Received: 4 November 2020 | Revised: 9 June 2022 | Accepted: 30 June 2022

DOI: 10.1111/1748-8583.12464

Human Resource Management Journal WILEY

RESEARCH ARTICLE

# Ownership power and managing a professional workforce: General practitioners and the employment of physician associates

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**Funding information**
Cornell Engaged Initiative

[Correction added on 8 August 2022, after first online publication: Author's affiliation has been updated in this version.]

## Abstract

The management of the professions has become increasingly challenging, reflecting the emergence of new work roles in professionalized workplaces. Human Resource Management (HRM) scholars have, however, been slow to study the professions, particularly how the power they derive from ownership interacts with other forms of power. This article explores the use of different forms of power by a profession, general practitioners (GPs), in engaging with a new healthcare role, the physician associate (PA). Despite policy support for the role, we find GPs' employment of the role in primary care is low. This is explained by two GP responses to the introduction of the role: employment denial and subordination. We theorize these responses as deriving from GPs' ownership power, enhancing their managerial and knowledge-based control over PAs. In doing so, we open-up a research avenue in the study of workforce management focused on professions' ownership power.

**KEYWORDS**
healthcare, ownership, professions, workforce innovation

**Abbreviations:** ANP, Advanced nurse practitioner; BMA, British medical association; GP, General practitioner; HR, Human resources; HRM, Human resource management; NHS, National Health Service; PA, Physician associate; PSF, Professional services firm; RCGP, Royal College of General Practitioners; SME, Small-and middle-sized enterprise; STP, Sustainability and transformation partnership.

### Practitioner notes

**What is currently known?**

- Authority from hierarchy and knowledge shape the management of professionals.
- Strategic Human Resource Management (HRM) emphasizes the importance of ownership in workforce management.

**What this paper adds?**

- Explains why general practitioners (GPs) have not widely employed a new professional role.
- Shows how GPs' ownership power enabled two control strategies: employment denial and subordination.
- Theorizes how ownership, management and knowledge interact in professionalized settings.

**Implications for practitioners:**

- Policymakers promoting workforce innovation and nascent professions must convince professional owner-managers of the business and professional benefits of a new role.
- Nascent professions may also seek ownership power through legal autonomy from superior professions to establish themselves.
- Professionals' ownership power may shape HRM in other professionalized settings too.

## 1 | INTRODUCTION

Social science disciplines have shown a longstanding research interest in the management of the professions. Although the Human Resource Management (HRM) literature has been slow to engage, professional work has generated debate in the field, particularly focusing on the HR profession (Currie et al., 2015; Sandholtz et al., 2019) and the professional services firm (PSF) as an organizational and managerial context for such work (Greenwood & Empson, 2003; Swart & Kinnie, 2013). The literature on professions has increasingly centered on the socio-political processes underpinning occupations' pursuit of professional status. These processes have rested on two forms of decision-making power: *managerial*, derived from administrative authority; and *knowledge-based*, rooted in theory-driven expertise (Freidson, 1970). Another form has gained less attention: decision-making power based on *ownership*. With the capacity to dispose of personal investments in an organization (Jensen & Meckling, 1976), ownership provides a *more authoritative and encompassing form of power* than managerial or knowledge-based power, not least in relation to workforce management.

The relative neglect of ownership in examining professional roles is surprising especially given the weight placed by various HRM scholars on this form of power as an influence on approaches to workforce management. For example, strategic HRM attaches importance to shareholder value, employee stock ownership and profit-sharing in shaping management attitudes and behaviors (Baron & Kreps, 1999), while an HRM research stream on management in small- and medium-sized enterprises (SMEs) emphasizes the role of owners in workforce decision-making (Edwards et al., 2006; Mayson & Barrett, 2006).

Our article brings this focus on ownership power to the study of the professions by examining how General Practitioners (GP) dealt with the emergence of a new medical role in England: the physician associate (PA). Despite public policy support, the PA role has gained little traction in GP practices, being found mostly in hospitals (Department of Health, 2017). In seeking to resolve this puzzle, we found that the power GPs derive from owning their organizations, typically small professional partnerships, allows them to deploy two forms of control: denying employment to or subordinating the PA role. This article contributes to the study of HRM in a distinctive sub-set of professionalized workplaces—small practice-based partnerships involving accountants, architects, solicitors, and surveyors—conceptualizing and analyzing how ownership power interacts with managerial and knowledge-based power as a

new work role emerges. In doing so, we open-up research into the power that ownership provides in managing professionalized settings.

The article comprises four parts: theoretical approaches to the management of professions; methodology; research findings; and discussion, including implications for studying the management of professionals.

## 2 | PROFESSIONS AND POWER

Research on the development and management of the professions has shifted from a concern with professions' traits and communal worth (Goode, 1957; Parsons, 1954) to exploring professional status as a contested process pursued by occupations seeking labor market privilege (Freidson, 1970; Larson, 1977). This research has concentrated on the power available to competing occupations in furthering their professional claims, typically conceptualized as assuming two forms: *managerial and knowledge based*. A third form of power derived from organizational *ownership* has often been overlooked. This section explores how scholars have used these forms of power to study the management of professionals, especially regarding the emergence of a nascent profession.

### 2.1 | Management

Managerial power rests on administrative seniority in an organization, generating the capacity to make strategic and operational decisions. In exploring the professionalization of the HR specialist, the HRM literature has given weight to this form of power noting that weak claims to senior management status have often undermined professional credibility. Jurisdictional entrenchment has resulted in HR specialists performing relatively mundane operational tasks (Sandholtz et al., 2019), disconnecting them from the organization's strategic management narrative (Roper & Higgins, 2020).

Other occupations have more successfully secured managerial power. Professionals taking up hybrid roles have enhanced their status by moving into senior management positions. Kirkpatrick et al. (2011) note how doctors in Danish hospitals colonized senior management positions to this end. Others highlight how professionals in senior management have consolidated their status by brokering close relations with frontline workers (Currie et al., 2015) and developing solutions to organizational challenges (Burgess & Currie, 2013).

The search for managerial power to advance status is not without its dangers for the professions. Scholars have highlighted tensions between the institutional logics of professionalism and managerialism (Reay & Hinings, 2009): the former founded on optimal service provision through technical expertise; the latter on discrete outcomes such as profit maximization through cost-efficient use of resources. These tensions are especially manifest in large professional services firms (PSFs). Studies have suggested professionals can elude the human resource systems used to tightly manage their performance (Alvehus, 2018; Faulconbridge & Muzio, 2008). Others, however, have noted the reliance of PSFs on corporate patronage commodifies service provision, corroding the traditional discretion characterizing professional work (Empson et al., 2013; Hanlon, 1998; Muzio et al., 2020).

### 2.2 | Knowledge

Knowledge-based power derives from an occupation's decision-making authority rooted in claims to expertise, for the profession grounded in a body of theory (Freidson, 1970). Johnson (1972) notes that knowledge-based superiority allows a profession to control aspects of service delivery through, for example, the exclusive performance of specialist tasks like *diagnosis*.

The sociology of professions concentrates on processes by which occupations *pursue* their knowledge claims. Such claims are *established* through mandate, license and forms of closure involving various societal actors (Freidson, 1970; Hughes, 1958; Larson, 1977). They have also served to *protect* claims from management control and from occupations keen to usurp tasks and responsibilities (Abbott, 1988). Playing out at the workplace through the 'negotiation of order' (Strauss et al., 1981) or 'institutional work' (Suddaby & Viale, 2011), such safe-guarding professional status has typically relied on maintaining the 'purity' of knowledge-based expertise by divesting 'dangerously' routine tasks to new roles (Abbott, 1988). Physicians in Canada, for example, delegated routine tasks, such as patient health education, to a new nurse practitioner role (Reay et al., 2006), while registered nurses in England transferred basic care tasks, as they deepened their clinical skills (Kessler et al., 2015). In delegating routine tasks while retaining their core expertise, professionals prevent their roles from being 'substituted' entirely by lower-skilled workers (Currie et al., 2009).

## 2.3 | Ownership

Organizational ownership provides occupations with a third source of power to pursue professional status. As an analytical construct, ownership power has received limited attention as a means of regulating the *professionalized* workforce. This is not to detract from streams of research in HRM and other fields, focused on the relationship between ownership and management power. A longstanding research interest has concentrated on the organizational consequences of the *separation* of ownership and managerial control in large corporations (Berle & Means, 1933). While the owners (principals) of such corporations retain the right to returns on their investments, they hire managers (agents) to control strategic and operational decision-making (Jensen & Meckling, 1976). This results in owners aligning agents' activities with their interests through different compensation and budgetary systems (Baron & Kreps, 1999). For example, in PSFs, these include the financial 'lure' of partnership (Greenwood & Empson, 2003) for senior, professional staff instead of tenure-based rewards for junior staff (Swart & Kinnie, 2013).

A second research stream on workforce management in SMEs presents ownership and management as less sharply separated. In contrast to the PSF, the SME owner is not a professional, and smaller organizational size allows the SME owner to fulfil both strategic—e.g., determining organizational structures—and operational administrative functions—e.g., hiring staff—according to their preferences (Jensen & Meckling, 1976). The SME owner-manager can adopt a range of competitive and workforce strategies sensitive to product and labor market context (Bryson & White, 2019; Edwards et al., 2006; Mayson & Barrett, 2006).

The close relationship between ownership and management control in the SME resonates with organizational arrangements underpinning longstanding forms of professional work. Johnson (1972: 84) presents the traditional professional as an 'independent solo practitioner', but noting that as professions embed themselves in large bureaucracies, they put this independence at risk. Thus, alongside the possible erosion of professional discretion in global PSFs, professionals working in public service settings are also vulnerable to state direction and a dilution of autonomy.

## 2.4 | Theoretical framework

The three forms of power presented as underpinning the establishment and protection of professional interests are distinct, resting on differences in the scope and nature of decision-making:

- ***Managerial power***, founded on administrative seniority, with the capacity to direct and dispose of labor in daily work processes.
- ***Knowledge-based power***, derived from expertise which ensures occupations' control over the performance of work tasks.

- ***Ownership power***, allowing for authoritative organizational decision-making on strategic direction, but also for choices on the delegation of operational issues.

Simultaneously, we have seen that the HRM and broader organizational studies literature brings to the fore intersections between these forms of power. Figure 1 below highlights these intersections, manifest in different socio-economic positions: the professional-manager ('hybrid managers'), exemplified in the physician manager; the owner-manager, most obviously found in SMEs; and the professional-owner, apparent in the PSF senior partners. Less attention has been devoted to the professional owner-manager, a role which connects ownership with the managerial and knowledge-based power.

The professional owner-manager in the guise of the independent practitioner is still common amongst established professions. In healthcare, the GP as an independent small business-owner, contracting with the state, has continued to underpin primary care in the NHS in Britain since the late 1940s (Klein, 2013). We take the case of the GP to explore how ownership, combined with management and knowledge, have been used to respond to the emergence of a new clinical work role in healthcare.

## 2.5 | The professional owner–manager in healthcare

Professionals' use of ownership along with managerial and knowledge-based power has underpinned various healthcare studies examining responses to nascent professional roles. Kitchener and Mertz (2012) and McMurray (2011) track how new occupations—dental hygienists and advanced nurse practitioners (ANP)—have furthered their status by forming small businesses and becoming owner-managers with the capacity to challenge established professions' job territories, respectively dentists and GPs. Drennan et al. (2017: 13) also point to ownership status as a prism through which GPs view the new PA role, distinguishing self-employed GP responses from hospital doctors working as NHS employees. Noting, 'The GPs were clinician-managers or more accurately clinician-business owners', the authors employ this perspective to explain why GPs 'described staffing decisions in terms of cost efficiency' (ibid.).

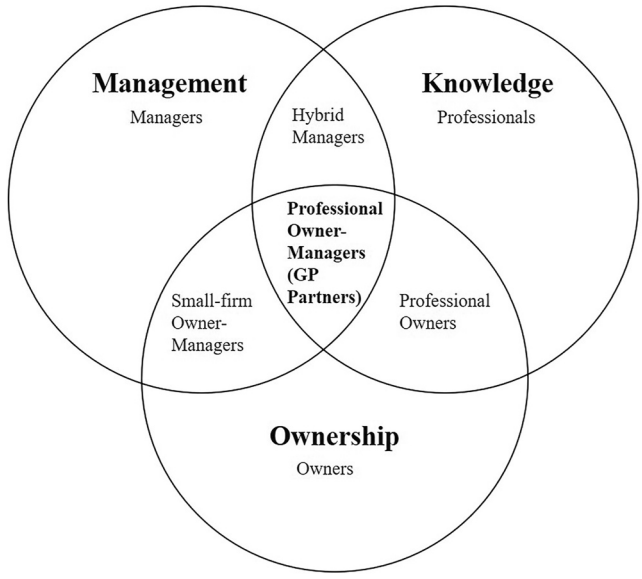


FIGURE 1 Actors and intersecting sources of power

These three studies highlight the ways in which professions draw upon ownership power, often in combination with other forms of power, in competing for or maintaining status. They suggest the significance of established policy and practice at different societal levels in informing, facilitating and constraining the use of ownership power in professionalized contexts. Yet they leave open various issues for further consideration.

Kitchener and Mertz (2012) and McMurray (2011) explore tensions between established and aspirant professions where the latter group can acquire a legal mandate to achieve ownership and independent practice status. However, these studies are not positioned to consider how such tensions play out where an aspirant profession is unable to secure an ownership mandate to increase its status.

Drennan et al. (2017) draw upon GP ownership status in explaining a shared view of the PA role in terms of cost efficiencies, distinguishing it from other occupations' views on PAs. However, such an approach side-steps questions related to whether and why views on a new role might vary ***within*** segments of the medical profession, for example, GPs.

More significantly, the interaction between *ownership and managerial control* in exploring the management of professionalized workplaces remains understated in these studies. Kitchener and Mertz (2012) and McMurray (2011) are unable to capture the distinction between ownership and management: with their professions practicing independently as owners, there is no need for them to exercise management control over other professions. Drennan et al. (2017) deal with this issue but risk collapsing the distinction between managerial and ownership power in viewing the term 'clinician-business owner' as only a 'more accurate' description of GP status than 'clinician-manager'.

In this article, we examine why and how an established profession, the GP, harnesses ownership with managerial and knowledge-based power, to engage with a nascent professional role, the PA. Drawing on Figure 1 above, we refer to GPs as 'professional owner-managers', signaling an appreciation of distinctive sources of power, but acknowledging their interaction in dealing with a new workplace role.

## 3 | METHODOLOGY

Introduced as an NHS pilot in 2004 and inspired by the established 'physician assistant' role in the USA, PAs are medical practitioners who following a biomedical science degree, have acquired a 2-year graduate qualification, including placements in acute and primary care settings. PAs pass a national qualifying exam, satisfying competencies established in a 2006 national framework. Un-like nurse practitioners, whose training is clinical, PAs are trained in the medical model of healthcare practice. Since September 2015, a dedicated Faculty in the Royal College of Physicians has overseen PA training and maintained a register (Faculty of PAs, 2018). The government has raised the possibility of statutory PA registration with a professional body, widely supported in a consultation exercise (DHSC, 2019), but by early 2022, not yet implemented. Indeed, despite these nascent professional 'trappings', PAs are 'dependent practitioners', working under the supervision of a qualified doctor in taking medical histories and developing treatment plans. They remain unable to perform certain tasks including prescribing medication or ordering x-rays.

In primary care, qualified PAs function alongside GPs, who work as self-employed partners of their own practice or as salaried employees and value their autonomy (Currie et al., 2012). While the proportion of GPs becoming partners reduced between 2015 and 2019 potentially due to rising workloads, by December 2019, most GPs were partners, with 63% of all qualified permanent GPs being partners and 31% and 5% being salaried and locum GPs (in full-time equivalents), respectively (Figure 2). GPs are the first stop for most patients, functioning as gatekeepers for referrals into secondary care. They have therefore traditionally claimed holistic care provision for the full spectrum of patients in a locality, relying on nurses in a limited way to do routine reviews such as of chronic conditions (McMurray, 2011). GPs are not formally part of the NHS but directly or through the British Medical Association (BMA)—the professional body for doctors—negotiate multi-year contracts with local commissioning bodies or centrally with the NHS. While GPs, therefore, depend on a single service commissioner, they typically own and operate their organization, retaining

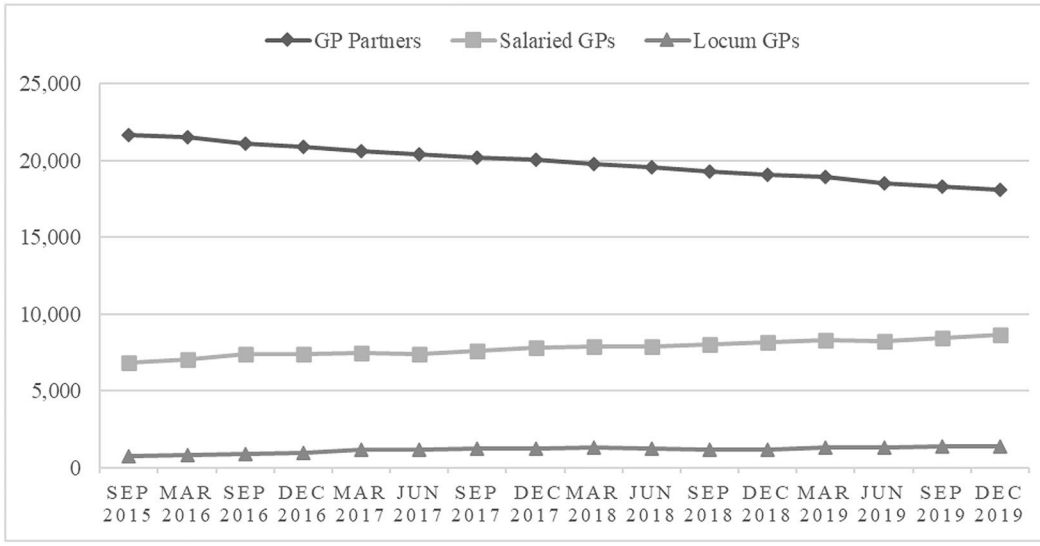


**FIGURE 2** Number of qualified general practitioners by type 2015–2019. *Source*: NHS Digital General Practice Workforce Report—31 March 2020. General practitioner (GP) numbers by type in full-time equivalents (37.5 h per week).

independence from the Service. Performance management systems continue to regulate this independence, with differences in GP care outcomes reflecting their independence (NHS England, 2016).

In exploring PAs' employment in GP practices, we chose an inductive methodology (Corbin & Strauss, 1998). Given uncertainty about patterns of PA employment and GP engagement with the new role, such a methodology allowed actor views to emerge in an unconstrained way. In the main between February and September 2019, we undertook three types of research activity. First, we assessed 49 policy documents covering workforce issues in primary care and focusing on development of the PA role. This provided the policy context for the emergence of the role, along with the systems and discourses influencing workplace actors.

Second, we engaged in informal discussion with innovative policymakers in London. They directed us to actors engaged with the PA role, and to a particular Sustainability and Transformation Partnership (STP) in London (henceforth 'London STP') promoting PAs with its GPs. STPs are non-statutory, strategic collaborations of healthcare organizations in a locality, with our STP covering health and social care commissioning for several boroughs with a combined population of around two million. It was the proactiveness of London STP in seeking to promote the PA role that encouraged us to select it as a case. The STP had established a PA working group comprising mainly GPs. We attended four meetings over the research period which, together with informal interaction, comprised 15 h of fieldwork.

Third, we completed an initial program of 20 semi-structured interviews with GP partners, PAs, and relevant stakeholders from London STP's region. We triangulated their different perspectives, increasing the validity of our findings (Patton, 1999) and helping us understand the conditions under which practices employed PAs. We purposively sampled interviewees, including respondents with considerable experience in primary care, involvement in promoting the role professionally and/or representing the medical profession. Between mid-September and mid-October 2021we conducted six additional interviews to validate our framework, especially in the context of unexpected developments such as COVID-19. While our initial interviews drew on a broad range of actors, these follow-up interviews exclusively focused on workplace figures: two GPs with PAs, one without, and three PAs. Averaging 45 min, all interviews were audio-recorded and transcribed. Table 1 below presents details on the full complement of 26 interviewees.

TABLE 1 Interview participants

| Participant role | Number of interviews | Level of participant's perspective |
|---|---|---|
| 2019 Interview participants | | |
| GP partners employing PAs | 3 | Practice |
| Practice manager employing PAs | 1 | Practice |
| PAs currently practicing in primary care | 2 | Practice and PA training |
| GP partner hosting but not employing PAs | 1 | Practice |
| GP partner not employing PAs | 1 | Practice |
| GP partner not employing PAs, local GP professional representative | 1 | Practice and local policy |
| GP federation representatives promoting PAs | 2 | Local workforce development |
| Hospital trust manager responsible for workforce innovation (including PAs) | 1 | Trust-level workforce development |
| STP representatives responsible for workforce innovation (including PAs) | 2 | Regional workforce development and policy |
| London-wide policymakers responsible for workforce innovation (including PAs) | 3 | London workforce development and policy |
| London-wide doctors' professional representative | 1 | London doctors' profession trends and policies |
| National PA professional representative | 1 | National PA profession trends and policies |
| National policymaker responsible for workforce innovation (including PAs) | 1 | National workforce development and policy |
| 2021 Interview participants | | |
| GP partners employing PAs | 2 | Practice |
| GP partner not employing PA in practice but considering to employ in primary care network | 1 | Practice and local policy |
| PAs currently practicing in primary care | 2 | Practice and PA training |
| PA currently practicing in primary care and assuming PA ambassador role | 1 | Practice, PA training and local policy |

We analyzed these data through iterative, line-by-line coding (Corbin & Strauss, 1998). We generated first-order codes from existing medical literature that attempted to identify the barriers and enablers of employing PAs (Drennan et al., 2015, 2017; Jackson et al., 2017). Then, we sorted these into whether they were organizational or professional. This early scheme guided our first round of data analysis, which yielded 21 new first-order codes and changed three codes. Then, we abstracted these codes' underlying themes into eight second-order categories and finally, associated these categories with two professional control strategies. Figure 3 summarizes this data analysis process.

## 4 | FINDINGS

This section first discusses the policy context of the PA role, with subsequent parts outlining GPs' different approaches to the role, derived from GPs' authority as professional owner-managers: employment denial and subordination.

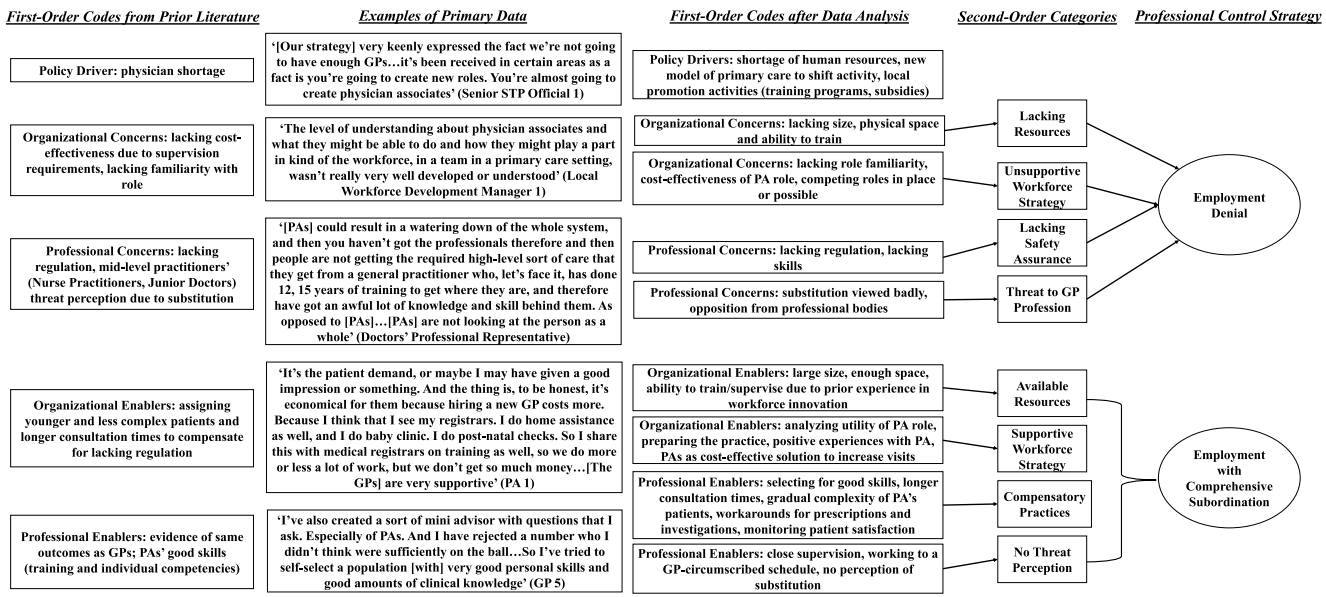


**FIGURE 3** Data structure

## 4.1 | Policy context

The policy context comprised several features. The first was a largely supportive discourse for the PA role, amongst national policymakers. NHS England's (2016) GP strategy targeted employment of 1000 new PAs in GP practices by 2020/21, underpinned by financial support for training, while the NHS Interim People Plan characterized the PA as becoming 'an indispensable part of our primary and acute care teams' (2019:43). The Royal College of GPs (RCGP, 2017, p. 1) expressed: 'Commitment to working with governments across the UK…to ensure that [PAs] in general practice were safely and effectively integrated into the multi-disciplinary team'. The medical profession's concerns about the PA role, nonetheless, tempered this positive discourse. A warning that PAs should be 'complementary to GPs rather than a substitute' for them informed the RCGP's support. The BMA's response in May 2019 warned the role might impinge on junior doctors' training.

These professional concerns reflected a second feature of the policy context: pressures on GP workforce supply. With a fall of 1000 GPs since 2015, the government committed to employing 5000 more by 2020 (NHS England, 2016). However, the King's Fund (2019) policy think tank calculated a 7000 shortfall in GPs by 2023-24, only likely filled by other occupations' skills.

A third contextual feature deepened pressure on workforce supply: the increasing demand for primary care services, as policymakers pursued a shift from in- to out-of-hospital care (Monitor, 2015). Underpinning this shift was the provision of more GP services and the need for a more sophisticated primary care workforce, with new roles such as the care coordinator and social prescriber (NHS England, 2016). As an STP manager noted: 'The GP is going to be the conductor of the orchestra, and we're going to have pharmacists, [PAs], and also the traditional roles of nurses, but also physios in that kind of general practice' (Senior STP Official 1).

This national policy context informed London STP initiatives designed to encourage GPs' employment of PAs. A multi-year plan included a steering committee to promote PAs in primary care and commission customized PA training. Recruitment fairs were held for qualifying PAs and potential GP employers. Funds were disbursed to primary care networks—consortia designed to provide shared administrative services—for 6 months' employment in GP practices. Local Community Education Provider Networks, facilitating the delivery of primary care workforce development, were tasked with promoting the role and offering it ongoing training.

Despite the supportive nature of the policy context, GPs in London STP, and indeed nationally, employed relatively few PAs. According to the PA Faculty's (2018) census survey, of around 2000 PA students and qualified PAs in the UK in mid-2019, only 28% reported working in primary care. Moreover, statistical analysis revealed a head count of 213 PAs in 6900 practices in England as of June 2019 (Spooner et al., 2020). London STP policymakers estimated only a dozen PAs were working in primary care in their region by September 2020, seven of whom had started working in early 2019 from an STP-funded training cohort of 21.

## 4.2 | Control strategies

Drawing upon our interviews in London STP, we found low PA employment was related to two generic control strategies: employment denial and subordination. Shown below in Figure 4, these control strategies derived from the interaction of GP power and interests along two dimensions:

- ***The hierarchical dimension*** conjoins ownership and managerial power, acknowledging their close relationship in GP engagement with the PA. Whilst bringing distinctive properties to this engagement, these forms of power share an interest in organizational efficiency, with both relying for their authority on an elevated organizational position. Ownership power manifests in issues of service and workforce strategy and their intimate connection between such strategies and GP practice resource and capacity required to realize strategies; once determined, GPs use their managerial power to implement strategies.

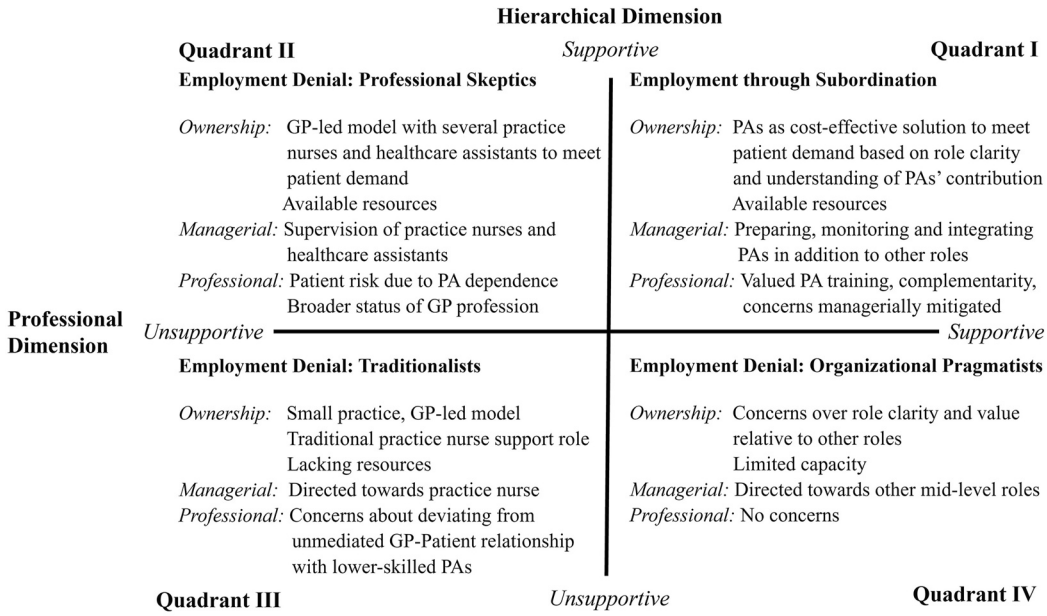


**FIGURE 4** General practitioner (GP) responses to physician associate (PA) employment

- ***The professional dimension recognizes*** the scope for GPs to mobilize their knowledge-based power to support or oppose the PA based on an assessment of whether the role is perceived to challenge self-seeking occupational interests and/or to protect care quality standards.

### 4.2.1 | Employment denial

As depicted in Figure 4, our interview data allowed us to distinguish three forms of denial: 'Traditionalist', 'Organizational Pragmatist' and 'Professional Skeptic'. These GP response types represent different configurations of support and resistance along the hierarchical and professional dimensions of our framework. The narrative of denial reflects a nuanced dynamic, whereby the lack of support along either the hierarchical or professional dimension proves critical in triggering the decision to bar the PA (along with lacking support on both dimensions).

#### *Traditionalist*

We found the most categorical form of employment denial in the 'Traditionalist' GP with the PA role lacking support along both hierarchical and professional dimensions (Quadrant III, Figure 4).

In hierarchical terms, the Traditionalist GP, typically owning a small practice, was wedded to a conservative service delivery strategy, opposed to the newer, larger care models, and committed to long-established personal relationships with patients. This care strategy mitigated against the introduction of new roles that might disturb the unmediated GP-patient-relationship.

> "[Patients] should always see their own named doctor and have a relationship over years…Anything that changes that model can seem like a threat…[There's] a nostalgic feeling of how general practice used to be and how it should always be and that's the gold standard" (GP 1, 2019).

Indeed, Traditionalists lacked sophisticated workforce plans. They relied on a practice nurse for their clinical support, with the exercise of any managerial power directed towards supervising this postholder. More prosaically as the owner of a small practice, the Traditionalist lacked the resources and space to employ a PA. Indeed, in handling all clinical and administrative work, this GP was often short-of-time to supervise or train other healthcare practitioners:

> "Across the country, general practice is on its knees and doesn't have enough people to supervise…it's sometimes challenged and limited by resource…with time, people to teach, the physical building size and space" (PA Professional Representative).

### *Organizational Pragmatist*

Employment denial was at its most fragile in the case of the 'Organizational Pragmatist'. Given support for innovative care delivery, including professional support for the PA role in principle, employment denial derived from an absence of hierarchal support (Quadrant IV, Figure 4).

While owning larger practices and employing other mid-level roles, the Organizational Pragmatist was uncertain about the PA's scope of practice and contribution to care delivery:

> "The PA is still so new, employers don't really know what we can do" (PA 2, 2021).

In developing a workforce strategy, this lack of certainty about the PA's contribution created difficulties in calculating the role's cost-effectiveness and long-term business impact:

> "[You must] make sure you've got the right member of staff in place, and then the other thing that can manipulate cost as well: how significant are they in impacting our practice?" (GP 2, 2019).

The availability of other mid-level roles, including physiotherapists, pharmacists and GP trainees, fueled GP uncertainty of PAs' relative worth. Indeed, where other roles were employed, managerial power was directed to their efficient use. For example, one GP argued the added training cost of a GP trainee at the practice meant employing a part-time GP instead of a PA was more cost-effective:

> "It's not entirely about service provision. It has to be [about] training…At this point, for the money that we're going to spend, we would get a GP for four sessions, which is better value, and in view also of the fact that we are having a trainee whom we have to support" (GP 3, 2019).

These hierarchical doubts stymied the Pragmatist's professional support of PAs:

> "[PAs] can have tremendous benefit to the practice, but we need to be mindful of their requirements in terms of training and supervision." (GP 1, 2021).

However, with underlying professional support, this approach could shift if hierarchical concerns were addressed:

> "Our concern would be the balance of supervision time from our GPs at the moment and blocking people out to supervise. And whether benefit is added, and whether they're able to take on the broad range of things that GPs can" (GP 2, 2021).

*Professional Skeptic*

The 'Professional Skeptic' represented employment denial based predominantly on professional concerns. While this GP had the hierarchical leverage to employ the PA, worries about the threat posed by PAs to GPs' professional values and status trumped any inclination to employ one (Quadrant II, Figure 4).

In hierarchical terms, Professional Skeptics owned large practices, and employed and supervised several practice nurses and healthcare assistants, suggesting their general capacity to employ PAs. Furthermore, they did not voice hierarchical concerns regarding PAs.

Instead, the Skeptic primarily voiced professional concerns as a basis for employment denial, viewing PAs as a potential threat to patient safety and their status.

Partly, these GPs felt the need to minimize patient risk, possibly raised by the employment of the less qualified PA:

> "[Employing a PA] needs a lot of careful thought because clearly, you don't want patients who are ill and need something picked up and referred to a hospital, you don't want to miss those" (Senior Trust Manager).

Despite their capabilities, this risk was seen as rooted in PAs' status as dependent practitioners, not fully accountable and responsible for their practice, and therefore lacking the professional hallmark of autonomous practice:

> "[PAs] are clinically very well-trained individuals…but they can't prescribe. So you can't let them do clinics independently" (GP 2, 2019).

A second professional concern was possible substitution of the GP profession through PAs, with implications for GPs' broader status:

> "We've had a few GPs who've felt…'Is this role being introduced to replace the GPs?'…[with] the government trying to look for the cheaper option and then get the same outcome" (Training Hub Manager).

This absence of professional support was also manifest in professional bodies' unclear position-taking: over 15 years after the introduction of the role, the London-wide Local Medical Committee—representing NHS GPs in the locality—had still not formulated a position on PAs:

> 'The London LMC…are very vague and they will then gather feedback through roadshows and develop a position then' (Senior STP Official 2).

### 4.2.2 | Subordinated employment

The second main GP control strategy to emerge from our interviews —employment with subordination (Quadrant I, Figure 4)—represents a singular combination of support for the PA along both the hierarchical and professional dimensions. With available resources and a strategic understanding of the role's value, these GPs allayed professional concerns with control systems derived from GPs' managerial power.

More specifically, ***along the hierarchical dimension***, and in common with Organizational Pragmatists, these employing GPs owned larger practices with the space for a PA to run clinics or use their facilities flexibly by allowing

PAs to use offices vacated by practitioners not on duty. Moreover, such GPs also pursued innovative service delivery that increased capacity to supervise and train:

> "We have telephone appointments…[which] opens up a bit of extra capacity, because you can do more telephone consultations than you can face-to-face ones…the second component we introduced…is an online platform. We now have quite a significant portion of that initial contact come from patients who've emailed us" (GP 4, 2019).

They also had experience in workforce innovation with other healthcare practitioners, hosting GP trainees or 'recruiting a pharmacist or potentially recruiting a social prescriber' (Senior Regional Policymaker).

Un-like Organizational Pragmatists, however, employing GPs had a strategic understanding of PAs' contribution to care delivery derived from having developed a business case for the role and analyzed the practice's service and skills mix requirements. For example, a management consultancy specializing in PA recruitment had assisted one practice to accommodate the role. Another managed its workforce through regular staff consultations, including on the use of PAs. A third practice had applied to join a PA pilot program, prompting policies on workforce and supervision planning.

These considered approaches established PAs as a cost-effective, accessible solution to the increasing number of patient visits:

> "The argument in favor is…that [PAs are] cheaper than doctors…and in many ways potentially more available…whereas GPs are very much at a premium" (GP 1, 2021).

While a certain patient list size was necessary to finance the transition to employing a PA, the fact that PAs received half of GP pay encouraged these practices to view PAs as a cost-effective way to increase their list size:

> "The cost [of the PA] was affordable on the basis of a five-year contract with [the PA]…I was going to save money. I was going to get rid of half the GPs" (Practice Manager).

Along ***the professional dimension*** and unlike Traditionalists and Professional Skeptics, employing GPs did not have fundamental professional concerns about PAs. They viewed the nature of PA training positively, as according more to a medical model than the training received by other clinical support roles such as the ANP. This close PA adherence to the medical model might well have prompted GP fears of substitution but for employing GPs, it instead allowed them to envisage the value of the role:

> "[PAs] are trained broadly on the medical principles, so they have the potential to best emulate what a general practitioner does. So, the scope of patients that they can see is quite broad, so that would potentially be quite helpful" (GP 3, 2021).

The value also consisted of viewing PAs' work as complementary, to meet the physician shortage and reduce GP workloads:

> "We were helping GPs think about how they could use [PAs] to relieve some of the kind of pressure in the GP system so that, actually, [PAs] were taking some of that workload from a GP" (Senior Manager GP Federation).

Over time, the experience of employing a PA also stimulated a more grounded GP appreciation of the role's contribution:

> "[The PA] left after some time [but] when we analyzed what she could do and how we'd integrate her into the practice, we realized that we could improve things…we set about recruiting another one with this improved program, and we haven't really looked back" (GP 5, 2019).

The absence of fundamental professional concerns about the PA does not, however, detract from the perceived need for initial caution, particularly in safeguarding patient safety. The GP-as-manager addressed this residual caution by their ability to regulate the PA role through the introduction of various managerial control systems and routines:

- ***Preparing***

GPs prepared for PAs using recruitment templates to judge capable candidates. They also gradually introduced the PA into their team, the PA initially shadowing GPs and being allocated 'less complicated' cases:

> "We were initially a bit cautious. [The PA] still doesn't see pregnant women. With children, we make sure that the supervisor's involved in reviewing the patient. But [the PA] sees a broad section of patients…[The PA's] been quite good at picking up on some of the long-term conditions as well" (GP 4, 2019).

With such preparation the GP could gauge PA competence, in time reducing supervision. As a PA noted in 2019:

> "Now [the GPs] feel I do not need too much supervision. I run my clinic even though I am still unable to prescribe…[GPs] are happy to [assign a patient to me] because I've been here a long time. So they do trust me".

- ***Monitoring***

GPs monitored PA performance tightly, while using patient satisfaction surveys to pick-up safety concerns:

> "No one's ever complained. Actually, the patients loved [PAs] because they got longer appointment times and they're usually very thorough…Patients always give them glowing feedback" (GP 6, 2019).

Supervision allowed GPs to control PAs' scope of practice. In the first month of employment, PAs typically discussed their management plans either directly after seeing a patient or at the end of the day. Thereafter, PAs sought out their supervisors when needed. In four GP practices, a designated GP with a lower workload supervised PAs for the day.

The performance of core physician tasks was often monitored through the development of workaround routines, procedures allowing the PA to take forward a task but requiring final GP sign-off for completion. For example, in one practice, PA engagement with the prescribing process was monitored in this way. As the practice PA noted:

> "[The NHS has] a system called 'electronic prescribing service'…I have the prescription form written out on the computer, and I'll just send a screen message to my supervisor, who will look at it, approve it, and send it straight to the pharmacy…that's very effective [and] overcomes that issue of PAs not being able to prescribe" (PA 2, 2019).

The same PA outlined another workaround by pre-filling forms for GP supervisors to order x-rays and ultrasounds.

- ***Integrating***

GPs had developed systems to safely integrate PAs into routine practice. Four GP practices had established telephone triaging arrangements, with GPs calling back all patients to assess whether they needed an appointment or could be treated telephonically, and which practitioner was appropriate. This system allowed GPs to safely steer patient allocation to PAs:

> "The triaging clinicians know what to send towards the PA, what not to. We try to avoid too complex cases for the PA. We favor sending patients to [the PA] where the diagnosis is clear and straightforward" (GP 1, 2021).

Close supervision also nurtured professionally acceptable treatment norms:

> "[PAs are] adaptive in picking up our prescribing habits which is very helpful because [we] operate a formulary…They're keen to prescribe within the formulary. If they're not sure…they'll call me and say: 'What shall I use for this?'. [That's] very rare now" (GP 5, 2019).

## 5 | DISCUSSION

As scholars have explored the socio-political processes underpinning the occupational pursuit and protection of professional status, so attention has focused on two forms of power: managerial, rooted in administrative position; and knowledge-based, derived from claims to theory-driven expertise. In examining the employment of the PA role in primary care in England, our article has highlighted a third form of power—ownership—which intersects with the other forms of power to elevate the GP to a professional owner-manager with a distinctive range of options to control a new, possibly substitutive work role.

Focusing on a single innovating STP case, our exploratory study sought to examine why and how these different forms of power interacted as GPs engaged with the potential employment of the new PA role. Following previous studies on the development of new healthcare roles (Kitchener & Mertz, 2012; McMurray, 2011), we initially assessed how public policy on the delivery of care services and associated workforce issues framed GP engagement with the role. With policy support for the role, GPs' limited employment of PAs in our case STP was noteworthy. It encouraged an interest in GPs' employment responses to the role, and how these served to limit its employment.

While Drennan et al. (2017) suggested a standard view amongst GPs to the PA, our interview data allowed us to develop a more refined and varied set of responses. Indeed, using these data to develop a taxonomy of GP approaches to the PA role, we suggested that forms of power were exercised along two dimensions, both resting on whether the new PA role was supported, or not: first, a hierarchical dimension presented ownership and managerial power as combining to allow decisions on workforce strategy, resourcing and capacity, to be taken in an integrated and authoritative, way; second, a professional dimension connected with knowledge-based power, informed by whether the PA was perceived to protect or undermine valued occupational and care quality standards.

The hierarchical and professional dimensions generated two ***generic approaches*** to the PA role—employment denial and employment subordination—manifest in four ***specific responses***. In latter case where employment occurs (Figure 4, Quadrant I), professional owner-managers view the new role as: supporting ownership strategies and furthering professional interests but conditional on its subordination to the established profession via techniques of management control. These techniques allow the professional owner-manager to address residual professional concerns, protecting against substitution and mitigating patient risk.

In the former case, denial was seen to take different forms. Unsurprisingly a lack of support along both dimensions—hierarchical challenges combining with professional concerns (Figure 4, QIII)—represents a major barrier to employment. Strong professional concerns centered on care standards and values can still stymy hierarchal support for the role (Figure 4, QII). Conversely, the perception of the new role as an unviable strategic option can block employment despite professional support (Figure 4, QIV).

Employment of the PA role highly depends on these GP approaches. In contrast to the nascent professions discussed by Kitchener and Mertz (2012) and McMurray (2011), the PA could not use independent ownership status to challenge established professions. Despite progression towards full professional status, PAs remained dependent practitioners, allowing GPs to use their ownership power to control the role's development: either denying employment or subordinating it.

Yet, we also viewed ownership power as complementary to other forms of power. In small businesses, like GP practices, professionals as owners have both strategic and operational control over their organizations, *enhancing* the mobilization of managerial and expert knowledge-based power. In larger organizations, such as global PSFs, these powers are separated and consequently more likely to be dissipated and difficult to articulate in combination.

Professional owner-managers, such as GPs, have a distinctive set of control strategies at their disposal not only to deny but to fully subordinate another occupation, for example, through the design of organizational structures and the positioning of the new role within organizational strategies. This intersection of the three forms of power distinguishes the professional owner-manager from other actors discussed in the literature: the hybrid professional-managers lacking the foundational control of owners; the SME owner-managers without the professional expertise to regulate specialist task performance; the PSF partner, unable or unwilling to exercise the managerial control required to prevent the dilution of professional autonomy.

Conceptualizing how ownership relates to management and knowledge transforms our understanding of the management of professionals in further ways. Ownership allows professions to dominate other occupations *unmediated* by other actors. Without ownership, established professions must either publicly delegitimate another occupation's knowledge base (Kitchener & Mertz, 2012); or seek managerial control over it (Currie et al., 2012). With ownership, established occupations can employ the authority over their organizations to decide how the occupation will be subordinated or refuse the occupation entry.

Ownership also transforms *the modes of interaction* between occupations. Without ownership, occupations must defer in workplace interactions to an occupations' broader knowledge claims (Abbott, 1988; Kessler et al., 2015). Professional owner-managers can exert power over other occupations *by pre-emptively framing* interactions with those occupations. Thus, GPs established organizational systems that regulated PAs' interaction through, for example, triage systems, or denied employment, precluding altogether the possibility of interactions with PAs. Indeed, more broadly, how professional owner-managers use their ownership power to determine organizational structures and interactions might account for recent changes away from professional discretion and peer structures (Faulconbridge & Muzio, 2008) in globalizing PSFs (Empson et al., 2013; Muzio et al., 2020).

More specifically, our conceptualization has strongly emphasized the strategic HRM dimensions of workforce innovation in professionalized settings. Previous studies on the PA role have narrowly emphasized (inter-)professional concerns as the main barrier for employing PAs (Drennan et al., 2017; Jackson et al., 2017). Our approach suggests engagement with a new role more broadly relates to *workforce strategies*. In smaller practices, employment denial reflected an under-developed workforce strategy, seen as unnecessary given the traditional nature of service delivery. In larger practices, employment denial rested on an unsupportive workforce strategy reflecting uncertainty about PAs' contribution, while subordination typically flowed from supportive workforce strategy preceding workplace micro-processes to embed it (Reay et al., 2006).

Our conceptualization has additionally highlighted *cost-competitive business strategy* as a motivator for workforce innovation, usually associated with a quality-competitive strategy, such as providing niche services or knowledge-driven products (Baron & Kreps, 1999). By contrast, our respondents did not emphasize that employing PAs enhances service quality but instead, PAs reduced costs and increased appointments. This may be because

professionals generally regard 'quality' as derivative of service inputs rather than outputs (Evetts, 1999). GP services' input is longer and more difficult regarding both training and licensing compared to PA services'. Consequently, our findings suggest high-status professional owner-managers will not regard lower-input workforce innovations as desirable from a quality perspective.

## 6 | CONCLUSION

We contribute to the study of HRM in professionalized workplaces in several ways. First, our approach brings in ownership power to analyze the under-examined category of professional owner-manager, presenting the GP as a case of such a position. Second, we have conceptualized how professional owner-managers' three forms of power interact regarding workforce innovation through a new role (Figure 4). In doing so, we make our final contribution of highlighting two new control strategies used by established professions to address a nascent profession: employment denial and employment with subordination.

Our research has several practical implications. Policymakers wishing to integrate the PA into the dominant GP- and nurse-led primary care model in England (Spooner et al., 2020) need to devise a business case establishing the new role's quality inputs and cost-benefits. The proposed statutory registration of PAs may only partially allay professional concerns. The 'Traditionalist' will continue to lack resources to supervise PAs, while the 'Organizational Pragmatist' will remain unclear about PAs' viability relative to other mid-level practitioners. This suggests workforce innovation in organizations owned and managed by professionals may be difficult to achieve without: a clear cost-benefit; resources to manage the new role; and professional concerns around safety being sufficiently allayed.

For representatives of a nascent professional role, there are gains to status from supporting government policies that allay GPs' organizational concerns. In dealing with the Traditionalist GP type, they might seek the legal right to own and independently manage their places of practice, limiting established professionals' power as highlighted in the case of dental hygienists (Kitchener & Mertz, 2012) and advanced nurse practitioners (McMurray, 2011). The profession could also present a stronger business case for PAs vis-à-vis alternative roles to convince Organizational Pragmatists or more evidence that PAs practice safely to convince Professional Skeptics.

This research has several limitations. As is common in theoretically-driven, qualitative research, our multi-source empirical approach aimed at enhancing the internal validity of the relations between categories in our conceptualization. The external validity of our conceptualization and findings could be further tested, for example, in large PSFs where professionals with ownership stakes might be less able to overview work processes (Greenwood & Empson, 2003); in other national contexts where primary care physicians have more or less autonomy from the state, like in the US where owner-partnerships also exist; or in relation to other emerging roles that are less clearly in the same knowledge domain as the established profession (e.g., physiotherapists).

Ownership power could also be studied for other partnership professions such as accountants, architects, and lawyers (Greenwood & Empson, 2003). Testing our findings for the case of PAs in primary care more formally might involve developing a database from a survey of practices employing PAs with administrative data about practices from NHS Digital to run regression or econometric analyses. Finally, while we have emphasized the power benefits of ownership, future research could examine any disadvantages of ownership power like large workloads that could make ownership unattractive for partnership professionals.

### ACKNOWLEDGEMENTS

We thank Elaine Farndale and Edel Conway for their excellent and constructive guidance as well as three anonymous reviewers for their constructive comments. We would also like to thank the policymakers and respondents who gave their valuable time and knowledge. Additionally, we thank Vari Drennan, Damian Hodgson, Adam Seth Litwin, Aoife McDermott and Steve Proctor for their excellent comments on an early version of this article.

## CONFLICT OF INTEREST

The authors declare that there are no conflicts of interest.

## DATA AVAILABILITY STATEMENT

The data that support the findings of this article are not shared to protect the anonymity and confidentiality of participants.

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**How to cite this article:** Krachler, N., & Kessler, I. (2023). Ownership power and managing a professional workforce: General practitioners and the employment of physician associates. *Human Resource Management Journal*, *33*(2), 287–306. https://doi.org/10.1111/1748-8583.12464