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Uniforms, status and professional boundaries in hospital

Stephen Timmons and Linda East

School of Nursing, Midwifery and Physiotherapy, University of Nottingham

Abstract Despite their comparative neglect analytically, uniforms play a key role in the delineation of occupational boundaries and the formation of professional identity in healthcare. This paper analyses a change to the system of uniforms in one UK hospital, where management have required all professions (with the exception of doctors) to wear the same 'corporate' uniform. Focus groups were conducted with the professionals and patients. We analyse this initiative as a kind of McDonaldisation, seeking to create a new 'corporate' worker whose allegiance is principally to the organisation, rather than a profession. Our findings show how important uniforms are to their wearers, both in terms of the defence of professional boundaries and status, as well as the construction of professional identity.

Keywords: professional boundaries, uniforms, professional identity

Introduction

In this paper we will analyse an initiative which, we argue, is a new development in terms of the managerial attempt to reduce the importance of occupational boundaries in healthcare. This initiative consisted of changes to staff uniforms in one United Kingdom (UK) hospital, to be described in more detail below. In the National Health Service (NHS), uniforms are the most visible symbolic manifestation of a professional or occupational group, as well as being a way of delineating professional boundaries and demonstrating occupational hierarchies. Change, and the conflict it entails, brings to the surface and makes observable issues which are normally smoothed over by the ongoing processes of negotiation in the workplace (Svensson 1996). As Allen (2001a,b) shows, overt conflict over occupational boundaries in healthcare is quite unusual. Thus, this change initiative offered a rare opportunity to explore how various professionals delineate and defend occupational boundaries in practice, and also to ascertain what health service uniforms mean to the public who use the service.

Following an analysis of existing research and policy related to professional boundaries and uniform in healthcare, this paper will present findings from a study of sartorial change. The paper will address the question of whether increased uniformity in professional work wear has the potential to promote corporate over professional identities, a question of significance within the sociology of professions.

Status and professional boundaries

Professional and occupational boundaries in healthcare have been of interest since the 1960s (Stein 1967) and a variety of analytical approaches have been used to study such boundaries over the intervening years (Hughes 1988, Porter 1991, 1995, Mackay 1993, Svensson 1996, Wicks 1998, Allen 2001a,b). These analyses have moved from a view where medicine was completely dominant (*e.g.* Stein 1967) to the contemporary position where boundaries are usually typified by negotiation (Svensson 1996, Allen 2001b), and can become sites of conflict (Timmons and Tanner 2004).

Understanding the relative status of the various healthcare professions is complex, except in so far as medicine is generally perceived to have a higher status than any other profession. For the purposes of this paper, however, we will be considering the boundaries between (and within) professions of roughly equal status, principally nursing, occupational therapy and physiotherapy. The main occupational boundary that has been studied previously is that between medicine and nursing (Stein 1967, Wicks 1998). Studies of occupational boundaries involving physiotherapy have also tended to focus on the medicine-physiotherapy boundary (Larkin 1983, Halpern 1992, Norris 2001). Studies of other occupational boundaries are limited, in common with a wider lack of sociological analysis of healthcare professions other than medicine and nursing (Timmons and Tanner 2004). An exception is found in the study of Smith and Roberts (2005), who analysed how occupational therapists and physiotherapists work together in a community setting. Smith and Roberts found that the more skills were shared between the professions, the more protective the therapists became of their perceived core skills, thus illustrating the persistence of 'professional tribalism'. Their findings reflect the earlier work of Brown *et al.* (2000), who investigated interdisciplinary working in community mental health teams. Brown *et al.* found that the organisational imperative to work in generic mental health teams led to occupational boundaries becoming further entrenched rather than weakened, as the various occupations defended their professional skill sets.

Professional tribalism has long been recognised in healthcare systems, where tribes include both managers and the various clinical professions: 'All of these tribes have slightly different goals and perceptions of what constitutes effective care and are pulling in somewhat different directions' (Hunter 1996: 799). Health policy analysts have suggested that the occupational boundaries that delineate the professional tribes may not necessarily be an asset to the smooth running of services (Strong and Robinson 1990). Braithwaite (2005) argues that professional tribalism is implicated in, for example, the failures in paediatric cardiac surgery at the Bristol Royal Infirmary. A key finding concerning what went wrong in Bristol was that there was a lack of teamwork between professional groups, strong hierarchies and occupational defensiveness.

With the advent of what has been termed the New Public Management (Hood 1995), managers in the NHS (along with managers in public-sector organisations across the developed world) began to challenge the authority of the professions over many areas of their work (Exworthy and Halford 1998). This was not a simple phenomenon and in some areas, depending on context and history, the relationship between managers and professionals became contentious to the point of breakdown, while in others it was characterised by negotiation and compromise (Ferlie *et al.* 1996). What was significant was that many areas that had hitherto been the remit of the professions alone became the subject of managerial interest and action. Among these issues were occupational boundaries, which came to be viewed by managers as inflexible and therefore inimical to the efficient running of the NHS. Nancarrow and Borthwick (2005) summarise these processes: 'disciplinary boundaries have

come under new pressures […], neo-liberal managerial principles have led to a redistribution of resources on the basis of professional accomplishment rather than the historical workforce hierarchies and roles' (2005: 898). In other words, managers have used their control over resources to change how services are delivered, including changes to which profession provides services for certain groups of patients.

There is, therefore, a clear policy push within the contemporary UK NHS for a reduction in the importance of occupational boundaries. Elements of this agenda include re-organisations of services, the creation of new professions and explicit exhortations for staff to work in a more multi-disciplinary way (Department of Health 2000, 2004). The *New Ways of Working* initiative (Department of Health 2007a), part of the NHS Modernisation Programme, is a good example of these kinds of policy changes. They included skill-mix adjustments, job widening, job deepening and the creation of new roles (Hyde *et al.* 2005), all of which constitute a managerial challenge to existing occupational boundaries. A related development in the UK NHS is the introduction of explicitly generic workers in healthcare, who bear no allegiance to any of the traditional professions and occupations. It seems likely that this approach will continue with the new UK government's emphasis on 'liberating' the NHS from tradition and bureaucracy (Department of Health 2010).

This programme of change in the UK NHS can be understood in a wider context as being an example of what the neo-Weberian Ritzer (1993) terms McDonaldisation. By this, Ritzer means the tendency for contemporary organisations increasingly to adopt the managerial practices of McDonald's, with a focus on efficiency, calculability, predictability and control. Through these practices, McDonald's restaurants are standardised the world over, offering an iconic vision of corporate identity. To health service managers striving to achieve national targets, the perceived protectionism of the professional tribes is a barrier to the greater efficiency and productivity McDonaldisation promises. As Hunter (1996) puts it, 'The task of management has been to bring the various tribes together in order to make them work as a team and to show corporate loyalty to the organisation as distinct from their particular profession' (1996: 799).

The salience of uniforms

Despite their comparative neglect in the literature, uniforms are one of the key ways in which occupational boundaries are enacted in practice. Clear, visible symbols make it easy for everyone to know where the occupational boundaries are, and not transgress them. It is possible that one of the things that made the occupational boundary dispute described by Timmons and Tanner (2004) so overt is that in the operating theatre all staff are dressed identically, thus blurring an occupational boundary which is usually very clear. In this case, nurses were seeking to defend work they perceived as legitimately theirs from the newer 'tribe' of operating department practitioners, who were seeking to expand their scope of practice by encroaching on traditional nursing roles.

There are only a few scholarly papers which take uniforms as their main focus, among them Joseph and Alex (1972). They show how uniforms are emblematic, indicate status and legitimacy, and suppress individuality. For Joseph and Alex (1972) 'The uniform is a device to resolve certain dilemmas of complex organisations – namely, to define their boundaries, to assure that members will conform to their goals, and to eliminate conflicts in the status sets of their members' (1972: 719). Despite the time that has elapsed since this analysis, Joseph and

Alex's broad focus means that their paper continues to serve as a useful basis for discussion. In an ethnographic study of imposed changes in uniform for volunteer reservists in the United States Air Force (USAF), Cheng (1998) shows how the changes caused substantial discontent, leading to many volunteers leaving the USAF, illustrating how significant changes to uniforms can be for their wearers. Again, the context is very different from that studied in this paper. However, these studies serve to illustrate the salience of uniforms in the construction and maintenance of professional ('tribal') identity and occupational boundaries.

Rafaeli and Pratt (1993) emphasise the symbolic importance of clothing in the workplace. They suggest a distinction between 'complete' and 'stratified' homogeneity in uniform design. The uniform worn by McDonald's staff would be an example of the former, with identical uniforms promoting a standardised corporate identity. Within most NHS hospitals, however, the traditional patterns of uniform fit into Rafaeli and Pratt's 'stratified homogeneity' category. For Rafaeli and Pratt (1993), stratified homogeneity is indicative of the division of labour within the organisation, thus distinguishing between different organisational groups and also indicating status and hierarchy within each group. In the case of UK hospitals, there are usually different uniforms for every staff group from porters to physiotherapists. Some professions, particularly nursing, also exhibit stratified homogeneity within their profession, for example wearing different shades of blue to indicate rank.

There is a larger number of papers in the nursing literature, though often focused on ergonomic and infection control issues. Sparrow (1991) studied a hospital ward that experimented with nurses not wearing uniforms for a two month period. She confirmed that uniform makes visible and reinforces hierarchy. The nurses involved in her study felt that uniform was an important part of their identity as nurses, particularly in terms of distinguishing them from other groups of staff. Shaw and Timmons (2010) show that uniform remains a site for a symbolic struggle in nursing. The only paper identified from the other professions in this study was Mercer *et al.*'s (2008) study of patients' perceptions of appropriate uniform for physiotherapists. The main shortcoming with the literature written by the professionals themselves is that it consists predominantly of opinion pieces, with only a very small number of empirical studies.

Thus, although there is a diverse literature on uniforms in an organisational context, there is only a limited amount which is theoretically informed and derived from empirical studies. Much of what exists is now quite old, and none of it explicitly addresses the role of uniforms in the context of organisational changes brought about by the New Public Management, which has organisational boundaries and professional tribalism as one of its main targets for reform. The literature reviewed here does, however, clearly demonstrate the continuing salience of uniform in healthcare services, and the strong emotional attachments uniforms generate among their wearers (Spragley and Francis 2006). When this system of delineation and reinforcement of boundaries is disrupted, it is perhaps unsurprising that people have strong feelings, as a key part of their social order has been disrupted. For Rafaeli and Pratt (1993), stratified homogeneity as an approach to uniform design is indicative of the division of labour within the organisation, suggesting that the move towards more complete homogeneity is indeed an attempt to symbolically re-order the division of labour within a hospital. 'Dress homogeneity will extend the extent to which individual behaviour is driven by organisation rather than individual [or professional] goals, attributes and values' (Rafaeli and Pratt 1993: 45). In the managerial battle to overcome NHS tribalism, therefore, disrupting the significance of uniform could be a powerful tool.

Background to the current study

In the hospital we studied, a new system of staff uniforms was introduced in 2005. What was significant, and we believe to be the first time that this had happened in the UK NHS, was that the new uniforms were identical for all professional groups, including nursing, physiotherapy and occupational therapy. It was immediately clear that the change in uniform was a highly charged event. The level of complaint and dissent seemed to take the initiating managers by surprise, even when the resistance of most organisations to change is acknowledged (Warner Burke *et al.* 2008). However, given the salience of uniform to professional identity and the protection of organisational boundaries described above, the strong reaction is not surprising.

A British hospital may well have 20 different uniforms designating professional or occupational groups, with each uniform further subdivided to indicate status. Within groups, hierarchy has traditionally been signified by another complex set of symbols (including hats, badges, collars, cuffs, belts and piping). Within nursing, these symbols vary from hospital to hospital, though many nursing uniforms in the UK have been some sort of variation on a blue dress. Though no central policy ever mandated this, in occupational therapy and physiotherapy most hospital professionals wear a de facto national uniform of white top and green trousers (occupational therapy) or white top and navy blue trousers (physiotherapy).

In the hospital we studied, the only signifier of professions that remained after the change was a small epaulette in the traditional colour indicating profession (royal blue for nurses, green for occupational therapists and navy for physiotherapists). Symbols of rank were also substantially reduced, with all grades wearing navy trousers or skirts with blue and white candy-striped tunics or dresses. The exception to this was nursing ward managers (sisters), who remained dressed entirely in navy blue. A thin stripe on the epaulette distinguished qualified from unqualified staff. According to the hospital website, the new system of uniforms was introduced both to make staff more identifiable and to save money. The situation in our local hospital, therefore, seemed to offer a unique natural experiment to explore the thesis of Rafaeli and Pratt (1993): that moving to a more homogenous, corporate uniform would symbolically re-order the division of labour and diminish the significance of occupational boundaries, leading to an enhanced sense of corporate identity, and reducing professional tribalism.

Methods

Our methodological stance is broadly interpretative, and for the purposes of this study we align ourselves with a symbolic interactionist approach, conceiving profession and identity as being socially accomplished, collective and meaningful phenomena. Focus group discussions were therefore chosen for data collection due to the nature of the phenomena being studied. Belonging to a professional tribe and wearing the uniform that signifies one's professional identity is always experienced by the individual as a member of a group. This is not to say that professionals do not have an individual identity, but that wearing a uniform is inherently a collective phenomenon.

The professional staff who participated in this study were recruited via their professional managers, who circulated an email invitation from the researchers.[1] Patients were recruited from the Trust's existing Patient Partnership Group (PPG) to give a patient perspective on uniforms, as patients are one of the main audiences for uniforms. As members of the PPG,

the patients represented various parts of the hospital, such as surgical wards, children's services or outpatients. All of the participants in this group were retired, as is typical of the wider population of hospital patients. However, a limitation is that their status as members of the PPG meant that they were better informed about the workings of the hospital than most patients would be.

Six focus group discussions were held between April and July 2008, making a total of 30 participants:

- Patient representatives (n = 6)
- Ward nurses (n = 3)
- Clinical nurse specialists (n = 4)
- Physiotherapists (n = 5)
- Occupational therapists (2 groups (n = 7) and (n = 5))

As a result of a recent organisational merger, the NHS Trust we studied now includes two main hospital sites. The new, standardised uniforms had only been introduced on one site at the time of the study. However, a managerial decision in occupational therapy meant that occupational therapists were the only professional group that wore the same uniform on both sites. Therefore, two focus groups were held for occupational therapists, one for each hospital within the NHS Trust, which provided some useful analytical insights. The membership of the focus groups was designed to allow for examination of the impact of the new uniforms both across professional boundaries (nursing, physiotherapy and occupational therapy) and within professional hierarchies (ward nurses and clinical nurse specialists).

The focus groups were facilitated by the authors, with one acting as moderator while the other recorded the conversation and took notes. The focus group schedule covered the process of implementation: what staff thought about the new uniforms; what their experience had been of wearing them in practice and how patients and other staff reacted to the new uniforms. The focus groups were conducted flexibly, following the issues and concerns of the participants, with follow-up questions where appropriate. With participants' consent, the group discussions were recorded and subsequently transcribed. The transcripts were analysed using the thematic content analysis approach (Green and Thorogood 2004). The first stage of the analysis was reading and re-reading of all the focus groups transcripts by both authors. Statements thought to be significant were noted by each author, and then compared. These statements were grouped into sub-themes, which were then organised into an overarching thematic structure, detailed below.

Focus group data pose particular analytical problems, in so far as the accounts given are constructed in the social context of the focus group itself (Kitzinger 1995). The limitations of focus groups include individuals dominating the discussion, a tendency to reproduce normative discourses and the effects of the researchers (as moderators) on the discussion. These were addressed by the method of facilitation, with one researcher acting as moderator, and the other monitoring the process as a whole in order to ensure that all voices were heard. Members of the groups were of equal status, and worked together regularly, meaning that all participants felt able to contribute to the discussion. The transcripts show that no one member dominated any event. The tendency to reproduce normative discourses, while an issue, was less problematic for this study, as professional identity is itself constructed through membership of a group; thus, the group interview is an appropriate method. The status of the researchers is that both are academic sociologists, but with extensive previous experience in the NHS, as (female) nurse and (male) manager. As Reventlow and Tulinius (2005) argue, focus group moderators' positions are conditional on the social relations within the group and are influenced by perceptions of power and expertise. In this case, group members

appeared to position the moderators as 'outsiders' to whom the issues needed to be explained, but with an underlying assumption of a basic shared understanding as healthcare professionals. The atmosphere in the groups was informal, with participants appearing relaxed and appreciative of a forum in which to discuss their concerns.

The technique of respondent validation was employed to increase the trustworthiness of the analysis, an approach first recommended by Lincoln and Guba (1985). All interview participants were offered an opportunity to check and comment on the transcripts of their focus groups, with no further comments received. A summary of the overall findings was also sent to each participant, with all agreeing that the summary was a fair reflection of the discussions that had taken place.

The Trust's Research and Development Department confirmed that the project should be classified as a service evaluation and did not require formal Ethical Committee approval. Nonetheless, appropriate ethical guidance was followed. Informed consent was assured by giving written information to all participants in advance of the focus group discussions; explaining the study verbally before the focus group began, and taking consent in writing. Confidentiality was maintained by storing transcripts and digital recordings securely. Anonymity was assured by removing information that could identify participants at the point of transcription. The limitations of this study in terms of whether the participants were fully representative of all staff and patients are acknowledged.

Findings

All the staff groups felt that the main reason the new uniforms had been introduced was in order to save money. Likewise, all the staff groups had negative comments about the fit and functionality of the uniforms, which will not be discussed further in this paper. Broadly, physiotherapists and occupational therapists saw the new uniforms as an attack on their professional identity, whereas nurses either accepted the new uniforms (ward nurses) or saw them as an attack on their status within their own profession (clinical nurse specialists). Although the illustrative quotes in the following sections are drawn mainly from individuals, the interaction between participants in the focus groups was significant. Participants took up the thread of conversation from the previous speaker, thus clarifying and strengthening their points. While the focus group discussions were wide ranging, this paper will concentrate on three key findings: professional versus corporate identity, mistaken identity between staff groups and mistaken identity within a profession.

Professional versus corporate identity

The groups who felt most strongly that the new uniforms were an attempt to impose a corporate identity (Rafaeli and Pratt 1993, Ritzer 1993), at the expense of professional identity, were physiotherapists and occupational therapists, who had similar views on this issue. This was because the new uniforms represent the biggest departure for them. There was a strong feeling among the therapists that their sense of professional identity and pride had been damaged by being forced to wear the same as other professional groups:

> I've only just been qualified for about six months and I was looking forward to wearing the green trousers and the white top – it actually represented occupational therapy (OT 3).

Physiotherapists and OTs saw their identity as being closely bound up with membership of a profession as symbolised by the national uniforms. The hospital was, for them, only the local

employer. Thus, the assault on their uniforms was perceived as a deeply symbolic step on the path towards genericism:

> They thought as well we'd be moving towards generic working, that we would lose our professions, that we would become generic therapists, generic ward workers – trying to dilute the profession a little bit rather than specialise in what we do (Physiotherapist 2).

Another respondent articulated a sense of the undermining of professional identity:

> We've actually lost our identity. We were easily recognisable, everyone knew us […] but now we have no identity at all (Physiotherapist 1).

This quote highlights a certain irony in respect of the rationale offered by the Trust for the introduction of the new uniforms, namely to make staff more 'identifiable'. It is unclear from the Trust's literature exactly how staff are now to be identified, but it is presumably as members of the organisation rather than discrete professions (an example of McDonaldisation (Ritzer 1993)). The staff recognised this:

> It has made me feel like less of a professional, and more of an employee (OT 5).

Indeed, one physiotherapist reported being asked by a visitor 'Do you work for McDonalds now?' This suggests the cultural symbolism of work wear standardisation is not lost on the public audience for UK health worker attire. However, this issue was not explicitly linked to managerial efforts to increase efficiency.

Mistaken identity between staff groups

The defence of professional identity against a perceived managerial assault was reinforced in the discussion of the practical impact of the new uniforms. The new uniforms were claimed to be the cause of problems that arose in the day-to-day organisation of work in the wards, disrupting long-established traditions of recognition and respect. Occupational therapists and physiotherapists appeared to be particularly aggrieved about being mistaken for nurses:

> When I first started on neurosciences, on the ward round in the morning when all the doctors go round, numerous times the consultants or registrars were turning to me and saying 'Has this person eaten, had their bowels opened?' It's only now that I've been there four or five months that they look to me for mobility issues rather than about whether the patient has been fed (Physiotherapist 4).

> I've been asked by a doctor to do a nursing task, something that we would never do as an OT. Just because they didn't realise, they thought you were an agency member of the nursing staff or something (OT 6).

It is significant that being mistaken for a nurse by a doctor was picked out on several occasions by occupational therapists and physiotherapists. We suggest that this might be particularly irritating for these groups as doctors are very influential in the attribution of status to other healthcare professions (Larkin 1983). There was a subtle suggestion that being mistaken for a nurse was somehow demeaning. However, it could also be difficult and embarrassing when the case of mistaken identity involved a patient or visitor:

> You can imagine the patient's dismay when they're shouting 'Nurse, nurse!' at you and you just walk away from them or say 'I'm sorry, I can't do it' or whatever, you know. They're obviously very fed up – they think that people are ignoring them and they just don't understand (Physiotherapist 2).

One of the physiotherapists kept a record of the number of occasions she was misidentified within two working days. She was mistaken for a nurse on 13 occasions. The physiotherapists also gave accounts of incidents where confusion caused by the uniforms was potentially dangerous:

> We've had a couple of dangerous incidents whereby there has been an auxiliary [nurse] standing around and somebody has arrested and somebody has shouted at the auxiliary 'Get the crash trolley!' Of course, she's not allowed to, so she's not done it and everyone is saying 'Why aren't you moving, why aren't you doing it?' And she just keeps saying 'I'm the auxiliary, I can't do it' (Physiotherapist 1).

Thus, occupational therapists and physiotherapists sought to reinforce their occupational boundaries (Allen 2001a) and resist the implementation of the new uniforms system by using two broad rhetorical strategies. The first of these was to argue that time (both theirs and others') was being wasted because of mistaken identity. The second was that patients would be dissatisfied, or even put at risk, by the problems that they identified. These strategies share narrative similarities with the 'atrocity stories' described by Allen (2001b) and Dingwall (1977), in so far as the narratives recounted showed that the transgression of the legitimate (in the view of the teller) occupational boundaries leads to disruption and danger, thus reinforcing the teller's moral standpoint that these boundaries should not be challenged.

Nurses, by contrast, were less concerned with their status vis-a-vis other professions, and more concerned about issues of status within the nursing profession itself. The nurses reported the issue of mistaken identity much less, although it did occur:

> It's frustrating because we can be mistaken for a porter[2] from a distance (Ward Nurse 2).

The issue of mistaken identity was reiterated in a slightly different way by the patients, who professed to find the new system of uniforms confusing:

> You don't know whether it's a porter in x-ray or whether it's a radiologist or a staff nurse, or whoever it may be. You know, it does create confusion (Patient Representative 4).

> If you're a patient in a bed close to the window of the ward and there are a number of staff at the far end they all look alike. You've got to get close up to distinguish between them all, so if you need to call for a nurse and no one comes, you can be a bit miffed. But of course, there isn't a nurse that can attend to you there, because they're all of different disciplines (Patient Representative 1).

Patients did not have anything to say specifically about the status issues that mattered so much to the professionals. The only comment from patients that could be linked to this issue was that they felt it was important to know who was in charge, and thus supported the policy whereby the sister/charge nurse in a ward or department wore a distinctive navy blue uniform, not worn by anyone else. However, this policy was problematic for the clinical nurse specialists, as discussed below.

Mistaken identity within a profession

The assumption made by most people in the hospital was that anyone wearing one of the new uniforms was a nurse. Hence, signifying professional identity was not a problem for general, ward-based nurses. However, the new uniforms did generate strong feelings among the group of clinical nurse specialists (CNSs) interviewed for this study. The nurse specialists had historically worn the same uniform as sisters or charge nurses, indicating their seniority and experience within the nursing profession. With the implementation of the new uniforms, however, the clinical nurse specialists were required to wear the same uniform as staff nurses, with no visible symbol of their superior status. This change was viewed as a studied insult:

> It's not just the staff nurse uniform, it's the nursing assistant uniform, the OT uniform, the physio uniform, the phlebotomist uniform, it's everybody's uniform. It's not on, not on! (CNS 1).

One of the male clinical nurse specialists felt that the new uniform was particularly demeaning for him, as a man:

> They're candy-striped; they make you look like a child – the kind of thing that you'd wear if you were at school. For a man to wear a uniform like that just looks absolutely ridiculous. I don't see how anybody can gather support or – you know, recognition, respect – wearing a uniform like this (CNS 4).

The CNSs were the only group to discuss the fact that doctors did not wear uniforms, relating it to their own perceived loss of status. When wearing the same uniform as staff nurses on the hospital wards and corridors, and in strategic meetings, the CNSs reported being virtually ignored, as if they had become invisible:

> If you're in your own clothes you are treated completely differently (CNS 1).

The clinical nurse specialists attempted to deny that the issue was one of status, emphasising again the significance of uniform in delineating role:

> It isn't even a status symbol, it's not about being seen as more important. It's about everybody understanding who we are and what we do (CNS 3).

However, the strength of feeling, even bitterness, expressed did not seem to be consistent with this rationalisation. The loss of status relative to ward managers (who remained in navy blue) was a more compelling explanation, reinforcing Rafaeli and Pratt's (1993) suggestion that stratified homogeneity of uniform within the professional group is central to clarifying status and hierarchy. At this point in the discussion, there was a clear example of the way in which the focus group method facilitates the development and amplification of a point through group interaction. The first respondent (CNS 3) comments on the importance of uniform in signifying identity, then this develops into a broader discussion of human resource management (CNS 1 and CNS 4):

> CNS 3: I think, you know, any uniform that made us look smart and professional and looked just a bit different, so that people knew who we were, what we do […] Whatever it was like, that people knew who we were, knew what we did, and

knew what we were trying to achieve, it would be fine for us, fine for the staff and excellent for the patient, and I don't care what colour it is.

CNS 1: It's simple isn't it, it really is simple, I cannot believe I'm saying this, but I cannot believe how stupid the management are not to see, or to recognise that by putting us in a uniform that's distinguishable, which is the same as many other places, it would make us happy. They must recognise that a happy workforce, they'll get sort of maximum effectiveness out of us. How could you not – you know, how do you ignore that?

CNS 4: That would be interesting research don't you think? Why on earth the managers don't seem to follow basic human resources guidelines as to how to manage people?

For the OTs and physiotherapists, there was also some concern over loss of status within their professions related to the new uniforms. For example, occupational therapy students were still wearing the national uniform of white tunic and green trousers, with unexpected consequences:

> Patients think my student's senior to me, because she's got green trousers and a white tunic on, and that's what they traditionally recognise (OT 7).

However, the OTs did not value the stratification of their uniform to the same extent as the clinical nurse specialists. Indeed, they were quite dismissive of nurses' perceived attachment to symbols of status and rank:

> It's only ever nursing sisters that feel like they need a separate uniform. Because I'm the same level as a sister, but I wear the same uniform, always have done (OT 2).

In summary, therefore, disrupting the established system of uniforms within the hospital brought into focus various themes around professional identity, recognition and power.

Discussion

The occupational boundaries literature (*e.g.* Allen 2001a,b, Timmons and Tanner 2004) makes very little mention of the role of uniforms. However, our study has shown how important uniforms are (not least to those who wear them) in delineating these professional boundaries. Changes to uniforms in this context were interpreted as an assault on professional boundaries, and thus on the status and jurisdiction of the professions themselves. Although this might have been predicted by literature on the New Public Management (*e.g.* Exworthy and Halford 1998, Nancarrow and Borthwick 2005) or McDonaldisation (Ritzer 1993), this type of symbolic assault on professional boundaries has not been analysed elsewhere. This study presents a good example of how the kinds of changes that these literatures discuss are made and resisted in practice.

In the fallout resulting from the change to the new system of uniforms, it is interesting that the professions of OTs and physiotherapists were mistaken for that of nursing. Nursing is the norm for a non-medical healthcare profession; it is recognised and understood by everyone (especially doctors and patients). Other professions have therefore to work harder at being recognised and understood. The findings of this study suggest that the de facto national uniforms worn by OTs and physiotherapists are a key element in maintaining their

professional identity. However, the change in the system of uniforms also affected specific groups of nurses within the NHS Trust. For them, the issue was not one of differentiation from other professionals, but of indicating status within their own profession. Nursing has a tradition of being one of the most strongly hierarchical of the healthcare tribes (Ford and Walsh 1994, Davies 2000), and uniform has been one of the clearest ways in which this was demonstrated. Therefore, the group of nurses who were most aggrieved about the new uniforms were the clinical nurse specialists, who had symbolically lost status within the nursing hierarchy by being moved from a sister's uniform to a staff nurse's uniform. This is a development of Rafaeli and Pratt's (1993) analysis of the importance of uniform in demonstrating hierarchy, in that we have shown how the standardisation of uniform undermines hierarchy.

It seems unlikely, therefore, that the new generic uniforms have done much to promote corporate identity or reduce professional tribalism, and may have exacerbated them. In relation to corporate identity, the rationale for the change has been undermined by the fact that many groups of staff at the hospital do not wear the generic uniform, from pharmacists to domestics. The drive towards a generic, corporate uniform has been further diluted by the fact that staff on the two different hospital sites in the Trust are still in different uniforms until the current contracts with uniform suppliers expire. From our findings, the loss of professional demarcation amongst some groups of staff does not seem to have resulted in a greater commitment to organisational identity over professional identity but, rather, a sense of loss and disempowerment. If the agenda is to promote flexibility in the workforce, this initiative also seems to have met with little success. If anything, occupational therapists and physiotherapists are spending more time defending their professional identity and verbally differentiating their role from that of colleagues, in line with the professionals studied by Brown *et al.* (2001).

This study illustrates how ideas about relative status are constructed within and between the healthcare professions. They have their own hierarchies of status, on which they do not all agree. While medicine is acknowledged by all the other professions to be the profession with the most status, they also have ideas about how they compare with each other. Thus, the physiotherapists and occupational therapists we spoke to had a sense that they were in some way superior to nurses, in so far as they found it demeaning to be mistaken for a nurse. The nurses, by contrast, did not talk about being mistaken for physiotherapists or occupational therapists, except in so far as they were concerned about the confusion for patients and visitors. Not only are doctors the most powerful profession within healthcare, and the group with the most status, they are also, effectively, the arbiters of status for other professional groups. The OTs and physiotherapists, when talking about being mistaken for a nurse, chose examples where they had not been recognised by doctors. Though examples of patients mistaking their role were given, these were less frequent, and not linked to statements about status. Doctors' role as the arbiter of status for other professional groups in healthcare derives from the medical profession's history of control of the professionalisation of those occupational groups (Larkin 1983). The importance of medicine in determining status is a development in our understanding of how the relative statuses of the non-medical healthcare professions are determined, about which little has been written hitherto.

Conclusion

It is reasonable to conclude that, given the policy context, the new uniforms were an explicit managerial attempt to reduce the importance of boundaries between (and within)

professional groups in hospital, and to re-align allegiances away from professions to the institution. It is, in microcosm, one of the initiatives Nancarrow and Borthwick (2005) describe as designed to challenge historical workforce hierarchies and roles. Unlike many such initiatives, it does not seek to transfer work or jurisdiction from one profession to another, but seeks to actively attack the identity of the profession itself, in so far as it exists as a potential place of allegiance outside the context of the institution.

It is, however, hard to say how far the managerial strategy has been successful. The staff have no choice in whether to wear the new uniforms and they continue to do so. Managers are still interested in moving (or removing) occupational boundaries in healthcare, and this initiative is probably only an early stage of that process. Professions will resist this, and it is possible that managerial initiatives will have the paradoxical effects described by Brown *et al.* (2008) where attempts to introduce multidisciplinary working actually result in a stronger insistence on professional identities and boundaries. As Hunter (1996) points out, 'Healthcare systems are not monolithic entities but pluralistic organizations in which competing interests jockey for attention' (1996: 799). This study suggests that manipulating staff uniforms as a strategy to reduce professional tribalism has its limitations. McDonaldisation is unlikely to be realised within the complex environment of an NHS Trust, at least in so far as it requires a corporate identity expressed through a standardised uniform.

Address for correspondence: Stephen Timmons, Division of Nursing, Midwifery and Physiotherapy, University of Nottingham, Queen's Medical Centre, Nottingham, NG7 2UH
e-mail: stephen.timmons@nottingham.ac.uk

Notes

1 In the UK, an NHS Trust is a self-governing organisation that may include several hospitals and other clinical services.
2 Some porters in the Trust wore the new uniforms, depending on the clinical area they were allocated to.

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