ERODING 'RESPECTABILITY':
DEPROFESSIONALIZATION THROUGH ORGANIZATIONAL SPACES

Sabina Siebert, Stacey Bushfield, Graeme Martin, Brian Howieson

Abstract

This article addresses the question – can a deterioration in organizational spaces erode a profession's status? It draws on organizational spaces literature to analyse the relationship between design of the physical work setting and senior doctors' experiences of deprofessionalization. Analysis of qualitative data from a study of senior hospital doctors identifies two main themes that link the experience of spaces with perceptions of the erosion of professional status and reduced knowledge sharing. These two themes are: emplacement, which is the application of coercive power both in and through spatial arrangements, and isolation, which refers to physical alienation in the workplace leading to disconnection and a perceived loss of power. Observing the changes in the physical environment over time and mapping them against these processes of deprofessionalization offers interesting new insights into the sociology of professions.

Keywords: deprofessionalization, doctors, healthcare management, organizational spaces, professions

Introduction

Nearly 30 years ago Keith MacDonald wrote a seminal article entitled 'Building Respectability' that highlighted the link between the processes of creating professional status and the acquisition, erection, and choice for interior design of buildings that housed professional bodies. Drawing on Larson's (1977) concept of the 'professional project' (p. 66) and the collective drive among professionals to enhance their social and economic position, MacDonald (1989) showed how spaces and symbols signal success, and are central to creating and maintaining collective professional status and individuals' respectability. This work provides the point of departure for this study, which reverses MacDonald's original question by asking whether a deterioration in organizational spaces can erode a professions' status. This article also extends MacDonald's thesis on the link between spaces and professional respectability by asking if a deterioration in organizational spaces can influence a profession's ability to produce and share knowledge. The answers to both questions have serious implications, not only for professional practice but also for the stakeholders professionals serve.

This article seeks such answers in the context of a study of senior hospital doctors. Healthcare systems across the world face serious challenges that potentially affect the the status of the medical profession and doctors' feelings of self worth. These challenges include: health insurance reforms in the US; serious financial constraints across all areas of the NHS in the UK; changes to junior doctors' contracts in England; and integrative health policies in Denmark, Norway, Sweden and Scotland. In many healthcare systems these challenges mean that managers have to make difficult decisions that impact on doctors' perceptions of their status, self-esteem and experience of work (Kirkpatrick et

al., 2015). This article focuses on an under-researched consequence of these reforms: changes to the physical organization of doctors' workspaces in the National Health Service (NHS) in the UK. Such changes arise from a constant re-organization of existing spaces and programmes of 'new build' hospitals to replace outdated stock. Re-organization and programmes of new builds present managers and hospital designers with serious challenges in a financially-constrained, and a space-constrained environment. These challenges include meeting increased public and staff expectations (e.g. access by car and public transport), resistance to centralisation, rising demand for hospital care for the elderly, and accommodation of new technology-based medicine and care. In the course of a much larger project on doctors' changing experience of work in the NHS, the project aimed to understand the consequences of the above challenges and the redesign of spaces for doctors' perceptions of their professional status and their ability to produce and exchange knowledge. Thus, this article seeks to address the question: can a deterioration in organizational spaces erode a profession's status?

In considering this question, this article offers new theoretical insights linking organizational spaces to deprofessionalization by drawing on the concepts of emplacement (Dale and Burrell, 2008) and isolation (Blauner, 1964). It extends the deprofessionalization of doctors thesis (Filc, 2006; Numerato et al., 2012), which proposes that doctors are subjects of an often deliberate strategy by managers and the state to deprive them of their professional autonomy so that a reform agenda is more easily implemented. This article draws on an analysis of interviews with 68 consultants, the most senior grade of specialist doctors working in hospitals in Scotland.

The article's contribution to the literature is two-fold. Firstly, it shows how workspace is designed. This includes the availability of social spaces, the allocation of offices and facilities, and the physical separation associated with specific workspace designs, all of which have major implications for doctors' experiences of deprofessionalization and, ultimately, for improving patient care. Two main themes are identified that link the experience of spaces with the perception of erosion of professional status and knowledge exchange. These are: emplacement, which is the application of coercive power both in and through spatial arrangements; and isolation, which relates to physical alienation in the workplace that leads to a sense of powerlessness. Secondly, it argues that observing changes in the physical environment over time, namely the processes of emplacement and isolation, and mapping these against the processes of deprofessionalization, may offer interesting new insights into the sociology of professions. The article begins with a brief discussion of literature on deprofessionalization and on how organizational spaces affect experiences of work. Following an outline of the methodology, we present the findings and discuss their implications for medical professionals and for professionals in general.

The deprofessionalization of doctors

Over the past thirty years, literature on the sociology of professions has offered various perspectives on the process of deprofessionalization of doctors in advanced economies (Currie et al., 2012; Filc, 2006; McDonald et al., 2009; McGivern et al., 2015; Ritzer and Walcak, 1988; Waring and Currie, 2009). This literature refers to two politically-driven trends to reform healthcare systems, both of which implicate doctors as irritants rather than lubricants in the change agenda. The first trend is managerial reforms aimed at creating efficiencies and controlling financial investments and costs in an increasingly

complicated context. These changes are motivated by ever-increasing demands due to ageing populations, epidemiological changes, more knowledgeable patients and their relatives, and well-publicized health system 'failures' typically attributed to poor medical practice and hospital leadership (Francis, 2013). The second trend is a political desire to make healthcare organizations and doctors in this sector more accountable to tax payers. Both trends are credited with developing an ideology of public sector managerialism: a set of ideas and a political discourse emphasizing rationalism and standardization through accountability, transparency and constant evaluation against targets (Ham, 2014).

Consequently, proponents of this structurally-oriented deprofessionalization thesis contend that hospital-based doctors in the NHS are losing aspects of their sociocultural professional identity and their autonomy over how work is organized and carried out (Ham, 2014; Numerato et al, 2012). They further argue that doctors' status in society, and power and influence over other healthcare occupations and patients, is diminishing because of these environmental changes and managerial reforms (Filc, 2006). This loss of status, power and influence is made all the more challenging due to patients' increased expectations of doctors and the populist politics fueling these beliefs. Doctors feel unable to meet these expectations due to resource constraints and the inability to control entry into the profession (McDonald et al., 2009; Timmerman and Oh, 2010). Finally, researchers in this tradition believe that managerialist and bureaucratic discourse in the medical profession has become so pervasive that it shapes not only formal systems of control and clinical practice, but also doctors' interpretations of their 'sense of place' in the healthcare hierarchy and what constitutes effective and reasonable clinical practice (e.g. Gordon et al., 2015).

Rejecting these somewhat deterministic explanations, Waring and Bishop (2013) offered a more agentive account of the potential for medical deprofessionalization in a study of doctors working for private sector providers in the English NHS. They argued for a 'mutual constitution' of structural and agentive accounts of doctors' work experience, showing how recursive social practices helped recreate the social structures connecting doctors 'in time and place'. Furthermore, they found that variations in the experience of work reflected variations in doctors' 'structured positions within the organizational setting', and their access to, and use of, strategic resources to 'co-create new ways of working' (p. 149). This co-creation was most evident among doctors in medical management and clinical leadership positions, who claimed to pursue a *commercial re-stratification* strategy, which was evident in their actions and commitment rhetoric. Equally important is the finding that disenfranchized doctors, without access to commercially valued resources, are more likely to experience extreme forms of *McDonaldization* or *McMedicalisation* (Ritzer, 1996), so confirming the rhetoric of deprofessionalization (Goodrick and Reay, 2010).

These deprofessionalization and re-stratification theses have neglected an important factor influencing doctors' status, which is their subjective and emotional sense of space. Professional status refers to: 'a socially constructed, intersubjectively agreed-upon and accepted ordering or ranking' of social actors (Washington and Zajac, 2005: 284), 'based on the esteem or deference that each actor can claim by virtue of the actor's membership in a group or groups with distinctive practices, values, traits, capacities or inherent worth' (Deephouse and Suchman, 2008: 59).

Studies of space and place are becoming increasingly influential in management literature on related topics such as identity and leadership (Ropo et al., 2015). However, our main contribution is to the deprofessionalization debate by examining how a sense of space affects self-perceptions of status and constraints on knowledge production. As noted earlier, MacDonald (1989) claimed that organizational space could enhance professional status. This article argues the converse - that the design of organizational spaces and how they are perceived by doctors can have an important influence on eroding doctors' sense of professional status. Moreover, it also extends this argument to doctors' ability to produce and share essential knowledge. To further develop our case, the literature on organizational spaces is now briefly introduced.

Organizational spaces

For over 30 years, organizational sociology has been subject to calls for a 'spatial turn' (Marrewijk and Yanow, 2010). Scholars within and beyond the discipline have argued that the inherent 'spatiality of social life' (Soja, 1985: 90) means that space should be a key consideration in the analysis of work organizations (e.g. Baldry, 1999; Czarniawska, 2004; Dale, 2005; Hatch, 2013; Kornberger and Clegg, 2004). Research in this area is underpinned by two key theoretical traditions: symbolic interpretivism and socio-materiality, which collectively emphasize the link between physical structures, social structures, and symbolic power relations (Hatch, 2013). The physical space of work not only shapes social behaviour, but is also developed and shaped by the social processes and practices of organizational actors (Alvesson and Wilmott, 2003; Lefebvre, 1991). Moreover, the symbols associated with a physical space can act as cues that reveal the underlying power relations and social status of individuals within the workspace (Baldry, 1999; Hatch, 2013).

Interest in the relationships between space and social relations has spawned literature on spatiality, a term which denotes the spatial organization of society (Soja, 1989; Hatch, 2013; Guthey, et al., 2014). The spatiality of an organization includes a number of elements of physical structure: geographical location, style of architecture, layout and spatial arrangement of physical objects, and interior design that offers important clues to the organization's culture. Scholars such as Bourdieu (1981) and Soja (1989) have argued that buildings are more than bricks and mortar, and the spaces within them are not merely a backdrop to behaviour, but a cultural space filled with politics based on embedded histories, hierarchies and the interests of the powerful. Similar perceptions are reflected in the work of Dale and Burrell (2008) and Smith and Bugni (2006) who argued that architecture is not independent art but a cultural practice that contains and communicates shared symbols of power.

Baldry (1999) argues that spaces are representative of the existing power structures in the organization and, at different levels, managers deliberately structure space as a form of control within organizations. He suggests that workspace spatiality can be structured at three levels: (1) the fixed environment (e.g. location, building office space allocation); (2) the semi-fixed environment (e.g. desks, chairs, decor); and (3) the atmospheric environment (noise level, heating, lighting, special comfort, privacy). Each of these aspects represents a series of social decisions and over time become the cultural cues that represent the way things are done within the organization. For instance, geographical location influences the social and political profile of an organization, as well as the demographics of employees and customers (Hatch, 2013). The building design and the arrangement of physical objects affect communication among people occupying these

spaces, and the nature of their activities (Smith and Bugni, 2006). The choice of interior design offers important insights to the organization's culture and promotes a particular image to outsiders (MacDonald, 1989). In addition to this, organizational symbols such as dress, uniforms, logos and other physical artefacts have the power to prompt emotional responses and mediate how individuals interact and behave (Rafaeli and Vilnai-Yavetz, 2004).

The physical workspace is a product of an organization's history, culture, politics and systems of power (DiMaggio and Powell, 1991; Kraatz and Block, 2008). Therefore, the literature on both institutional work and organizational spaces reminds us that the experience of every employee in, for example, an office, factory, shop, or hospital is influenced by the qualities and organization of the physical workspace (Baldry, 1999). Yet, workspaces have the potential to become 'contested terrain' as workers will often resist order imposed by managers (Baldry, 1999: 536). Several management scholars have explored the micro-processes of organizational sociology and spatiality. For example, using the concept of the generative building, Kornberger and Clegg (2004) demonstrated how power based on control can be transformed into a more positive power that accounts for ambiguity and contradictions through the facilitation of more random encounters between people across the organization. Similarly, Fayard and Weeks's (2007) qualitative study of photocopier interactions in three organizations drew on the notion of social affordance to ascertain the social and physical characteristics that produced the privacy, proximity and designation of space necessary to encourage informal interactions.

In summary, different theoretical traditions have different ways of looking at space but what all of these perspectives have in common is that physical structure have a potential to guide people's actions. In other words, the embodied knowledge based on spatial relations shapes individual, group and organizational identities, how they interact and produce knowledge (Brown and Duguid, 2000, Ropo et al., 2015).

Methodology

Data collection. Data were collected through in-depth interviews with 68 consultants working for NHS Scotland. Interviews were semi-structured, typically taking 1–1.5 hours; they were audio-recorded and subsequently transcribed. The sampling approach was not governed by a need for representativeness in a statistical sense nor for generalization to the population of consultants in Scotland — rather the core focus was around understanding how consultants interpreted and accounted for their experiences. Hence, in-depth interviews were conducted with consultants in all 14 regional boards in Scotland (large urban, remote/small/located on Scottish islands, and medium sized), from most specialties (paediatrics and child health, anaesthesia, surgery, psychiatry, and general internal medicine) and with different lengths of experience (from one to over 20 years since becoming a consultant).

The number of interviews conducted was also guided by theoretical saturation, which applies when there are rapidly diminishing marginal returns from conducting additional interviews. More than half of interviewees were from an initial volunteer pool and from contacts provided by the British Medical Association. This then led to a form of snowball sampling produced by contacts enlisting colleagues to be interviewed. Finally, to overcome sampling bias (as much as possible), interviewees who were neither initial

volunteers nor volunteers secured through existing contacts were recruited to assess whether their views were different from those consultants motivated to volunteer.

The interviews included questions about tensions between medical consultants, other clinical professions and managers; and how consultants would like issues concerning any negative experiences of work to be resolved, especially in relation to delivering clinical outcomes. The senior doctors were also asked how the experience of work and employment in the NHS had affected them, their clinical freedom, control over workload and ability to do their job well.

Data analysis. The interview questions were informed by our initial review and knowledge of the literature on deprofessionalization of doctors. Therefore, initial coding focused on how consultants accounted for the changes in their experience of work over the course of their careers, their views on deprofessionalization, trust dynamics, voice and engagement, and the relations between them. Additional codes relating to the theme of organisational spaces began to emerge from the very first interviews. Over the previous 20 years, NHS Scotland has undertaken a series of initiatives across Scotland to modernize and replace older facilities no longer considered to be fit for purpose. This gave health service managers and planners the opportunity to make significant changes to the spatial layout of existing hospitals, meet the need for increased bed space and achieve greater integration between clinicians. In many cases, the estates policy led to the building of new hospitals. Initially, these new builds were backed by the Private Finance Iniative (PFI) and more recently through public funding and the non-profit-distributing (NPD) method. During the reported study which ran between 2014-2015 three new hospitals were being built while others were being redeveloped. According to some

consultants, both the modernization agenda and the new hospital building policy (with tightly constrained funding schemes) resulted in doctors being much less involved than previously in the design of spaces. This lack of involvement in the design of spaces had important consequences for the lived experience of doctors.

The doctors' comments on spaces were coded separately and the analysis of the interviews took the form of meaning condensation into themes. Interview transcripts were coded to identify references to the geographical setting, the physical location and the internal spaces of hospitals. These included references to, for example, offices, canteens, social spaces, designs of wards, operating theatres, physical moves to new locations, and the design of new hospitals. The analysis process involved looking for evidence of the micro-dynamics of socio-spatial relations. In line with grounded theory research (Glaser and Strauss, 1967), recurring categories were identified through reading and re-reading of the material. These categories formed the first-level codes. Coded data were then constantly compared with a view to identifying emerging patterns (Strauss and Corbin, 1998).

Emergent codes were grouped into three themes: (1) Lost social spaces, (2) Design of working environment: sharing offices and deterioration of facilities and (3) Physical distance, material and symbolic disconnects. Out of these themes two theoretical concepts emerged: isolation and a sense of emplacement. Analysis of doctors' responses revealed how the two phenomena are linked with their subjective sense of deprofessionalization. The data structure in Figure 1 illustrates the emergence of theoretical categories from the empirical data.

Findings

Lost social spaces. A key theme to emerge was a loss of ownership of social spaces dedicated exclusively for clinicians. One such space that appeared to have particular significance was the doctors' mess, a term analogous to the social space reserved for officers in the British military, in which officers enjoy separate eating and social space from the 'rank and file'. Many consultants saw the removal of the mess as a deliberate or misguided act of social engineering to break down barriers between doctors and other clinical professions. Such social engineering, they claimed, led to feelings of isolation from fellow doctors and identity loss, and prevented essential opportunities for knowledge exchange and communal learning. In the excerpt below, reflecting on a conversation with a medical director involved in the design of a new hospital, one consultant highlighted that, in his view, a key space for social support and advice had been lost:

> I said well where's the junior doctors' messes, where's their restroom, have they a restroom or a rest area and he said no they hadn't (…). When I was a junior doctor all hospitals had these (…) which were incredibly supportive because it's a place that you can go and you can actually get food which is important but probably what's more important was that you got colleagues that you could bounce things off and get support from (Physician).

Changes in the way services were structured left the consultants feeling that they are often "working in isolation" and the loss of a social space, where they could discuss challenging cases with colleagues, compounded these feelings of alienation. In the redesign of hospitals, architects and managers intended to create communal space through shared canteens. However, these were seen as poor substitutes for a doctors'

mess or staff common room because of simple things such as opening times that did not fit in with doctors' working hours, the expense involved, and the lack of privacy doctors needed for essential conversations:

> That was one thing they didn't build. There was no staff room. The only coffee shop is Costa. Costa is too expensive. You're out in the middle and its open plan, there's not even rooms, so you can't really discuss patients there. (…) There is no social space really (Surgeon).

> The fact that there are no areas where clinical staff can eat, or have coffee, without knowing you're being overheard by patients. (Physician).

There was a perception that the removal of communal spaces for doctors and other clinicians appears to have decreased their morale and their sense of being part of a community of practice. The lack of private spaces, away from patients and relatives, was identified as one cause of poor teamwork and cross-specialist knowledge exchange because consultants had lost an opportunity to discuss patient cases in informal settings:

> When I think back to when I was a junior doctor, how much business was done in the doctors' dining room at lunchtime with people just saying: 'Can I talk to you about so and so?' or, 'What do you think? What would you do about this', … lots of learning went on over the table, lots of advice freely given and shared but also we've lost the actual caring for the juniors in particular. (…)Now, at night, if the canteen is shut, you're basically on your own (Physician).

The consultants interviewed also felt that they had 'lost the value of having that downtime' together and they did not, as suggested by managers, see technology as a replacement to the type of knowledge shared in a social space:

> The decision's been made to build a new hospital (…) I said well this is all very interesting, [but] where's the junior doctors' office? Erm, we're not having one. I said well why are we not having one? Because we've got iPads [laughs]. I said sorry? Well we've got iPads right OK (Paediatrician).

Thus, regaining a shared social space, such as a doctors' mess or a coffee room, was one of the principal items on the 'wish list' of many interviewees for improving their sense of psychological ownership of space and their ability to share knowledge. A consultant psychiatrist expressed the links between knowledge exchange and doctors' morale:

> Especially when you are a young doctor in training, most days you're confronted with something that makes you feel you're working at your limits or even out of your depth and having, kind of support, somebody else to sound things off or just to ask informally (…) that's really helpful when it comes to getting advice (Psychiatrist).

Across the interviews there was a recurring view that morale was enhanced by having a place where doctors with varying experience levels and from different specialisms could informally exchange knowledge. The quote below from a consultant physician illustrates the view that cross-professional private social spaces could improve patient care:

> There are really simple things, which would improve morale (…) things like a senior staff coffee room… so you could actually have conversation, without it being in the canteen, without knowing which patient is at the next table, listening to you. I think that would facilitate patient care, actually (Physician).

Several consultants went so far as to suggest that the removal of the doctors' mess and staff common areas was indicative of a wider bid by management to 'strip out the human values' of the health service (Sauer, 2015). Such feelings are reflected in the literature on the wider eroding of medical professionalism (Ham, 2014; Numerato et al., 2012). It was found that managers increasing control over time, space and resources had left doctors with little discretion in how they treat individual patients.

Design of working environment: sharing offices and deterioration of facilities. In many work situations, architects and managers have redesigned office spaces to co-locate

professionals, improve communications between them and reduce the costs of putting up what are sometimes seen as necessary boundaries (Baldry and Barnes, 2012). The negative material and symbolic consequences of such social engineering were expressed forcefully by interviewees. Two material consequences were the logistics of separating doctors from administrative staff and the lack of basic amenities, such as having a computer and telephone located where doctors needed them most. Interviewees also referred to the practical challenges arising from not having a private space to reflect and consider difficult cases. For instance, one interviewee expressed his concern over the need for privacy generated by the stressful nature of surgical work and his perceptions of the problems of sharing offices:

> In this new built hospital we won't have offices, there's going to be four of us sharing a room. (...) we do some pretty complex surgery, deal with some pretty horrible situations every day and sometimes you just need a little sanctuary just to have ten minutes time out (Surgeon).

However, most dissatisfaction was reserved for the symbolic consequences of sharing offices, which were often interpreted as part of a wider agenda to erode consultants' privileged elite status:

> I am no longer an important person, someone whose views are listened to. I am a hospital technician, whose daily life is dictated by someone with no medical training whatsoever. I now share 'my' office with two others, and 'my' secretary with three others (Physician).

> You need to have space, so you are employing a very expensive asset, I should be anyway, to the hospital and yet you don't give me the tools that I need to do my job effectively, you know it doesn't make you feel valued (Radiologist).

The quotes above emphasize that the design and coordination of the fixed work environment was seen as a form of control within the organization and that the allocation

of space was a representation of power. There was a perception that management had deliberately allocated consultants with shared office spaces as a means of reducing their status, effectively using their power over space to put them in their place (Baldry, 1999; Dale and Burrell, 2008). The feelings of being: 'dictated to', 'no longer important', 'disenfranchized', and 'undervalued' were indicative of the symbolic messages that the doctors associated with the move. Status is a relative concept and this loss of status was sometimes expressed in relation to other clinical professions and managers:

> Some of the management offices, some of the Nursing Managers – they've got one – an office to themselves, a nice big desk, and stuff. And I've got, you know, three colleagues sharing the same office. And again, it just comes down, a wee bit, to this, this erosion of clinical respect (Surgeon).

The move to new, often larger hub hospitals led to tensions for the consultants. Discussing a major new teaching hospital in Scotland prior to its opening, one consultant produced a long list of his concerns:

> It's built in completely the wrong place (…) there's no parking actually, there's going to be about ten thousand people in there and probably about a thousand parking spaces. (…) You have to have safe access for your staff walking in a rather nasty part of the city. The building itself, well my understanding is two of the lift shafts are actually not big enough to take a hospital bed which would imply a complete failure of the planning process. (…) The top two floors the floors are uneven. (…) The size of the hospital is wrong. (…) it will be the death of the NHS in [the city] (Physician).

Moving was often associated with a deterioration of space. The quote begins by emphasizing the challenges around location facilities such as transport and parking. The suggestion that it is located in a nasty part of the city also provides a parallel to MacDonald's work where the professions sought prestigious locations to enhance their status. The second part refers to alleged problems in design which the physician felt would hinder effective working. Within the clinical working environment, consultants

often failed to understand the logics used by managers and politicians, which differed markedly from their medical–professional rationales for hospital building and design decisions. In a near stream of consciousness, which exhibited a significant sense of frustration, one radiologist expressed the feelings of many of his colleagues:

> It's madness, utter madness! It is not necessary, it's crazy. (…) We're not building the best hospital that we can that's future proofed (…), we are building the best hospital we can for two hundred million pounds because that is all the money we've got, it's clearly not quite enough. There will never be enough beds (…)The whole thing defies belief (Radiologist).

The interior design of new buildings, in particular the allocation of space to different activities and the perceived flow between spaces was a key issue of contention for consultants. A surgeon in one hospital, where a new build was about to begin, complained that, at the time of the interview, the views of their surgeon colleagues on theatre design had not been taken on board by managers, despite them pointing out the likelihood of long term problems for infection control:

> It's been decided that in theatres there won't be a thing called a dirty corridor. So at the moment what we have [is] sterile instruments come in one door, go into the operating theatre, patient comes back out, and dirty instruments, swabs, the whole thing go into a sluice room and then a dirty corridor and go out a separate door so there's no contact between dirty and clean. There's been a trend to build a couple of hospitals … that don't have this dirty corridor ….They [managers] say you don't need it, you just need a utility room so we've got things bypassing in the same corridor.   (…) I would anticipate that, in five/ten years' time or less, wound infections, infective complications might increase (Surgeon).

The quote above reiterates the belief that the move to a new building will involve working in spaces with reduced functionality, which, as Dale and Burrell (2008) suggest, will change the accepted ways of doing things, in this case clinical behaviour. Ultimately, clinicians will work within the material constraints and opportunities provided by the

space (Lefebvre, 1991) to minimize any impact on patient care, but there was a real sense of frustration amongst consultants that managers and architects were making these types of clinical design decisions.

Physical distance, material and symbolic disconnects. Finally, physical separation from key actors was seen as an important factor in creating and sustaining material and symbolic 'disconnects' between doctors and managers (Martin et al, 2015). This manifested itself in a number of ways, one of which was physical separation from support staff, which hindered work efficiency:

> When I started, I had two Secretaries, and two offices, because we worked in two sites (…) and I shared an office with one other. My Secretary and my office were adjacent to each other, in both places. But now I still do work in two sites and, I have an office on the twelfth floor. My Secretary is on the fourth floor. I don't have a phone that works in my office (…). And so I spend a lot of my time, 'admining', standing beside my Secretary's desk. And it just does not help how efficiently you can work – and it gets frustrating (Physician).

The statement above further emphasizes the view that facilities were often inadequate with only limited consideration being given to ensuring that basic amenities are available and in working order. This left consultants feeling undervalued and contributed to their sense of deprofessionalism. Distancing doctors from support services was thought to create barriers to effective working and communication. Moreover, it was seen as a further move by managers to reduce their status amongst wider colleagues. Thus, social relations were seen to be affected by the reorganization of physical objects and people (Soja, 1989; Guthey et al., 2014).

Being co-located with managers was seen as an important feature of good relational coordination (Gittell, 2002) between consultants and medical and non-clinical managers. However, many of the consultants interviewed sensed that managers often deliberately maintained physical distance from clinicians. This was particularly true in large hospitals, where distance and anonymity of managers negatively impacted workplace relations. One interviewee commented:

> The way services are structured they [junior consultants] are often working in isolation. When I was a consultant I had a colleague in a room next door that I could go and seek advice and not everybody has ... a senior colleague that they could discuss that with (Psychiatrist).

In contrast, relations between consultants and managers in small hospitals in remote parts of Scotland were often better, partly due to co-location which facilitated direct communications. As one surgeon commented: 'We have quite a content unit. It's because, we still do speak to each other.'

Discussion

The research question, which was a byproduct of a larger study of consultants' sense of deprofessionalization, was aimed at understanding the extent to which organizational spaces can not only erode a profession's status, but also reduce knowledge production. This question was generated initially by MacDonald's (1989) seminal article on the impact of buildings, and their organizational spaces, on professionals' feelings of self-worth and sense of high social status. However, MacDonald's observations focused on how impressive spaces enhanced professional status in a positive sense. He did not address the question of whether the opposite was also true: could spaces diminish

professionals' status and knowledge production, and thus contribute to deprofessionalization?

The three main themes that emerged from the research were: (a) loss of social space and its effects on consultants' perceptions of status, isolation and their ability to share knowledge; (b) design of the working environment and its impact on consultants' perceptions of their own diminished status; and (c) physical separation through the design of spaces that lead to perceptions of disconnect from other professions. Each theme is now discussed in turn to explain their meaning, why they are important, and their significance for understanding deprofessionalization.

The most recurrent theme was the loss of psychological ownership (Sauer, 2015) over the doctors' social space – the doctors' mess. This loss was seen to have strong symbolic and material consequences, especially in relation to their previous elite status in the organization. This view was typical among older consultants who had been socialized into a system in which doctors were 'first among equals' (Thorne, 1997). Younger and less experienced consultants tended to be more satisfied with the new facilities, which was explained by older and more experienced consultants as 'the young doctors don't know any better'. In line with previous research on deprofessionalization (Currie et al., 2012; Martin et al, 2015), consultants generally resented increasing managerial control over their working lives and its impact on doctors' autonomy. These findings also resonate with similar attempts to break down material and symbolic distance between professions through the management of space (Baldry and Barnes, 2012).

It was not only loss of status that was an issue; the loss of communal space for doctors was interpreted as a major impediment to the social production of knowledge and knowledge sharing (Brown and Duguid, 2002), especially by consultants in the earlier stages of their careers. The removal of the doctors' mess was seen to prevent essential communication between doctors, such as open and frank discussions of patients' cases and different specialties meeting to discuss matters of mutual interest. Both of these factors have serious implications for patient care. These negative expressions of the loss of social space resonate with other studies in healthcare management that point to an erosion of the sense of community among doctors through an increasing fragmentation of the postgraduate training. For example, Spilg et al. (2012) found that a competence-based approach to training, introduced to the UK NHS in 2005 and branded as 'Modernising Medical Careers', led to doctors in training having less direct contact time to observe consultants, and less time to gradually build up essential communities of practice. In addition, proximity associated with organizational space has been seen as important in relational coordination among healthcare staff. This refers to the frequency, timing and accuracy of communications, and the quality of relationships among staff (Gittell, 2002).

The second theme that emerged from the study was a deterioration of hospital facilities and its impact on doctors' work and patient care. The increasing requirement for consultants to share offices was interpreted by some interviewees as an exercise of managerial power. In the literature on organizational spaces, spatial arrangements are an obvious corollary to the detection of power (Keith and Pile, 1993; Dale and Burell, 2008), and the doctors participating in the study linked their feeling of deprofessionalization with the managers' attempt to symbolically assert their superiority

over them. However, shared offices posed risks for patient privacy, and were seen as damaging effective working relationships. Thus, a business-related rationale, rather than a clinical rationale, was seen to dominate the design of hospital facilities (Waring and Bishop, 2013). Consultants associated the loss of control over space with a loss of control over their clinical work (Baldry, 1999), suggesting that the limitations of the new facilities would negatively impact clinical practice and patient care.

The third theme was physical separation through the design of spaces leading to perceptions of isolation and disconnection, both of which had potential implications for patient care. A physical separation from managers was a recurring cause for complaint. The managers' offices were perceived to be the spaces where real decision-making takes place, while doctors were left 'at the coalface'. Managers were seen to be deliberately erecting boundaries between them and the real issues related to patients. The literature on organizational spaces has long commented on the economy of boundaries (Keith and Pile, 1993) as boundaries include some people and exclude others, so in effect they represent an automatic exercise of power. Thus, as Dale and Burell (2008: 171) stated, 'drawing boundaries is a political act'. Boundaries shape people's identities and guide their actions; hence, groups in the process of forming a strong identity tend to construct visible spatial boundaries (Hatch, 2013; Massey, 2005). Conversely, our data revealed that where doctors and managers were co-located, particularly in smaller hospitals, relationships between them were typically better.

So how are these three themes linked with the processes of deprofessionalization? Two concepts – emplacement, from the literature on spaces, and isolation, with a longer history in industrial sociology – allow this phenomenon to be better understood. The

degree of emplacement identified in this study reflects the application of coercive power both in and through spatial arrangements (Dale and Burrell, 2008). It is derived from the concepts of enclosure, classification, partitioning and ranking introduced by Foucault (1975). Emplacement implies that there is a regulation of space that encourages certain activities to take place in constructed spaces. This creates an environment that is fixed and makes it possible to classify and compare people within those places. It also results in people both 'knowing their place' and being motivated to stay within these boundaries because of economic rationality as well as fear of the other. The doctors in this study were 'kept in their place' by being given inferior spaces to work in. The contrast with perceived 'glamorous' spaces occupied by non-clinical managers emphasized the sense of loss of professional status.

The degree of isolation identified in the study reflected the type of isolation Blauner (1964) discussed many decades ago as part of his explanation of alienation at the workplace. Drawing loosely on Marx's objectivist notion of alienation by giving it a subjective twist, Blauner attempted to explain workers' attitudes and responses to technological change in terms of four emotional states: powerlessness, meaninglessness, isolation and self-estrangement. Blauner used the concept of isolation to explain how the design of assembly lines led to employees feeling socially isolated from colleagues, trade unions and managers. This explanation of alienation, based on advances in automation during the last century, was criticized for being technologically deterministic. However, there has been a general resurgence of interest in the concept of alienation , and social isolation in particular, generated this time by combining new forms of technology, organizations and work forms, for example, homeworking, hot-desking, e-lancing, etc. (Orlikowski and Scott, 2012; Shantza et al., 2012). Our data evidence another facet of

social technology by pointing to the managerially integrationist aims behind the design and redesign of hospitals. These decisions are often made without consulting doctors and are aimed at breaking down barriers between doctors, other clinical professions and, indeed, patients. Such changes, however, had the effect of building barriers, this time between doctors. Like Blauner's assembly line workers, doctors in the study experienced social isolation from other doctors and from centres of decision-making.

Conclusion: Consequences of deprofessionalization through organizational spaces

The challenges faced by managers and planners in the re-design of existing hospitals and the design of new hospital spaces presents major problems for all stakeholders in healthcare systems. The focus on spaces is not aimed at diminishing the importance of other issues mentioned at the beginning of the article, but offers an additional insight into the difficulties faced by healthcare professionals. Consideration of a perceived deterioration of space draws attention to the day-to-day lived experiences that affect doctors' working lives, knowledge production, and consequently, patient care. These experiences lead to two interlinked outcomes of interest for sociologists of work. The first is the perception among doctors that their professional status is being eroded to a point that they may no longer feel themselves to be members of the privileged elite. The second is that their reduced sense of ownership over space makes their jobs more difficult by isolating them from other doctors hindering sharing of knowledge. Taken together, both imply detrimental impacts on patient care. If the advice of doctors and other clinicians is disregarded in the design of social spaces, wards and operating theatres, this can lead to resource constraints being prioritized over knowledge exchange between doctors and their clinical teams.

Finally, the study has methodological implications, as it found that the theme of hospital spaces and their impact on doctors' experience of work is neglected in the sociology of medical professionals. This neglect is reflected in empirical studies of deprofessionalization, which rarely draw on the conceptual framework of organizational spaces. Thus, observing changes in the physical environment and mapping them against the processes of deprofessionalization may offer interesting new insights transferrable to professionals other than medical doctors.

References

Alvesson M, Wilmott H (2003) *Studying Management Critically*. London: SAGE.

Baldry C (1999) Space-the final frontier. *Sociology 33*(3): 535-553.

Baldry C, Barnes A (2012) The open-plan academy: space, control and the undermining of professional identity. *Work, Employment and Society* 26(2): 228-245.

Blauner R (1964) *Alienation and Freedom*. Chicago: University of Chicago Press.

Bourawoy M (1979) *Manufacturing Consent*. Chicago: University of Chicago Press.

Bourdieu P (1981) Men and machines. In Knorr-Cetina K, Cicourel A (eds.) *Advances in Social Theory and Methodology: toward an integration of micro- and macro-sociologies*. London: Routledge, 304-18.

Brown, JS, Duguid P (2002) Local knowledge innovation in the networked age. *Management Learning 33*(4): 427-437.

Currie G, Lockett A, Finn R, Martin G, and Waring J (2012) Institutional work to maintain professional power: recreating the model of medical professions. *Organization Studies* 33(7): 937-962.

Czarniawska B (2004) On time, space and action nets. *Organization* 11(6): 777-95.

Dale K (2005) Building a social materiality: spatial and embodied politics in organizational control. *Organization* 12(5): 649-678.

Dale K, Burrell G (2008) *The Spaces of Organization and the Organization of Space: Power, Identity and Materiality at Work*. Basingstoke: Palgrave Macmillan.

DiMaggio PJ, Powell WW (1991) Introduction. In: Powell WW and DiMaggio PJ (eds) *The New Institutionalism in Organizational Analysis*. Chicago: University of Chicago Press, 1–38.

Dovey K (1999) *Framing Places: Mediating Power in Built Form*. New York: Routledge.

Fayard AL, Weeks J (2007) Photocopiers and water-coolers: the affordances of informal interaction. *Organization Studies* 28(5): 605-634.

Filc D (2006) Physicians as 'organic intellectuals': a contribution to the stratification versus deprofessionalization debate. *Acta Sociologica* 49: 273-285.

Foucault M (1975) *Discipline and Punish: the Birth of the Prison*. New York: Random House.

Francis R (2013) *The Mid Staffordshire NHS Foundation Trust Public Enquiry: Final Report*. Available at http://www.midstaffspublicinquiry.com/report (accessed 21 February 2015).

Gittell JH (2002) Coordinating mechanisms in care provider groups: relational coordination as a mediator and input uncertainty as a moderator of performance effects. *Management Science* 48(11): 1408-1426.

Glaser BG, Strauss AL (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research*, Chicago: Aldine.

Goodrick E, Reay T (2010) Florence Nightingale endures: legitimizing a new professional role identity. *Journal of Management Studies 47*(1): 55-84.

Gordon LJ, Rees CE, Ker JS, and Cleland J (2015) Leadership and followership in the healthcare workplace: exploring medical trainees' experiences through narrative inquiry. *BMJ open* 5(12): e008898.

Guthley GT, Whiteman G, and Elmes M (2014) Place and sense of place: Implications for organizational studies of sustainability. *Journal of Management Inquiry* 23(3): 254-265.

Ham C (2014) *Reforming the NHS from Within: Beyond hierarchy, inspection and markets,* London: Kings Fund.

Hatch MJ (2013) *Organization Theory: Modern, symbolic and postmodern perspectives*. Oxford: Oxford University Press.

Keith M, Pile S (1993) Introduction part 1: The politics of place. InKeith M and Pile S (eds) *Place and the Politics of Identity*. London: Routledge, 1-21

Kornberger M, Clegg SR (2004) Bringing space back in: organizing the generative building. *Organization Studies* 25(7): 1095-1114.

Kraatz MS, Block E (2008) Organizational implications of institutional pluralism. In Greenwood R, Oliver C, Sahlin K, and Suddaby R (eds) *The SAGE Handbook of Organizational Institutionalism*. London: SAGE, 243-275.

Larson MS (1977) *The Rise of Professionalism: A sociological analysis*. Berkeley, California: University of California Press.

Lefebvre H (1991) The *Production of Space* (Vol. 142). Oxford: Blackwell.

Macdonald KM (1989) Building Respectability. *Sociology* 23(1): 55-80.

McDonald R, Checkland K, Harrison S, and Coleman A (2009) Re-thinking collegiality: restratification in English general medical practice. *Social Science and Medicine* 68(7): 1199-1205.

Marrewijk VA, Yanow D (eds.) (2010) *Organizational Spaces: Rematerializing the workaday world*. Cheltenham: Edward Elgar Publishing.

Martin G, Beech N, MacIntosh R, and Bushfield S (2015) Potential challenges facing distributed leadership in health care: evidence from the UK National Health Service. *Sociology of health & illness 37*(1): 14-29.

Massey D (1984) *Spatial Division of Labour: Social structures and the geography of production*. New York: Methuen.

McGivern G, Currie G, Ferlie E, Fitzgerald L, and Waring J (2015) Maintenance and hybridization of medical professionalism in managerial contexts. *Public Administration* 93(2): 412-432.

Numerato D, Salvatore D, and Fattore G (2012) The impact of management on medical professionalism: a review. *Sociology of Health and Illness* 34(4): 626-644.

Orlikowski WJ, Scott SV (2008) Sociomateriality: challenging the separation of technology, work and organization. *Academy of Management Annals* 2 (1): 433-474.

Rafaeli A, Vilnai-Yavetz I (2004) Emotion as a connection of physical artifacts and organizations. *Organization Science* 15(6): 671-686.

Ritzer G, Walczak D (1988) Rationalization and the deprofessionalization of physicians. *Social Forces* 67(1): 1-22.

Ritzer G (1996) The McDonaldization thesis: is expansion inevitable?, *International Sociology* 11(3): 291-308.

Ropo A, Salovaara P, Suaer E, and De Paoli D (2015) *Leadership in Spaces and Places,* Cheltenham: Edward Elgar.

Royal College of Physicians (2005) *Doctors in Society: Medical professionalism in a changing world*. Report of a Working Party of the Royal College of Physicians of London, London: RCP.

Sauer E (2015) The hospital as a space of power: ownership of space and symbols of power in a hospital setting. In Ropo A, Salovaara P, Sauer E, and De Paoli D (eds) *Leadership in Spaces and Places*. Cheltenham: Edward Elgar, 242-264.

Shantza A, Alfes K, and Truss K (2012) Alienation from work: Marxist ideologies and twenty-first-century practice. *The International Journal of Human Resource Management* 25(18): 2529-2550.

Smith RW, Bugni V (2006) Symbolic interaction theory and architecture. *Symbolic Interaction* 29(2): 123-155.

Soja E (1989) *Postmodern Geographies*, London: Verso.

Spilg E, Siebert S, and Martin G (2012) A social learning perspective on the development of doctors in the UK National Health Service. *Social Science & Medicine*, *75*(9): 1617-1624.

Strauss A, Corbin J (1998) *Basics of Qualitative Research: Techniques and procedures for developing grounded theory*. London: SAGE.

Tally RT (2013) *Spatiality*. New York: Routledge.

Thorne ML (1997) Being a clinical director: first among equals or just a go-between? *Health Services Management Research* 10(4): 205-215.

Timmerman S, Oh H (2010) The continued social transformation of the medical profession. *Journal of Health and Social Behavior* 51(S): s94-s106.

Waring J, Bishop S (2013) McDonaldization or commercial re-stratification: corporatization and the multimodal organisation of English doctors. *Social Science and Medicine*, 82: 147-55.

Waring J, Currie G (2009) Managing expert knowledge: organizational challenges and managerial futures for the UK medical profession. *Organization Studies* 30(7): 755G 788.

Sabina Siebert is Professor of Management in the Adam Smith Business School, University of Glasgow. Her research focuses on organizational change, organizational trust and the study of professions, including lawyers and doctors. She has recently researched trust and distrust in secret organizations, trust in science and differentiation in elite professions. She has published in the Academy of Management Journal, Organization Studies, Human Resource Management Journal, Sociology, and Work Employment and Society. Sabina is a Visiting Professor at the University of Gothenburg.

Stacey Bushfield is a Lecturer in Management at the University of Dundee School of Business. Her research focuses on healthcare management, organizational change, and professional and leadership identity. She has recently researched the role of identity workspaces in development, hybrid professional-leader narratives, and the disconnects that can arise in distributed leadership.

Graeme Martin is Professor of Management and Director of Research in the University of Dundee School of Business. He has published widely in management, including seven authored/edited books and numerous articles, including papers in *Organizational Studies*, *Human Resource Management Journal*, *Social Science and Medicine*, and *Sociology of Health and Illness*. He is currently working on research and knowledge exchange projects in healthcare management in the UK and Australia.

Brian Howieson is a Senior Lecturer in Management in the University of Dundee School of Business. His research covers the broad spectrum of leadership including its history and the current state of the field. He is the Editor and principal author of *Public and Third Sector Leadership: Experience Speaks* (Emerald). He was a full Council Member of the Foundation for Management Education, a previous NonG Executive Member of the Medical Directorate within NHS Scotland, and a Fellow of the Royal Society of Arts.

Figure 1: Isolation and emplacement as contributory factors to the deprofessionalization of doctors