Chapter 1 **To begin at the beginning …**

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Identity and self at work

The subject of identity at work is complex and can be viewed from a whole range of different perspectives. It is important that we have an understanding of this so that we can appreciate different views of what it means and feels like to be at work and as nurses and midwives why we do what we do.

This chapter will take you through some of the theoretical aspects of identity, specifically identity in the context of work and also in the context of being part of a profession. The professions of nursing and midwifery can represent, through the work they do, all that is best about the NHS and society more broadly. Society places trust and an expectation on the people in these roles that they will be technically capable and proficient and equally able to deliver that technical capability in a kind and compassionate way. The profession holds something for the collective societal psyche so when tragedies occur, such as the appalling failings in care at Mid-Staffordshire NHS Trust, they undermine the trust that has been hard won and afforded by society and the best efforts of those committed to excellence in care delivery. 'Kindness is not a side issue, it is what we are about and it is what leadership is about' (Ballatt and Campling, 2011). Or as one nurse put it:

> '*The technical work of nursing is one thing, of course it can be emotionally difficult and demanding. Leading a team to maintain compassion in care is another matter… it's what I've signed up to do, it's what I will do… otherwise why bother? You've got to be technically up to the job and you've got to be emotionally literate, attuned.*' (Ward Sister, acute trust)

In this chapter we will address the notion of how we, and others, might see ourselves as nurses and midwives and specifically as leaders in those professions.

How to be a Nurse or Midwife Leader, First Edition.
Edited by David Ashton, Jamie Ripman and Philippa Williams.
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We will also explore something of what it means to be a professional. The following vignette refers to the aunt of the chapter author and illustrates the deep attachment of one person to her professional identity – the story of one individual that can be applied to many people.

Edie and the story of is/was.

Edie, my aunt, is/was a nurse. She had been a ward sister in what was termed a psychiatric hospital, in fact her mother had also been a sister at the same hospital and her father had been a charge nurse there. As a nurse I broke the mould a little, but only a little, I was a registered general nurse, my wife was a nurse and midwife and one of our daughters was a dental nurse… as you see, it runs in the family. A family tradition that isn't that uncommon in nursing or in fact other professions and occupations.

At the time of writing this, Edie was in a state of is/was being a nurse. Again, at the time of writing, she was 86 years old and had dementia. As many of you will know, this cruel disease, which gradually corrupts then wipes your memory, was little by little taking her away from herself and the people around her, at first disconnecting her personal and social constructs, then moving around and finally removing the pieces of her personal and social jigsaw. Yet her identity and recollections of her time working as a nurse are a common touching place in our conversations, somewhere where her memories are clear and still have meaning. The is/was comes into play because there are times when she knows she ***was*** *a ward sister, she recounts incidents both good and bad accurately, the level of detail and recall is accurate and focused. When ex-colleagues come to visit, she knows who they are and what they did. There are also times when she still* ***is*** *the ward sister, she talks as if she is on duty, at times referring to the other care home residents as her patients, admonishing the staff if she thinks they are late with meals and then praising them for something she has approved of. By and large people go with the* ***was*** *and* ***is*** *quite readily – it regulates everyone. I think there is something helpful about sharing common ground and looking through a window at a shared memory of what was and who she was.*

We, the family, fill her room with artefacts of her past, including a picture of Edie and her mother, my grandmother, resplendent in starched hats and cuffs, big silver buckles gleaming on blue belts – and to be frank looking pretty forbidding! She takes pride in this and refers to it often – it is a powerful connection to her mother and their shared identity. The very way they stand in the photograph speaks of their professional position and their pride in it. For my part, when Edie first arrived in the care home, I too was keen to make sure the staff knew she had been a nurse and had also cared for people with dementia.

The relevance of this story in the context of this book is that Edie's identity as a nurse still matters to her, it matters to the author and it matters as information to the staff and how they relate to Edie as someone in their care. Until recently, when her condition deteriorated, it mattered to some of the other residents as she tried to organise them in her role as 'ward sister'! Her state of is/was is a story of her identity and whilst there are other aspects to her personal construct, her identity as a nurse is hugely significant – it forms part of her psyche, the essence of who she is. There is often something very important to people, especially people whose role sits somewhere on a spectrum of a calling or vocation at one end and a transactional paid-for or waged task at the other. And, like Edie, it can be one of the most significant aspects of their personal construct. This nurse's description of going back to work after a career break captures the excitement of returning to her calling beautifully.

> '"*Nursing is the art of caring" – a tutor told me that when I first started my training and I've always treasured it. I'd had a break from nursing while my children were small, and was so excited to return to the bedside. I had missed the action, the passion and that great feeling of making a difference. The night before I could barely sleep – I was back to where I wanted to be. I couldn't wait to put my medal back on.*' (Unit Co-ordinator of a frail care unit, BUPA)

First impressions and identity

It's pretty common in a social setting for people to introduce themselves by their name, fairly obvious really, not to mention immensely helpful. However, the introduction is frequently followed by a question, particularly when meeting someone for the first time, and that question usually goes something like 'and so, what do you do?'. At one level this is a pleasantry, a show of interest to find out more about the person you have just met. There is also a deeper reason, a question behind the question if you like, something of which the questioner may not even be consciously aware. Why we do this is pretty complex but the reason can be that we need to place the other person somewhere in the social structure or, more specifically, somewhere in the social structure in relation to ourselves – it's a social anthropologist's field day!

> Make a note of this 'and so what do you do?' the next time you're in a social setting – try and gauge the other person's response and reactions, and just as importantly, note your own! Notice what you feel as well as what you think. If, like me, you're a people watcher, see how other people interact.

The reality is that our decisions about who the other person is generally start before any words are spoken at all. Depending on our senses, we might make an assessment of the other person's gender, ethnicity, sexuality, age, language or accent, their smell, their attractiveness, their clothing, mannerisms, etc.; a whole range of data is taken in and processed. Some of us more than others will then start to formulate judgements, make assumptions, position the individual by social grouping, putting them into one or more social categories. Our known, and also our unconscious, biases will kick in, arousing different types of emotion both positive and negative and whether the other person is more or less like us; are they part of our 'in-group' or do they belong to some other 'out-group'? Another reason the 'and so, what do you do?' question is asked is that the questioner is really more interested in telling you about themselves, their achievements, their status. They may, in fact, not be that interested in what *you* do; they aren't on receive; they are much more invested in telling you what *they* do. They are on transmit and seeking to impose their social standing, their level and sources of power, their ego. In effect, it's about superiority and privilege.

We know also that privilege, bias and discrimination can be barriers in colleague-to-colleague relationships that can have direct and negative effects on patient care. This has been increasingly evidenced by the work of Dawson (2009, 2014), Kline (2014) and West *et al*. (2011). The relevance here is that we need to understand our personal construct, to help us understand the perspective of others and how we can interact positively; we all have prejudices and biases. As mentioned previously, this applies to difference in relation to minority groups in their broadest sense and particularly to those who are visibly different from the majority. Black and minority ethnic (BME) colleagues and BME people receiving care can face more challenging barriers to their personal identity than those of the majority group. The adoption across the NHS of the Workforce Race Equality Standard (WRES) is testament to the amount that needs to be done to improve matters in relation to diversity and inclusion in the NHS. As this book is being written, the WRES is in its very early days and it will be crucially important for improved patient care that its adoption is supported by deeper organisational development work across the NHS if the care system is to become a place that is truly inclusive for staff and, importantly, for the people receiving care.

> If you haven't looked at it already, get a copy of Roger Kline's paper 'The "snowy white peaks" of the NHS'. It's well worth considering how this impacts you, or not. Discuss it with colleagues and think about your reaction to this as you continue your leadership journey.

Our attempts to work out our social fit also depend on context – it's one thing at a party, it would be different in the street and it is different again in a work setting and particularly so when that work setting involves the mental and physical health of others – what Strauss *et al.* (1982) referred to as 'sentimental work':

> '*Sentimental work is an ingredient in any kind of work where the object being worked on is alive, sentient, reacting an ingredient either because deemed necessary to get the work done effectively or because of humanistic considerations. Sentimental work has its source in the elementary fact that work done with or on human beings may have to take into account their responses to that instrumental work (as with medical work); indeed their responses may be a central feature of that work.*' (Strauss *et al.*, 1982, p. 254)

The point here is that definitions of what constitutes our work identity and a simple 'and so, what do you do?' are not simple at all. We need to understand these constructs as we develop as leaders – we may have spent many years training and honing our technical skills to be highly competent practitioners, a journey which will continue through our working lives. For some of us our professional identity will be a large part of our personal construct (Kelly, 1953) – it may in part define who we are in the world, it holds something of the essence of who we are and purport to be. At other times it is more background as other identities, or aspects of our identity, come to the fore.

There is a huge amount of literature and many schools of thought that explore the notion of self and identity in society; you may well have covered much of this during training and since qualification, particularly in relation to health and ill health. There is equally a large body of literature that covers the subject of self and identity in relation to work, both paid and unpaid. Much of this is beyond the remit of this book but it might be helpful to touch on a couple of definitions about self and identity in relation to work roles.

The author Ashforth (2001) suggests that we define our work roles and identity using two different perspectives, and although the terms and descriptions themselves seem at first sight to be complex, they provide a helpful lens through which to make sense of the differing approaches to identity at work.

- *Structural functionalism* – a theoretical approach stemming from the work of Emile Durkheim which suggests that we enact our role based on a whole range of socially constructed norms. This is particularly true for people in 'professional' roles where there is a historical identified norm – teachers, nurses, the police. As relationships with the recipients of 'care' change, along with the standing of professionals and the professions in society, this equilibrium of relationship is being challenged, and often rightly so.

- *Symbolic interactionism* – the basis of this is that roles are an emergent and negotiated understanding between individuals. This is based on Blumer (1969) and Mead's (1934) work and not dissimilar to the internal dialogue described from a psychological perspective by Kelly (1953) in personal construct theory. This approach acknowledges much more the subjective, interactive and fluid nature of co-created social and psychological relationships, the self being shaped by social interaction (Hogg and Vaughan, 2006, p. 116).

You might ask why these definitions matter. I would suggest that the first construct, structural functionalism, speaks to the historical past of how our profession is seen. As mentioned previously, this might be for better or worse. The second construct, symbolic interactionism, provides both opportunity and threat. We, the system, society, have an opportunity to generate a new identity – a co-created state. Where professionals and the people we are employed to work with, our patients and clients, negotiate our identities. Moving from a paternalistic model of care to one where openness and responsibility are shared.

Professional power and responsibility

It is also helpful to consider for a moment what we mean by a profession. Again, there are many definitions but here are a couple to play around with. First, Fish and Coles (1998) restated Friedson's definition of a profession as:

- *An occupation exercising 'good' in the service of another*
- *Specialised work in that it cannot entirely be understood by the layman*
- *Not measured by financial reward alone*
- *Ethically and morally based*
- *Having an esoteric and complex knowledge base*
- *Exercising discretion*
- *Dependent upon professional judgement.*

Or this by Miller *et al*. (2002, p. 26) who suggest that a profession has:

- *A high degree of self-regulation*
- *Activities founded on an abstract body of knowledge*
- *Entry to the profession controlled by qualification and certification*
- *A private language that serves both to unify the group and mystify others*
- *Claims of exclusive competence to carry out certain types of work*
- *A set of values, often made explicit in a code of ethics.*

It's worth noting that in these definitions there are some positive qualities as well as some that are much less flattering, particularly in relation to language and how it can be used to mystify others. A number of authors have written about differences in power and authority both within and between professions. In his writings about the sociological development of the medical profession, Friedson (1970, p. 72) noted that 'the work of one professional group overlaps, even competes with that of other occupations', and he goes on to comment that:

> '*A profession attains and maintains its position by virtue of the protection and patronage of some elite segment of society which is persuaded that there is some special value in its work. Its position is thus secured by the political and economic influence of the elite which sponsors it – an influence that drives competing occupations out of the same area of work, that discourages others by virtue of the competitive advantages conferred by the chosen occupation, and that requires still others to be subordinated to the profession.*' (Friedson, 1972, p. 72)

Lingard *et al*. (2003, p. 614) discuss this as a world-view held by one clinical group about another where clinical colleagues are described as 'others' and 'unreliable enemies' in the competition for authority and resources. Ferlie and Geraghty (2007) note this as a phenomenon across the UK public sector more generally.

> '*The relationship between professional groups is as important as that between professionals and managers. The public sector contains an extensive range of professional groupings. Dominant professionals typically seek to marginalise the jurisdictions of subordinate professions.*' (Ferlie and Geraghty, 2007, p. 426)

If you want to know more about this in relationship to 'the professions' in general, look up Eliot Friedson, who did much research and wrote extensively about the sociology of the professions, or Guggenbuhl-Craig (2015) who covers power in therapeutic relationships.

> As an exercise, talk to colleagues and, if you can, people who don't work in nursing or midwifery, and see what terms they would use to describe their profession – do they in fact actually view it as one?

There are challenges as you develop as a leader. First, how do you hold onto your credibility as a clinician, something probably very dear to your heart, as your leadership responsibilities increase? Second, does your very identity as

a nurse or midwife act as a boundary to your acceptance by other groups, including other professionals, and is it something that might in fact be a barrier to developments and improvements in patient care? These two quotes suggest these are points worthy of consideration.

> '*… a "supra-non-profession": that is, an occupation which has emerged from the ranks of the professionals, to run the profession from a managerial rather than a professional perspective. The irony, as we shall see, is that enhanced status is dependent on managerial rather than professional expertise.*' (Healy and Kraithman, 1996, p. 188)

> '*The problem is one of managing elites. Each profession tends to regard itself as an elite.Members look to their profession and to their peers to determine codes of behaviour and acceptable performance standards. They often disdain the values and evaluations of those outside their discipline … Most professionals are reluctant to subordinate themselves to others, or to support organisational goals not completely congruent with their special viewpoint.*' (Quinn *et al*., 1996, p. 11)

If these points are valid, and experience suggests that this can be the case, we have a responsibility to be mindful of this for our own practice as leaders and also the practice of others. Equally, rather than being suspicious of the motives of other groups, we need to maintain a curiosity and openness that allow the possibility of different approaches that encourage creativity and innovation – to paraphrase a well-known saying, 'no profession is an island'.

As a nurse or midwife, you are subject to a range of emotions – it's the nature and substance of the job, it's ever present in what we do. As you evolve as a leader, this will become more complex. As mentioned earlier, you will continue to evolve as a clinician, so too will you evolve as a leader. Diagrammatically, a typical career journey may go something like Figure 1.1.

One ward sister noted that:

> '*I sometimes get more anxious, nervous, when dealing with managerial issues. They can be more costly – you know I get physiological symptoms. One minute you have to pull someone up about a performance issue and the next minute you're asking them a favour, to work an extra shift or something. I have to do a lot of steeling inside.*' (Ward Sister, acute trust)

The notion of leadership, how best to lead and the tools and techniques of leadership will be constant themes throughout this book. It is also important to consider as an individual who you are as a nurse or midwife, your position not only within the profession but also society more broadly. I mentioned earlier that the meaning we make of work can sit somewhere on a continuum

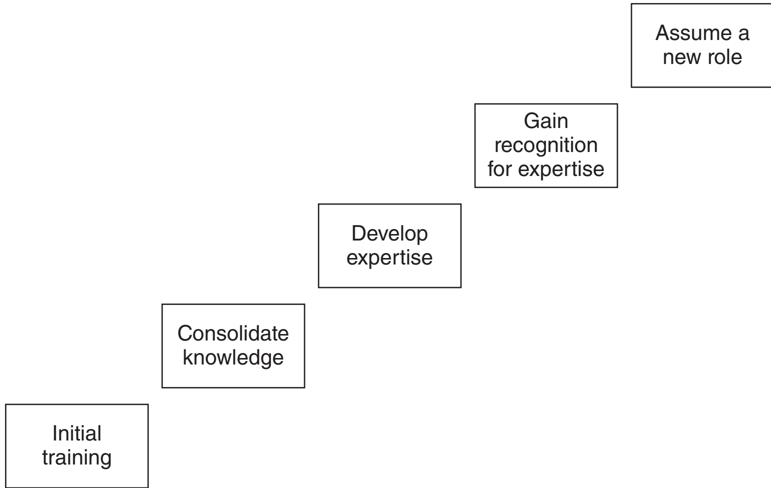

Figure 1.1 Role transition ladder.

between a calling or vocation and a paid-for or waged task. The reality is that at times it may feel like one thing and at others it will take on a different meaning in our lives as personal priorities change. We will look at this in two stages: first, we will explore what it means to be a professional and second, we will delve into personal identity and how the changes in your role might affect your identity.

The 'professions' have arguably come under an increasing level of scrutiny over recent years. No longer is it sufficient to say that the nurse, the doctor, the teacher, the solicitor knows best. That said, even in his 1906 play *The Doctor's Dilemma*, George Bernard Shaw castigated the professions as 'a conspiracy at the expense of the laity',

This at times rather messy interprofessional dynamic can be further compounded by what Lord Rose, in his review of leadership in the NHS, refers to as the 'balkanization of trusts and silo working'. In his words:

> '*There are currently 211 CCGs, 158 Acute Trusts, 10 Ambulance Trusts, 51 Mental Health Trusts and 31 Health and Care Trusts as part of the NHS federation as well as a myriad of other providers of care. The landscape of this federation has become fragmented in terms of both the numbers and activities of Trusts; within many Trusts silo working is endemic. This means that any activity within a Trust is horizontally separated from the same activity in other Trusts and vertically separated from other activities in its home Trust.*

> *The same is true for CCGs, where there is a need for greater local and regional collaboration. Yet collaboration is more difficult in an environment that has been designed to create competition. Better communication between Trusts and CCGs would help reduce fragmentation of the landscape. There are too many "city-states" and not enough cooperation between them.*' (Department of Health, 2015, pp. 42–43)

While it might seem that these system-level or interprofessional tangles belong elsewhere, their effect can be systemic and, more importantly, they can have an impact on day-to-day patient care. As someone in a leadership role or about to take on leadership responsibilities, it is important that you develop an understanding of the organisational and professional geographies around you. That way, you can better understand the context in which you work and also how to inform it in a positive way. As your career as a leader progresses, so too do the scope and breadth of your responsibility and accountability; this in turn can be matched by your levels of influence and authority. These latter two factors – influence and authority – can be utilised for good or ill to exert power and control. This is an emotive area and many will already recognise, and have experienced, the well-known phrase 'power corrupts; absolute power corrupts absolutely'.

> As someone nearing the end of their training, you should consider the increasing responsibilities you hold, and also how you will utilise the corresponding influence and authority this carries with it.
>
> Those who have been qualified for some time will be aware of the added tensions this can bring – some of these challenges and opportunities will be addressed later in this book.

It's worth considering for a moment how to acknowledge and access the different sources of power at your disposal; those that you have experienced and those that you have knowingly, or indeed unknowingly, exercised. There are many variations on the model used here to suggest sources of power but this list, taken from Pedler *et al.* (2003), is a helpful place to start. It is also worth considering these in relation to the leadership styles referred to in Chapter 4 to see if there is any crossover.

There are three types of position power.

- *Role power* – derives from your role and status and the perception that you have the right to exercise influence because of this. This kind of power is linked to the hierarchical structure of an organisation and defines the scope of your authority.

- *Coercive power* – is based on the use of fear. It depends upon other people thinking that you can punish them if they do not comply. Examples of this might include strong measures such as formal reprimands, the withdrawal of promotion or privileges, the allocation of unpleasant duties and even dismissal. But there are many highly effective and subtler forms of coercion such as disapproval, withdrawal of friendship, exclusion from key meetings.
- *Reward power* – the twin of coercion, the carrot to go with the stick. Reward power is based on the perception that you have the ability and resources to reward the compliant. There are many ways to reward people including praise, recognition, increased responsibilities and the granting of individual privileges. Pay or promotion or the allocation of 'desirable' work are other possibilities.

There are also three types of personal power.

- *Expert power* – based on your competence or special knowledge in a given area. Expert power is based on credibility, and the value attached to the particular field in which you can show competence.
- *Referent power* – based on the influence that comes from your personal attractiveness to others. It is the power which arises from your personal characteristics and charisma, your reputation, and the respect of others or esteem in which you are held.
- *Connection power* – derives from networks and relationships. This kind of power can be used to build political knowledge, gather information, gain personal support and feedback or build trust and alliances. This source of power is becoming ever more relevant in a networked workplace and through the increasing use of social media.

This isn't an exhaustive list and you could certainly alter the definitions somewhat. However, it illustrates the fact that power, influence and control can be used negatively as well as positively. It is within your gift as you develop as a leader to determine how you use them.

As an exercise, either with peers or with a supervisor, have a conversation about occasions when you have experienced the use/misuse of power. Think also about times when you might have avoided the use of your own power when it might have been more appropriate to exercise it.

As mentioned power can be a term that evokes a negative reaction - what other terms might you use?

Before finishing this section, I want to focus in particular on the use or, possibly from my observations, denial of two aspects of power mentioned above – the 'twins' of power *coercion* and *reward*.

Twins appear frequently in many cultures – Apollo and Artemis, Hypnos and Thanatos, Freya and Freyr. They are sometimes portrayed as the alter ego of each other, an aspect of the self that we might prefer to keep out of view, hidden or in the shadow, even out of our own view. So too in leadership and the life of work teams and organisations in general. Most of us will have come across the work of Carl Jung; Hede (2007) picks up on his writings and works with the notion of the shadow in exploring the negative side of emotions in work groups – this shadow or twin he calls the shadow self. The overt self is those characteristics and qualities which we are aware of and that we use to self-define ourselves and reveal to others. On the other hand, our shadow self is the part of our psyche that we do not readily recognise in ourselves and that we may project onto others.

- Our overt self – in our awareness
  - defines us to ourselves
  - reveals us to others
  - manages our interactions
- Our shadow self – out of awareness
  - opposite of overt self
  - qualities of our self that we do not accept.
  - projected on to others

The link to coercion and reward is of particular relevance to privilege and specifically how some people in society are more privileged than others – we need to seriously consider this as clinicians in relation to the patients we work with and particularly so as leaders. There is a great deal of evidence that describes how minority groups are excluded from certain privileges; we tend to privilege those who are like us. This may not be a conscious act but it exists – it often resides in our shadow self and leads to the creation of excluded individuals and groups and those who are included. Our society is a male-gendered hegemony – that is, men tend to hold positional power, role power in our earlier model, and the NHS is no exception to this (Beardwell and Holden, 1997).

As you evolve as a leader, part of your role will be to hold a line in relation to acceptable and unacceptable behaviours – someone once said that 'we judge ourselves by our intentions and we judge others by their actions or behaviours'. This clearly applies to activities that sit within the clinical realm of your practice; however, as importantly, your responsibility will increasingly become ever more salient in the managerially focused aspect of your leadership role. The gravitas and personal authority you portray will become more visible and an increasing part of who you are at work. If you work and live in a community setting, and are known by neighbours and your broader community, the 'segmentation' of work identity and non-work identity becomes ever more blurred; this is where the definitions of 'structural functionalism'

and 'symbolic interactionism' come into their own. Your 'professional self' and your 'personal' or 'private self' become ever more merged. This can be applied to anyone whose role is publicly visible in their community such as teachers, social workers and the police – community workers in the broadest sense of the term.

Roles and role transition

Does our role or job define who we are, or do we define our role or job? Maybe you view it as a vocation? One reality is that as our careers progress, particularly as clinicians and people who are paid to care, the expectations that others have of us will change. The expectations placed on you as someone in training will be very different from those placed on you as a qualified person. The moment you put on a different style of uniform and your name badge has a different title, you will be different – or will you? You're still pretty much the same you as you were the day before. What has changed, though, – other people's perception, be they patients or colleagues, and very probably our own perception.

In life, we have a whole range of roles beyond those that are work related. Some are defined by our position in our family: mother, son, sister, aunt, stepfather, etc. Others by our connection to social groups, for example political party member, netball team member, social class, ethnic group, and also our position within that social grouping, such as party leader, secretary, head chorister, alto, soprano, team captain, wing defence, wing attack, etc. So too at work we have formal job titles that denote our position and give us some level of formal authority or power. This collection of identities or self-images is referred to as our 'role set' (Katz and Khan, 1978). However, in a work setting we also occupy a host of other informal roles or duties; some of us may be seen as more nurturing of others, some as holding the organisation's or team's knowledge and history, some as holding the real source of power in the team. It's a key leadership skill to identify and work with the people whose names may not appear on an organisation's organogram, which links back to the earlier point about sources of personal and positional power.

An organogram is the pictorial representation of an organisation's structure, often set out in a hierarchical way. Take a look at your organisation or team structure and who holds what sort of power – you could compare this with who in reality impacts on your sphere of work and who doesn't appear on the chart. Lastly, consider where you might feature and how you use your sources of power.

Leadership, power and emotional work

> '*Emotion! Most of my work is dealing with staff problems, involved in dealing with people's emotion and the problems people have at work and at home. You have to do emotion work – it doesn't just apply to patients. But being emotional isn't all negative, you have to be in touch with the real world, sometimes it hurts but you shouldn't split it off.*' (Senior Sister, accident and emergency)

So to end this chapter, I will touch on leading in an emotional workspace. As our roles change and we become clinically more proficient, the potential for our standing as a leader increases; remember the links to sources of power. Leaders can be good and they can also be bad – the NHS has some excellent leaders at many levels and there are some examples of poor leadership too. However, a particular and unique responsibility is placed on those people who lead in a world where the very nature of the work is with sentient beings – there is an emotional aspect to what we do. This applies in many walks of life where the employee is paid to care; you can read more broadly about this in the seminal work of Arlie Hochschild, called *The Managed Heart*. In short, Hochschild made observations of people who were paid to 'care' and she coined the term 'emotional work', something she defined as follows.

> '*Emotional work is the effort we put into ensuring that our private feelings are suppressed or represented to be in tune with socially accepted norms – such as looking happy and enthusiastic at a friend's party, when we actually feel tired and bored. Emotional labour is the commercial exploitation of this principle; when an employee is in effect paid to smile, laugh, be polite, or be caring.*' (Hochschild, 1983, p. 7)

To paraphrase the NHS Constitution, 'when that work touches lives at times of basic human need, when care and compassion are what matter most', that work assumes a different level of gravitas. In a wonderful book by John Ballatt and Penelope Campling, they reframe the notion of work as the application of 'intelligent kindness', saying that:

> '*It is a binding, creative and problem-solving force that inspires and focusses the imagination and goodwill. It inspires and directs the attention and efforts of people and organisations towards building relationships with patients, recognising their needs and treating them well. Kindness is not a "nice" side issue in the project of competitive progress. It is the "glue" of cooperation required for such progress to be the most benefit to most people.*' (Ballatt and Campling, 2011, p. 16)

Finally, to go back to Edie for a moment, she wrote a piece in the final in-house magazine to be published on the closure of a psychiatric hospital she had worked at. Some of her thoughts and opinions may be of a different time and others may have a different view from her, but I believe some of her opinions have relevance for today. She believed in tolerance of others, she believed powerfully that those with a duty of care should practise professionally and knowledgeably. Above all, she felt that care wasn't something that existed solely in the domain of the 'professional' – it was a societal responsibility.

She wrote this when the hospital closed in 1989:

> '*I was one of our family's second generation at Broadgate [Hospital, nr Beverley in East Yorkshire]. My parents worked there as well as my brother and uncle.*
>
> *The closure of Broadgate is very sad, but we are now entering an exciting time for psychiatry. It remains to be seen whether society will give the care that has been promised. I realise nothing can remain at a standstill, but a nice hospital has gone. It was one of the better ones – in my view unique.*
>
> *I had 20 years* [working] *in acute psychiatry from 1950 to 1970 and feel that this was the period of biggest change. These were the years when they let us unlock the doors. I witnessed the introduction of psychiatric drugs which had a profound effect on the care of patients. Methods of treatment will always change but patients' problems never will.*
>
> *I am not altogether against community care but I hope the community can cope with the mentally ill. The basic needs are tolerance, knowledge and care. It doesn't matter whether these things are given within a hospital or in the community, as long as they are given.*'

Edie's mantra of tolerance, knowledge and care is as applicable to our roles as leaders as it is to our life working in a caring profession. We need the self-insight and acceptance to tolerate and understand difference and the views of others, we need to be knowledgeable and informed about the context and environment in which we operate and we need to care for others and ourselves.

> As a final closing exercise, try and find some time to write a piece that captures your reflections on this first chapter. Consider those concepts that have meaning for you, in particular those that you connected with in a positive way. And, as importantly, those which you found less helpful. I would suggest that those concepts, models and theories which might have seemed less helpful are often the ones you need to revisit over time.

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