing Management*, Vol. 12, pp. 201–209.
23
24
25
26

27
28
29 Butler J. (1997), *Excitable Speech: A Politics of the Performative*. Routledge, London and
30 NewYork.
31
32

33
34
35
36 Checkland, K., Harrison S., McDonald R., Grant S., Campbell. and Guthrie, B. (2008),
37 Biomedicine, holism and general medical practice: responses to the 2004 General Practitioner
38 contract, *Sociology of Health and Illness*, Vol. 30 No.5, pp. 788-803.
39
40
41
42

43
44
45 Checkland, K., Harrison, S. and Marshall., M. (2007), Is the metaphor of 'barriers to change'
46 useful in understanding implementation? Evidence from general medical practice, *Journal of*
47 *Health Services Research and Policy*, Vol. 12 No.2, pp. 95-100.
48
49
50
51

1
2
3 Davies, C., Anand, P., Artigas, L., Holloway, J., McConway, K., Newman, J., Storey, J. and
4
5 Thompson. G. (2004), Links between Governance Incentives and Outcomes: A Review of the
6
7 Literature: Report for the NCCSDO.
8
9

10
11 Doolan, DF., Bates, DW., and James, BC. (2003), The use of computers for clinical care: a
12
13 case series of advanced U.S. sites. *Journal of the American Medical Association*, Vol. 10, pp.
14
15 94-107.
16
17

18
19
20
21 Evetts J. (2003), The sociological analysis of professionalism: occupational change in the
22
23 modern world. *International Sociology*, Vol. 18 No. 2, pp. 395-415.
24
25

26
27
28 Ferlie, E., Fitzgerald, L. and Wood, M. (2000), Getting evidence into clinical practice: an
29
30 organisational behaviour perspective, *Journal of Health Services Research and Policy*, Vol. 5
31
32 No. 2, pp. 96-102.
33
34

35
36
37 Giddens, A. (1984), *The Constitution of Society: Outline of the Theory of Structuration*.
38
39 Polity, Cambridge.
40
41

42
43 Good Medical Practice. (2006), Regulating Doctors, Ensuring Good Medical Practice.
44
45 General Medical Council.
46
47

48
49
50 Green, J., Durand, MA., Hutchings, A. and Black, N. (2011), Modernisation as a
51
52 professionalising strategy: the case of critical care in England, *Sociology of Health and*
53
54 *Illness*, Vol. 33 No. 6, pp. 819-36.
55
56

1
2
3 Grol, R. and Grimshaw, J. (2003), From best evidence to best practice: effective
4 implementation of change in patients' care. *Lancet*, Vol. 362, pp.1225-1230.
5
6
7

8
9
10 Harrison, S. and Dowswell, G. (2002), Autonomy and bureaucratic accountability in primary
11 care: what English General Practitioners say, *Sociology of Health and Illness*, Vol. 24 No. 2,
12 pp. 208-226.
13
14
15

16
17
18 Harrison, S. and Checkland, K. (2009), Evidence-based Practice in UK Health Policy, Gabe
19 J. and Calnan M.W, *The New Sociology of the Health Service*, Routledge, London, pp. 121–
20 42.
21
22
23

24
25
26
27 Haug, M. (1973), Deprofessionalization: an alternative hypothesis for the future, *The*
28 *Sociological Review Monograph*, Vol. 20, pp. 95-211.
29
30
31

32
33
34 Haug, M. (1976), The Erosion of Professional Authority: A Cross-Cultural Inquiry in the
35 Case of the Physician. *The Milbank Memorial Fund Quarterly. Health and Society*, Vol. 54
36 No. 1, pp. 83-106.
37
38
39

40
41
42 Hill, JC., Whitehurst, DG., Lewis, M., Bryan, S., Dunn, KM., Foster, NE., Konstantinou, K.,
43 Main, CJ., Mason, E., Somerville, S., Sowden, G., Vohora, K. and Hay, EM.. 2011.
44
45 Comparison of stratified primary care management for low back pain with current best
46 practice (STarT Back): a randomised controlled trial, *Lancet*, Vol. 378 No. 9802, pp. 1560-
47 1571.
48
49
50
51
52

53
54
55
56 Iles V. (2005), *Really Managing Healthcare*. Open University Press, Maidenhead.
57
58

1
2
3
4
5 Kennedy, A., Rogers, A. and Bower, P. (2007), Support for self care for patients with chronic
6 disease, *British Medical Journal*, Vol. 335 No. 7627, pp. 968-70.
7
8

9
10
11 Lave, J. and Wenger, E. (1991), *Situated Learning: Legitimate Peripheral Participation*.
12 Cambridge University Press, Cambridge.
13
14

15
16
17
18 Lupton, D. (1997), Doctors on the medical profession, *Sociology of Health and Illness*, Vol.
19 19, pp. 480-97.
20
21

22
23
24
25 May, C., Mort, M., Williams, T., Mair, FS., Gask, L. (2003), Health Technology Assessment
26 in its local contexts: studies of telehealthcare. *Social Science and Medicine*, Vol. No. 57, pp.
27 697-710.
28
29
30

31
32
33
34 May, C., Gayle, A., Chapple, A., Chew-Graham, C., Dixon, C., Gask, L., Graham, R.,
35 Rogers., A. and Roland, M. (2004), Framing the doctor-patient relationship in chronic illness:
36 a comparative study of general practitioners' accounts, *Sociology of Health and Illness*, Vol.
37 26 No. 2, pp. 135-58.
38
39
40
41

42
43
44
45 May, C., Finch, T., Mair, F., Ballini, L., Dowrick, C., Eccles, M., Gask, L., MacFarlane, A.,
46 Murray, E., Rapley, T., Rogers, A., Treweek, S., Wallace, P., Anderson, G., Burns, J. and
47 Heaven, B. (2007), Understanding the implementation of complex interventions in health
48 care: the normalization process model, *BMC Health Services Research*, Vol. 7 No. 148.
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3 May, C and Finch, T. (2009a), Implementing, embedding, and integrating practices: an
4 outline of Normalization Process Theory, *Sociology*, Vol. 43 No. 3, pp. 535-54.
5
6
7

8
9
10 May, C., Mair, FS., Finch, T., MacFarlane, A., Dowrick, C., Treweek, S., et al. (2009b),
11 Development of a theory of implementation and integration: Normalization Process Theory,
12 *Implementation Science*, Vol. 4 No. 29.
13
14
15
16

17
18 McDonald, R., Cheraghi-Sohi, S., Sanders, C. and Ashcroft, D. (2010), Professional status in
19 a changing world: the case of medicines use reviews in English community pharmacy, *Social*
20 *Science and Medicine*, Vol. 71, pp. 451-8.
21
22
23
24
25

26
27 McDonald, R., Harrison, S., Checkland, K., Campbell, S. and Roland, M. (2007). Impact of
28 financial incentives on clinical autonomy and internal motivation in primary care: an
29 ethnographic study, *British Medical Journal*, Vol. 334, pp. 1357-9.
30
31
32
33
34
35

36 McKinlay, J. (1977). The business of good doctoring or doctoring as good business:
37 reflections on Friedson's view of the medical game, *International Journal of Health Services*,
38 Vol. 7, pp. 459-83.
39
40
41
42
43
44

45 Mintzberg, H. (1973), *The Nature of Managerial Work*, Harper and Row, New York.
46
47
48

49 Nancarrow, S. and Borthwick, A. (2005), Dynamic professional boundaries in the healthcare
50 workforce, *Sociology of Health and Illness*, Vol. 27 No. 7, pp. 897-919.
51
52
53
54
55
56
57
58
59
60

1
2
3 Nordgren, L. (2010), Mostly empty words: what the discourse of “choice” in health care
4 does, *Journal of Health Organisation and Management*, Vol. 24 No. 2, pp. 109-26.
5
6
7

8
9
10 Parmelli, E, Flodgren, G, Beyer, F, Baillie, N, Schaafsma, M. and Eccles, M.P. (2011). The
11 effectiveness of strategies to change organisational culture to improve healthcare
12 performance: a systematic review, *Implementation Science*, Vol. 6 No. 33.
13
14
15

16
17
18 Roland, M. (2004), Linking physician pay to quality of care: a major experiment in the UK.
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
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42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

New England Journal of Medicine, Vol. 351, pp. 1438-54.

Salhani, D, and Coulter, I. (2009), The politics of interprofessional working and the struggle
for professional autonomy in nursing, *Social Science and Medicine*, Vol. 68, pp. 1221-8.

Sanders, T and Harrison, S. (2008), Professional legitimacy claims in the multidisciplinary
workplace: the case of heart failure care, *Sociology of Health and Illness*, Vol. 30 No. 2, pp.
289-308.

Sanders, T, Foster, NE. and Ong BN. (2011), Perceptions of general practitioners towards the
use of a new system for treating back pain: a qualitative interview study, *BMC Medicine*, Vol.
9, No 49.

Sowden, G., Hill, JC., Konstantinou, K., Khanna, M., Main, CJ., Salmon, P., Somerville, S.,
Wathall, S., Foster, NE., IMPaCT Back study team. (2012). Targeted treatment in primary
care for low back pain: the treatment system and clinical training programmes used in the
IMPaCT Back study (ISRCTN 55174281). *Family Practice*, Vol. 29 No. 1, pp. 50-62.

1
2
3
4
5 Strauss, S. and Corbin, J. (1990), *Basics of Qualitative Research: Grounded Theory,*
6
7 *Procedures and Techniques.* Sage, Newbury Park.
8
9

10
11 Svensson, R. (1996), The interplay between doctors and nurses-a negotiated order
12 perspective, *Sociology of Health and Illness*, Vol. 18 No. 3, pp. 379-98.
13
14
15
16

17
18 Tennant, M. (1997), *Psychology and Adult Learning*, London: Routledge.
19
20

21
22 Tomorrow's Doctors. (2003), General Medical Council, London.
23
24
25
26

27 Weick K. (1995), *Sensemaking in Organisations.* Sage, London.
28
29
30

31
32 Wood, M., Ferlie, E. and Fitzgerald, L. (1999), Achieving clinical behaviour change: a case
33 of becoming indeterminate, *Social Science and Medicine*, Vol. 47 No. 11, pp. 1729-38.
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
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