NEGOTIATING PROFESSIONAL BOUNDARIES: PROFESSIONAL AND ORGANISATIONAL CONTINGENCIES FOR PHARMACIST PRESCRIBING

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Abstract

This thesis explores boundary work, practices and changes in the pharmacy profession. Specifically it examines boundary changes that support non-medical prescribing practice for pharmacists in the context of prescribing policies and strategies which both utilise the skills of the pharmacist and also give patients greater choice and access to services.

The last decade has observed a transformation in the boundaries of health professionals enabled through the creation of new roles and the expansion of traditional roles. With reference to the principles set out in the NHS Plan, NHS modernisation and the subsequent introduction of non-medical prescribing have brought about a number of changes in policy and practice for health care professionals. In addition, The Royal Pharmaceutical Society's 2013 Medicines Optimisation, good practice guidance outlines guiding principles for medicine optimisation that compliment and support improved patient outcomes and NHS policy – in particular empowering patients and the public to make the most of medicines. Research shows that while there are increasing numbers of pharmacists registered as non-medical prescribers and the numbers of those who are actually practicing as non-medical prescribers has continued to rise, there are still areas where groups are having to make "significant personal sacrifices" to implement and maintain the necessary competence to prescribe. Research suggests that there is still more that needs to be done in order to achieve more supportive environments for non-medical prescribers.

Pharmacists have been referred to for many years as being “underutilised” and “over trained” and capable of a far greater remit than the dispensing of medication that has typically been associated with pharmacists. In addition, the policies that developed to address different health care needs and outcomes also go some way towards changing boundaries and adapting the roles that pharmacists have.

This thesis first considers, the role of the pharmacist and what their occupational and professional boundaries are perceived to be. The thesis goes on to examine how pharmacists enact extended roles in practice. Lastly, the institutional and organisational factors that impact the subsequent practices of pharmacists and the services they deliver is explored.

Using qualitative research techniques, this study was carried out in three NHS Trusts across a range of settings with a range of health care practitioners. The study was organised in two parts, First, a series of exploratory interviews were carried out with a pharmacists, medical and support staff. Second, ethnographic non-participant observations with pharmacists in different settings were undertaken.

The empirical findings suggest that the boundary work between third parties is not a tension point or a point of conflict as suggested in theory and previous research around boundary work in the health care setting and the inter-professional context. Rather, the boundary is a non-issue in relation to role expansion of pharmacist non-medical prescribers. The findings

imply that the ability to share tasks, expand, and change roles is largely shaped by changing contexts and organisational factors. The study data has been used to help develop a model whereby different practices and principles that affect and guide the position of pharmacists and their boundaries as well as negotiations of practice are considered. The model uses the principles Scott's (2008b) Three Pillar and combines elements of Zietma and Lawrence's (2010) boundary and practice work cyclical diagram. The model in this thesis is developed alongside the data analysis. The intention of the model. is to provide a template that with further refinement could be used when looking at other professionals or professional groups interchangeably. The features of the model in theory will be able to be adapted when considering different professional interactions, task sharing or role identification within an organisation for example. The model and its development will be discussed in further detail throughout the thesis. The overall research findings, suggest that the scale to which non-medical prescribing is practiced by pharmacists across the range of settings is greatly determined by the organisation. This includes the way in which pharmacist non-medical prescribing is used in practice, its ease of implementation and the subsequent role of the practicing health care professional.

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Chapter 1: Introduction

1.1 Overview

This thesis is concerned with understanding professional boundary negotiation in the context of the current workplace changes that advocate enhanced skill and task sharing and multi-professional work. The work focuses on the implementation and enactment of extended roles and health policy that aims to deliver these changes. It examines professional boundaries, boundary change in terms of delegation and substitution, and institutional boundary work, using pharmacist non-medical prescribing as a case study.

1.2 Background to Research

Past decades have witnessed a number of changes in the delivery and practice of health care. The traditional roles carried out by health care professions have seen changes in what were fixed roles as there is the increasing practice of task sharing. For pharmacists in particular the occurrence of change is no new experience. Arguments and discussions about the pharmacy profession and the role of pharmacists have been under scrutiny for many years as we have witnessed the pharmacist's role evolve (Crellin 1967; Abbott 1988; Bissell and Traulsen 2005). The tasks that pharmacists do are somewhat varied and rather different to the traditional compounding and dispensing role. One of the significant changes in the United Kingdom (UK) health care delivery is the development of non-medical prescribing (Tonna, Stewart, and McCaig 2007). It was suggested at one point, that the UK had the most extended non-medical prescribing rights in the world (Carey 2011). There has been a

tremendous shift in the boundaries that exists within pharmacy and the role of pharmacists in hospitals, community and primary care settings (Edmunds and Calnan 2001).

Together with the efforts from within the pharmacy profession to improve the status of pharmacy, the Government has intervened by incorporating further developments and extending roles within pharmacy. The reformation of the National Health Service (NHS) has been the driver to a number of changes that have impacted on the roles carried out by health care professionals. The Department of Health (2000a) published a health service plan that includes a summary of some public concerns about the NHS. The health service plan suggests that "Patients want to see all NHS staff used more effectively, with an expanded role for GPs and pharmacists" (Department of Heath 2000a: p. 135). The health service plan, which seeks to outline different ways of working, goes on to state:

> *"Pharmacists will be able to take on a new role as they shift away from being paid mainly for the dispensing of individual prescriptions towards rewarding overall service" (Department of Health 2000a: p. 84).*

The extension of prescribing rights to non-medical healthcare professionals has been a key feature in NHS modernisation policy changes (Department of Health 2000a, 2003a, 2003b, 2008a, 2008c, 2010a). This extension is responsible for some of the "over-lapping" of inter-professional roles within healthcare (Blenkinsopp et al. 2008). The Crown Report (Crown

1996) was a major driving force in the introduction of independent and supplementary non-medical prescribing. As independent prescribers, nurses and pharmacists can prescribe any licensed medicine, and some controlled drugs, provided they are working within their specified areas of competence. Supplementary prescribers can prescribe any medicine stated in a patient-specific clinical management plan once the patient has been diagnosed by a doctor (Department of Health 2006b).

As healthcare professionals work towards delivering government modernisation policies in the NHS, service re-design and role re-configuration are high on many agendas. Various initiatives and policies to drive and facilitate these changes are evident in the Crown Report, Pharmacy in a New Age (PIANA), which originated at the time under the Royal Pharmaceutical Society of Great Britain (1996). The Royal Pharmaceutical Society of Great Britain (RPSGB) launched the Pharmacy in a New Age (PIANA) initiative in 1995/1996. PIANA raised the profile of the pharmacy profession and demonstrated that pharmacists were not only prepared but also qualified to provide increasing contributions to the wider NHS agendas (Royal Pharmaceutical Society of Great Britain 1996; O'Hare 2012). PIANA was carried out in phases. The first phase was a consultation exercise where members of the society were asked to provide their views on how pharmaceutical services should be developed to meet the needs of the public (Stone and Curtis 2002). At the end of the consultation phase five, extended roles were identified (Royal Pharmaceutical Society of Great Britain 1997). Previous published literature shows that current undertakings of pharmacy have changed over centuries and the parameters of pharmacy continues to shift. The tasks that pharmacists now routinely perform are markedly different to tasks that were

previously the core tasks of the pharmacist. Pharmacists provide 'services' such as smoking cessation, NHS men's health checks, sexual health screening, blood pressure, weight management and blood glucose monitoring (Department of Health 2008a). Pharmacists, particularly community and hospital pharmacists, are increasingly taking on more clinical roles; an evident shift from traditional drug preparation, supply of medicines and retailing activity. In addition to the attempts to improve the status and direction of pharmacy, there has also been a range of policy documents and initiatives which have gone toward redefining the remit of pharmacy and determining the current role of pharmacists (Department of Health Health 2000a, 2003a, 2003b, 2008a, 2008c, 2010a; Royal Pharmaceutical Society of Great Britain 2009; RPS 2013).

Utilising the skills held by health care professionals and increasing access to healthcare for patients has been an NHS aim (Department of Health 2010b: 2013). While non-medical prescribing has been deemed a useful practice and activity that healthcare professions have elected to pursue, the number of non-medical prescribers who practice in different settings do not directly relate to the number of professionals who have gained the qualification (Adigwe and Strickland-Hodge 2012). This is particularly true in pharmacy and pharmacy practice. The number of pharmacists who have the non-medical prescribing qualification and the number of those pharmacists who are able to utilise their qualification and are prescribing in practice is disproportionate (George et al. 2007). There are a number different policies and papers TJETBT1 0 0 1 174.2BT1 0a1 0-3(l)-333(h)-4(ea)-2(ltlt)5(h)-4( )-50x0 to1n

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non-medical prescribing and the number prescribing, this provokes questions as to why there is a difference and what this means to pharmacists.

Prescribing in the UK, up until the early 1990's, was once an exclusive activity carried out by only doctors and dentists. As noted earlier, previous decades have seen prescribing rights being extended to a range of other health care professionals. The different debates around non-medical prescribing and the impact and opinions concerning the shift in tasks carried out by different healthcare professionals is still ongoing. Rhetoric suggests that doctors are opposed to non-medical prescribing and the notion of pharmacists and nurses carrying out such tasks as part of their role and, as such, resist the implementation of such practices (Blenkinsopp et at. 2008; Edmunds and Calnan 2001; Cooper et al. 2008):

> *"GPs had most reservations about pharmacists taking on more clinically orientated activities… A number of pharmacists reported that GPs were not always co-operative and that some doctors felt threatened by their activities and were being obstructive…. At the micro-level then, there is evidence that some doctors perceived some of the pharmacists' activities as threatening" (Edmunds and Calnan 2001: p. 952-953).*

In addition to the rhetoric and the debates around doctors and pharmacists, there is research to suggest that non-medical prescribing is a threat to medical power (Britten 2001;

Edmunds and Calnan 2001; Weiss and Sutton 2009). This has also been explored with empirical research (Cooper et al. 2012; Edmunds and Calnan 2001). Edmunds and Calnan (2001) found that their:

> *"…study showed that although pharmacists may not be aiming to dismantle the boundaries between their occupation and medicine, at the micro-level some doctors perceived some of their activities as a threat and responded by trying to reinforce the existing division of labour between pharmacy and medicine" (Edmunds and Calnan 2001: p.954).*

Literature has suggested links between the shortage of doctors and non-medical prescribing acting as a solution to this incidence. There have also been concerns raised around the impact that non-medical prescribing has and will have on junior doctors and their prospective training and prescribing development. It has been suggested that non-medical prescribing will be perceived as de-skilling doctors and in turn, harming future delivery of medicines as boundaries and practices are redrawn (Lloyd and Hughes 2007).

Other debates have seen professionals question the legitimacy, competency and appropriateness of healthcare professionals other than doctors prescribing. Questions around pharmacology, knowledge, clinical training, the ability to examine and diagnose and also the overall lack of training and experience to safely prescribe. In the UK, these

discussions have queried NHS trusts and service providers motivations in employing the use of non-medical prescribers and questioned if such an introduction is a money saving exercise over that of the role of the professional and patient choice. Some non-medical prescribers are doing the "same" job as a doctor but are being paid a lot less to carry out their role. This conception has, however, been disputed by the Government and health care service providers who insist that the driving force behind non-medical prescribing is improving patient care, choice and patient outcomes (Department of Health 2000a, 2003a, 2003b, 2008a, 2008c, 2010a).

Patients and service users were identified by the government as major beneficiaries of the non-medical prescribing policy (Department of Health 2003a, 2003b, 2008c, 2010a). Research suggests that overall there have been positive outcomes as a result of non-medical prescribing (Latter et al. 2011; Hobson 2008; Adigwe and Strickland-Hodge 2012). However there are still areas which require further attention and explanation. For example, the extent to which this practice impacts on the role of the pharmacist, the boundaries that the pharmacist works within, as well as the process of implementation and how this goes towards the overall outcomes of non-medical prescribing.

1.3 Research Strategy

The methodology proposed for this study followed a qualitative approach. The research project was developed in two distinct stages and was stratified; including pharmacists from hospitals, community and practice settings; medical doctors (consultants, GPs), hospital and

community nurses, management and administrative staff and support workers. The initial stage involved one-to-one semi-structured interviews. The second stage involved gathering data from non-participant observations and observing pharmacists working across a range of settings.

Twenty four in-depth semi-structured interviews were carried out with pharmacists, doctors, nurses, midwives and also a general practice receptionist. Their experiences, views and practices were explored. Three pharmacists were observed using non-participant ethnographic observations. These were conducted in hospitals (n=2) and community pharmacies (n=1). Ethics approval was sought and the present study was granted a favourable ethical opinion. NHS R&D approval was obtained from three NHS Trusts.

1.4 Structure of Thesis

The thesis is divided into eight chapters. The introduction chapter (Chapter 1) offers background information that seeks to situate the research in the current and acts as a guide through the thesis.

The next two chapters (Chapter 2 and Chapter 3) of this thesis make up the literature review. Chapter 2 looks at the main theories on the professions, examining the existing body of knowledge regarding the history of the professions, professional boundaries and competition. The first part of negotiations of practice model is introduced (See Figure 1:

Pharmacy Work Sphere). Chapter 3 looks at the evolution of the pharmacy profession, pharmacy and boundaries around non-medical prescribing. This chapter goes on to evaluate the literature and data published around non-medical prescribing and the practice of prescribing in pharmacy and in other healthcare professions. The development of the *"negotiations of practice"* diagram is explained and depicted in Chapter 3. The subsequent data and outcomes from existing empirical research are also considered.

After taking into account the existing literature, Chapter 4 outlines the research objectives and the qualitative methodology utilised in this thesis. It summarises the suitability of a qualitative approach to address the research questions presented. A full account of the methods used to collect the data and the way in which the data was analysed is reported. The results are organised in Chapters 5 to Chapter 7.

Chapter 5 illustrates where the boundary domain is for pharmacists in community, hospitals and general practice settings. This chapter explores what these boundaries of the profession are based upon and how it is changing in the current context. This is important because it shows not only where the profession currently stands, but it also begins to explain how and why pharmacists are adapting their roles and how this adaption fits within their profession and careers.

Chapter 6 shows how the boundaries are being extended in pharmacy and why this is happening. More specifically, this chapter will look at non-medical prescribing by

pharmacists and the reasons why some pharmacist undertook training to prescribe. It will also present the reasons behind why some professionals chose or were able to use their prescribing qualification. This is particularly important in terms of how pharmacists are able to enact non-medical prescribing roles in terms of intra and inter professional issues, especially in light of the on-going rhetoric and debates about professional jurisdictions and boundary breaching. In addition, the data illuminates the working context of the organisation and the impact of its role.

Finally, Chapter 7 examines how pharmacists enact non-medical prescribing when considering organisational and contextual factors. More specifically, this chapter will explore how the boundary change is negotiated and whether this negotiation is successful and amenable to all involved. This is important as it show how pharmacists respond to these challenges, and changes and in turn, shows how this affects pharmacy as a profession.

The Discussion chapter (Chapter 8) is presented in two parts; the first part presents a discussion of the research findings in light of other research and policy changes in the area. The second part presents recommendations for pharmacy, pharmacists and the role of non-medical prescribing based on the data collected, as well as recommendations for future research. The study both highlights and generates implications for pharmacists, other healthcare professionals and organisations.

Chapter 2: Literature Review

This chapter looks at the main theories on the professions, examining the existing body of knowledge regarding the history of the professions, professional boundaries and competition. The British healthcare service is currently undergoing a number of structural and political reforms (Department of Health 2000a, 2000b, 2008a, 2008b). In the UK, the NHS Plan (Department of Health 2000a) set out to reconfigure traditional professional hierarchies to create more flexible team working with a focus on improved access to patient-centred care at its heart. Developments in non-medical prescribing go as far back as 1986. To date, there has been considerable progress made with the introduction and implementation of non-medical prescribing and the permissions it provides groups of health care professions to prescribe in the UK. In addition to looking at the literature on professions, pharmacy and its changes in status and practices will be explored.

2.1 Professions, Professionalisation and the History of Social Pharmacy

The concepts of profession, professionalism and professionalisation have received significant (sometimes critical) attention in sociology. Vocations, occupations, and professions; the working role of a person in society has long been described in a number of diverse ways, by different people, who in fact express some quite different ideas:

> *"In early British sociological analysis, the key concept was 'professionalism' and the emphasis was the importance of professionalism for the stability and civility of social systems (e.g. Tawney 1921; Carr-Saunders and Wilson 1933; Marshall 1950)" (Evetts 2005).*

A profession is generally recognised to be related to a formal work organisation or a group of experts with a special skill or monopoly of knowledge. Provision for professional training and education, adherence to a code of conduct, self-defined and socially necessary (social function) and accepted. For example, Etzioni claims, that the basis of professional authority is knowledge (Etzioni 1969). The definition of professions has long been debated and continue to develop over time. The formal academic and sociological study of professions did not begin until the 1930s:

> *"By common consent certain vocations now rank as professions…those vocations which, whatever their status and characteristics at the time, ultimately assumed features which entitle them to rank in the professional class…vocations, which have grown into professions….lawyers, physicians, and civil servants" (Carr-Saunders and Wilson 1933: p. 289-290).*

Abbott suggests that professions exist in a system, thus, they are interrelated and never seen alone (Abbott 1988). The nature of professions is that they are positive and adapt to the needs and demands of society. Examples of some of the earliest professions include law and medicine. These professions have been portrayed as special, and have maintained power and knowledge, handing down knowledge and values. Professions are said to have derived from medieval origins and have long occupied a special position in sociology (Abbott 1988; Carr-Saunders and Wilson 1933; Freidson 1970; Hughes 1963). However, Abbott states that the first development of modern liberal professions and the first attempts to study them was by the English in the nineteenth century (Carr-Saunders and Wilson 1933 was the first attempt at this):

> *"The nineteenth century saw the first development of professions as we know them today. In England, the merging of apothecaries with surgeons and physicians, the rise of the lower branch of the legal profession, and the appearance of the surveyors, architects, and accountants signaled [sic] the change... The nineteenth century professions were important but peculiar social creatures" (Abbott 1988: p. 3).*

Theory on professions have developed and evolved over time. Dingwall (2008: p. 99) maintains that, for the best part of a generation, sociologists have analysed the creation of professions as a process of regulatory capture: professions were well-organised occupations

that could close markets and create shelters. Dingwall (2008) suggests that research in the sociology of the professions has to date, been essentially founded on the contributions of Talcott Parsons and Everett Hughes. He goes on to say that the turning point for sociology of the professions came in the 1970s with a series of major theoretical contributions – most notably from Johnson (1972), Freidson (1970) and Larson (1977) (Dingwall 2008). There are massive variations between groups classed as professions in society and how they define themselves and how they are accepted. Dingwall suggests that the concept of professions is

There is little agreement on the meaning of a profession in terms of a social structure and the meaning of professionalism as a culture and practice. Thus, it is difficult to reveal what it is that actually unites professions. Many writers have studied professions over the years and have made significant contributions to the debates around the professions, including Alexander Morris Carr-Saunders and Paul Alexander Wilson, Talcott Parsons, Eliot Freidson, Magali Sarfatti Larson, Terence Johnson and Andrew Abbott. All have studied professions and have arrived at a number of different interpretations of what defines a profession. This section aims to go through the contributions of some of the prominent authors through the eras (from the 1930s through to recent times) and attempts to follow the journey of the professions, professionals, professionalisation and professionalism and examine the meanings attached to them. This section will focus on structural-functional trait theories (1930s – 1960s), market monopoly or power theories (1970s – 1980s) and the 'third logic' theory (1990s – 2000s). With opposing positions, there are divides between emotions and knowledge, private and public (Parsons 1939), and in some respects the social and the scientific (Freidson 1970; Larson 1977). Using examples from pharmacy and other occupations, this section seeks to examine sociological writings on the institution of professions to identify how sociologists define a profession, the journey that professions take, what it is that makes a person a professional and what this means both culturally and socially. A profession can be described as an occupational category. There are many claims that professions have evolved over hundreds of years. Exploring the professions literature helps to identify and put into context the different interpretations of the professions. Looking at the professions also helps to understand the journey and stages that pharmacy has had in relation to its many occupational changes, pharmacy as a profession, de-professionalised and re-professionalised (Evetts 2003; Denzin and Metlin 1968; Larson

1977). Given the current changes in the pharmacy profession, the history of the professions and the different schools of thought will help to understand pharmacy as an organisational groups or profession and how these are defined and the different impact extensions of roles make to the pharmacy profession.

2.1.1 Structural-Functional

The structural-functional writer's and Trait Approach Theories are some of the earliest examples of ways in which the professions were described and acknowledged. Carr-Saunders and Wilson and Parsons develop their debates around occupations and professions and their contributions resulted in these theories. The structural-functional writers consider the occupational and professional structures and their social and cultural function; in other words, the function of a profession and how this holds society together. The Trait Approach Theories take into account precise technical expertise and other necessary qualities to be a profession, for example a code of ethics. A code of ethics focuses on specific elements, a core set of traits that are collectively considered obligatory to constitute a profession. For example rigorous academic screening and training programs, occupational licensing, codes of ethics, autonomy and self-governing occupational communities. This next section will focus on three major contributors to this approach (Carr-Saunders and Wilson and Parsons).

Carr-Saunders and Wilson have been described as having provided a keystone for the approach to the area of professions (Elliott 1972). They carried out the first key sociological

study of the professions in the 1930s. The purpose of their study was to provide a historical background on all groups that could, at that time, be considered to be professions. They documented that whilst trade unions and social and economic problems had received attention, professional associations had been "almost entirely neglected" (1933: p. iii). Carr-Saunders and Wilson consulted text and documents from the middle ages in an attempt to show the journey of professions and thereby provide a definition of a profession. They describe professions as the formation of associations which exist around aspects of social life and amid these associations, they perform specialised functions and they carry out specialised crafts (1933). Carr-Saunders and Wilson describe professions as a rapid movement of a living problem. In their 1933 book, 'The Professions', Carr-Saunders and Wilson (1933) assert:

> *"...techniques may exist and men may practice it, and yet there may be no profession...a number of men, though they perform similar functions, do not make a profession if they remain in isolation. A profession can be only said to exist when there are bonds between the practitioners, and those bonds can take but one state, that of formal association" (p. 298).*

There is a prominent association identified with the church and the subsequent growth of early professions throughout their text. They explained that the church ultimately was the origin of a number of early professions, such as law and medicine. Carr-Saunders and

Wilson expressed that the earliest phases of certain vocations that have evolved into professions were accepted within the church and that education was closely bound up with ecclesiastical functions that the priest and teacher distinguished with difficulty (1933). The church and the clergy form a central element in the portrayal of the professions as described by Carr-Saunders and Wilson. At one time, the clergy were the only profession or the basis on which other professions were built. Carr-Saunders and Wilson (1933) recounted that, at one time, it would be true to say that the specialised functions of professions were performed by ecclesiastics, although this was not true of the fully developed medieval system. Carr-Saunders and Wilson (1933) go on to comment on the on-going growth of secularisation and the decline of the central role of the church:

> *"About the same time that the recession of the Church hastened the secularization of the physicians and civil servants, the trading community began to free itself from the dominance of the gild form of organization" (1933: p. 294).*

Carr-Saunders and Wilson illustrated the different ways in which a profession may be conceptualised and considered by communities in society and groups of practitioners. During the early eighteenth century and throughout, professions were regarded as "gentlemen's occupations" first and foremost (Carr-Saunders and Wilson 1933: pp. 294-5). Professional associations did not offer large material rewards but they did provide a safe niche in the social hierarchy.

What professions are and how they came to be identified as such was examined by Carr-Saunders and Wilson. They set out a number of what they deemed to be occupations, as chapters in their book titled; Lawyers, Doctors, Dentists, Nurses, Midwives, Pharmacists, Opticians, The Merchant Navy, Engineers, Chemists, Architects, Accountants, Secretaries, Teachers and Journalists to name a few. In each chapter, the authors show the historical growth and evolution of that 'profession' in terms of Acts and bills passed, the development of societies and associations and the function the profession, as well as the requirements needed to be deemed a professional within that field and the rules and codes to be followed. This is particularly relevant for non-medical prescribing as non-medical prescribing is an example of legal and formal and sanctions that have enable pharmacists to develop their role. Carr-Saunders and Wilson placed significant importance on the professional association in relation to their stabilising effect on society (1933: p. 497). Their analysis is said to have showed that the nature of professionalism, for a number of centuries, (for around half a dozen professions) provided all the skilled intellectual services upon which the functioning of society depended. Carr-Saunders and Wilson (1933) suggest that:

> *"…within the ranks of the professions are to be found most of those upon whose special skill the functioning of modern society depends" (1933: p. iii).*

Carr-Saunders and Wilson (1933) found that professions fell into five groups. First, professions whose services rendered vital (the medical group for example) including medicine, dentistry, pharmacy, and nursing. Second, professions where the service is fiduciary (the legal group for example) marked with a degree; barristers, solicitors. The first two groups share the common characteristic. Third, professions whose service has an intimate relationship to public safety (the merchant navy, for instance). Fourth, professions in with individuals have passed the necessary tests and whose eligibility to practice is documented on a register (civil servants and teachers in grant-aided schools). Fifth, architects and registered teachers (Carr-Saunders and Wilson 1933: p. 306):

> *"We have found that the application of an intellectual technique to the ordinary business of life, acquired as the result of prolonged and specialised training, is the chief distinguishing characteristic of the professions" (Carr-Saunders and Wilson 1933: p. 491).*

Pharmacy remains within the medical group. They rather crudely suggested that regulated professions all share common characteristics from one of the five groups listed, thus highlighting a set of 'traits' which go toward the foundation of the trait theories. The work of Carr-Saunders and Wilson has been criticised and challenged. At the time when their work was made public, it provided a foundation for studies exploring professions and was proved to be a platform that enable other scholars to develop the literature in this area.

Talcott Parsons, one of the key contributors to professions literature, stated that the most important 'civilisations' showed that professions occupy a position of importance in society (Parsons 1939). Parsons was fascinated by the fragility of social order (Dingwall 2008). Parsons described a profession as a cluster of occupational roles; roles in which certain functions that are valued in society are performed. These functions usually enable those performing them to earn a wage. As an occupational role, it is institutionalised about the technical content of the function which is given a high degree of primacy relative to other status determinants (Parsons 1991; Parsons 1954). In his chapter titled 'The Professions and Social Structure', Parsons critically reflected on professions; why they were so developed and why there was such a clear division of labour. He suggested in this chapter that the similarities between professions and business were more important than their differences (Elliott 1972). Parsons suggested that the study of professions throw light on the essential features of the occupational structure of modern society and social structure and he goes on to say that many of the important features of society are, to a considerable extent, dependent on the smooth functioning of professions (1939: p. 457). He believes that the central focus of the professional role lies in technical competence. For Parsons, he conceptualises professions primarily in terms of their "functionally specialised fields" (1954).

Parsons stated that one basis for the division of labour was the specialisation of technical competence suggesting that:

“”There is an intrinsic connection between achieved statuses and the requirements of high technical competence, as well as universalism and competence” (Parsons 1991: p. 434).

Dingwall described that Parsons questioned why the professions were so highly developed and why there was such a highly refined division of labour. The question of motive and persons acting in their respective occupations; the idea that it is simply individuals' utilitarian self-interest was rejected by Parsons. He says it is part of society, institutional. Parsons wanted to show that, perhaps, the acquisitiveness of modern business is institutional rather than motivational. Parsons attempted to specify the vocabularies that are drawn upon to impute motives to professionals and businessmen: the ‘functional attributes’ (Dingwall 2008). Parsons asserts, “On the one hand the typical motivation of professional men is not in the usual sense “altruistic”, nor is that of business men typically “egotistic”” (1939: p. 458). It is not accurate to say that business men are purely egoistic, nor is it accurate to assume that professionals are purely altruistic. Both have the same sorts of motivation, and the differences in normative behaviours are institutionally defined definitions of the situation. The institutional framework of the professions is maintained by a complex balance of diverse social forces rather than a belief in the importance of the professions’ social functions (Dingwall 2008). Parsons illustrated that:

“The business man, the foreman of labor, and not least the non-scientific professional man such as the lawyer, is enjoined to seek the

"best," the most "efficient" way of carrying out his function, not to accept the time-honoured mode" (1939: p. 459).

Social roles, business and professions share the same characteristics that Parsons calls, scientific rationality, functional specificity of technical competence and universalism. These three characteristic elements distinguish 'our' society from others and contribute to the unique importance of modern occupational structure in our society. Parsons accepted that there were important organisational differences between business and professions as groups, however, not in terms of their motivation (Elliott 1972).

Parsons explained that scientific rationality is not simply accepting traditional explanations because they exist and, therefore, searching for better ways and explanations. Scientific rationality is not just something that comes naturally to all human beings, "rationality in this sense is institutional, a part of a normative pattern...it is not a mode of orientation which is simply 'natural' to men" (1939: p. 459). Parsons believed that altruism and acquisitiveness were both false motivational assumptions when actions were carried out within institutionally defined patterns of social roles (Elliott 1972). The desire to attain reward and to achieve success is part of human nature.

For Parsons, a professional's power over their clients was necessary for successful treatment and did not prevent any other professional power (Abbott 1988). Functional specificity of technical competence refers to professional authority. Certain people have authority in

certain realms but not in others. For instance, regardless of their financial backgrounds or upbringing, doctors are given authority in the field of medicine because it is their specialty. Parsons illustrated that “professional authority is limited to a particular technically defined sphere. It is only matters touching health that a doctor is, by definition, more competent than his lay patient” (1939: p. 460). This is what Parsons called the ''functional specificity'' of technical competence or authority.

Commercial or contractual relationships, which are functionally specific, contrast to kin relationships that are functionally diffuse. In a contractual relationship, rights and obligations, limited to the terms of the contract are featured and guide a response given or carried out by a profession. Kinship employs a subjective basis to determine an outcome. Parsons (1939) asserts that ‘A’s’ father is distinguished from all other males of a particular generation, not by his financial status, administrative qualities, physiological characteristics or pathological characteristics but by his particular relation by which he stands to ‘A’. Parsons called for a thorough study and explanation of functional specificity, since it is a product of our unique modern division of labour (Parsons 1939).

Parsons discussed two kinds of particular societies or social relationships among people; value-orientations, universalistic and particularistic. Science is described as essentially universalistic; it states that the proposition is irrelevant to the question of its scientific value. Parsons (1939) suggested that universalism is by no means confined to professions. Parsons maintains that:

> *"While there are a variety of reasons why disinterestedness is of great functional significance to the modern professions, there is equally impressive evidence for the role of rationality, functional specificity and universalism...society calls attention to the importance of elements other than the enlightened self-interest of economic and utilitarian theory" (1939: p. 463).*

Parsons sums up the importance of the professions by stating that the professional type is the institutional frame work in which many important social functions are carried out.

2.1.2 Market Monopoly and Power Theories

Following on from the supposition developed by Carr-Saunders and Wilson and Parsons; Freidson, Johnson and Larson developed the concept of professions using theories that concentrated on market monopoly and theories of power as spheres in which professions were constructed and sustained. McDonald (1995) states that the power approach, whether reasoned from the interactionist or Marxist tradition, was more useful than the Trait Theories. Monopolising the market meant that only certain individuals, belonging to a particular profession, were able to perform tasks apportioned to that job. Consequently, due to the apparent restriction imposed and sustained by professions, markets or areas of practice were closed to the professions whom were 'qualified' to do these specific jobs. Educational documentation and permits in addition to occupational licensing restrict labour

supply and create market 'shelters'. Thus, power theories in relation to professions tie in where professions present as an institutionalised collective of power based on knowledge and skills.

Elliott Freidson (2001) asserts that those occupations that became distinguished from others by being called "occupational professions" or professions are considerably more superior than those that remained occupations:

> *"The general public's views of that occupation can facilitate and support such recognition, as can the views of some influential elite, but recognition and support from the state or some other paramount power is essential" (Freidson 2001: p. 83).*

Freidson (2001) argues that one can distinguish between adopting an ideology of professionalism, which displays the various kinds of features described by the attribute theorists and the location 'profession' holds within a given social structure. Freidson suggests that:

> *"The ideal-typical ideology of professionalism is concerned with justifying the privileged position of the institutions of an occupation in*

> *a political economy as well as the authority and status of its members" (Freidson 2001, p. 106).*

Professions are a special occupation and a "profession" is an avowal or promise. Freidson considers the members of a profession to exhibit extraordinary trustworthiness and the most reliable authority on the nature of 'reality' which it deals with. Abbott described Freidson's stance, stating that Freidson believed that dominance and authority, not collegiality and trust, were the hallmarks of true professionalism (Abbott 1988: p. 5). Freidson suggested that professions deal with clients' problems differently to the way in which a layman would deal with them. According to Freidson (1970), the professional approach changes the definition and the shape of problems as interpreted by the layman. In his book, "Profession of Medicine", Freidson used medicine as a case study to contribute to the understanding of professions. Freidson (1970) put forward the proposition that expert knowledge was a source of power and authority capable of tempering the calculative rationality of managed care:

> *"...the profession of medicine, not that of law or the ministry or any other [profession], has come to be the prototype upon which occupations seeking a privileged status today...are modelling their aspirations. The better we understand medicine, then, the better we will be able to understand the problems that may be posed by the*

professionalization of the key service workers of the welfare state" (Freidson 1970: p. xvi).

Professions are presented as different to 'ordinary' occupations. Occupations are massively varied, however, Freidson explains that occupations as groups use the term profession to identify themselves, to "flatter themselves" or to try and persuade others of their importance. Occupations that do this actually have nothing in common with true professions, merely a hunger for prestige (1970: p. 4). Freidson refers to professions as collective human enterprises, vehicles for special knowledge, and beliefs and skills. He states that, in its elementary sense, professions are a group of people who perform a set of activities which provide them with their major source of subsistence; activities which are termed "work" as opposed to leisure and vocation rather than "avocation" (1970: p. 71). Freidson defends his view that an essential feature of a useful concept of profession is the possession of something of a monopoly over the exercise of its work (1970: p. 21), "a profession attains and maintains its position by virtue of the protection and patronage of some elite segment of society which has been persuaded that there is some special value in its work" (1970: p. 72). Technical adequacy, a professional's knowledge about medicines, and illness and its treatment is considered to be authoritative and definitive. The position of medicine today, with its monopoly and prestige, is reflected in the esteem in the public mind. The relationship between society and profession is an important relationship. If the work of a profession has little connection to the knowledge and values of its society in which it exists, it could very well have trouble surviving and, in turn, maintaining its professional status (Freidson 1970).

Medicine, as a case study, has developed into a complex division of labour. Unlike the law professions and ministry, medicine has a strong association with science and technology. Autonomy is dubbed the most strategic and treasured characteristic of professions, owing to its relationship to the sovereign state (Freidson 1970). From an autonomous position, professions manage in a new social reality which permits their re-creation. Unlike occupations, professions are intentionally and consciously granted autonomy, including the exclusive right to decide who can legitimately do its work and how the work should be done (Freidson 1970). Edmunds and Calnan (2001) suggest:

> *"The social position of the 'traditional' professions such as medicine is thought to depend on a number of factors one of which is having access to and control of a unique body of specialist knowledge. Pharmacists were no exception to this as their original role of compounders of medicines had involved an understanding of and control of an exclusive field of knowledge that led pharmacy to enjoy a status comparable with occupations such as medicine" (Edmunds and Calnan 2001: p. 943).*

However, Freidson suggested that professional autonomy is not absolute, in as much as the state has ultimate sovereignty over all professions but grants conditional autonomy to some [namely to professions]. Freidson continues:

> *"…so long as a profession is free of the technical evaluation and control of other occupations in the division of labor, its lack of ultimate freedom from the state, and even its lack of control over the socio-economic terms of work do not significantly change its essential character of a profession" (1970: p. 25).*

According to Freidson, professionalism is fairly widespread among the service orientation of occupations that are not autonomous and which are not likely to ever be so autonomous in the future (1970). He states that he believes that expertise is more and more in danger of being used as a "mask for privilege and power" rather than as a mode of advancing the public interest as it claims. Freidson describeshis position with regard to this is:

> *"…that there are good reasons for considering it appropriate to place restrictions on the scope of professional autonomy, particularly when the work involved directly affects the public interest" (1970: p. 344).*

Freidson suggested that medicine has come to dominate an elaborate division of labour, and its jurisdiction is broad and far ranging having expanded into areas that were once dominated by religion and law (1970: p. 337).

Professionals are considered to be experts as they are thought to possess some special knowledge unavailable to layman who have not undergone specialist training. However, Freidson suggested that knowledge or expertise [using medicine as an example] is "extremely limited as a reality" as it is locked up in books or in heads, and as it is defined, it has in fact no link with the activities of consulting, treating, advising or otherwise working at "being" an expert. An expert consulting practitioner engages in activities and activity is not, after all, knowledge. The lack of equivalence between knowing and doing requires "knowledge" to be redefined or to distinguish knowledge as such and analyse its relationship to what reputedly knowledgeable people do (Freidson 1970: p. 339). Speaking about knowledge, Freidson discussed honesty as a concept as he claimed that professions have not only created their own knowledge independently and imposed it on their clients. Rather, they have also created their own conception of themselves as a profession and their subsequent conception adopted by outsiders, to represent what professionals actually are, rather than what professionals think they are or claim to be (1970: p. 380).

> *"The profession is...now blinded by the glitter of its own status...it is the special status that is the villain. If the profession is to be made more honest its status must be modified" (Freidson 1970: p. 381).*

Freidson continues to say that, in his opinion:

> *"There is a real danger of a new tyranny which sincerely expresses itself in the language of humanitarianism and which imposes its values on others for their own good. Insofar as my analysis has been successful in delineating the question of what is expertise and what concerned class morality, and what is expertise and what concealed class morality, and what is actual performance rather than unrealisable ethical intent, I hope it can clarify the problem of determining how far professions may be given the authority to determine their own work...the professions' role in a free society should be limited to contributing to the technical information of men...When he pre-empts the authority to direct, even constrain men's decisions on the basis of his own values, the professional is no longer the expert but rather a member of a new privileged class disguised as [an] expert" (1970: p. 382).*

In order to understand professional work, Freidson did not think that it was enough to delineate it as 'complex' and requiring a long period of training based on a body of theoretical or scientific knowledge (1970). The varying types of work for different individuals requires different amounts of knowledge and different combinations of learned elements that need to be known. Freidson states that:

> *"It is intellectually and practically inexcusable to accept a global characterization of professional knowledge and work when uniformity of quality is not present" (1970: p. 340).*

Johnson and Larson have engaged in discussions around the relationship between professions and the market for their services and of their wider societal context (Dingwall 2008). Johnson wrote a 'booklet' titled Professions and Power (1972), in which he took a critical approach and focused on the professions and power. He developed the existing work on professions and he defined a profession as a method of controlling work – one in which an occupation exercises control over its work. He emphasised the role of power in establishing and maintaining such control. Johnson (1972) stated that the increase in the number of professions and the growth of professionalism has been accepted generally by social scientists as a "major if not a defining characteristic of industrial societies". Johnson quoted Goode that "an industrialising society is a professionalising society" (1972: p. 9). He explained that the endeavour to define a profession as an occupation with certain characteristics, academics have in fact limited their analysis to theoretical statements at various levels of abstraction related to these characteristics. This endeavour, he stated, had resulted in "confusion so profound that there is even disagreement about the existence of confusion" (1972: p. 22).

Johnson (1972) used ideas from Foucault's late text. Johnson's work reflected a departure from the traditional stance of the structural-functionalists and trait theorists to a position

that questioned the self-interests of professions. Johnson made obvious references to the power relationships between consumers, producers and society.

Subsequent literature from both the UK and the United States was described by commentators as favouring or taking a “power approach” rather than the “trait approach” of earlier structural-functional writers, such as Parsons and Carr-Saunders and Wilson. Johnson offered an alternative framework to that presented by the trait theorists – a theory which he rejects as inadequate. The focus of Johnsons’ work is the relationship between the producer and consumer of professional services. When writing about professionalisation and professionalism, Johnson stated that, the ‘trait’ approach was proven inadequate in a number of ways (Johnson 1972: p. 23). He suggested that because of the atheoretical character of the ‘trait’ theory, it too easily falls into the error of accepting professions and professionals own definitions of themselves (1972: p. 25).

Johnson is explicitly critical of professions., He claimed that the division of labour (occupational specialisation) created varying degrees of social distance between the producer and consumer. He argued that professionalism is one form of occupational control that is used to impose the definition of a relationship on the client. Johnson stated that the dynamic process of professionalisation as a concept can be seen as a:

> *"...straight jacket imposing a view of occupational development which is uniform between cultures and uni-linear in character" (Johnson, 1972: p. 37).*

Johnson believed that it was middle-class power that provided the basis from which the expanding 'professions' created their own autonomous organisations. Under professionalism, the producer-consumer relationship will typically be fiduciary; a one-to-one relationship initiated by the consumer and terminated by the professional. Although consumer choice is a form of consumer control, it is professionals, and not clients, that hold the power in society (Johnson 1972). Johnson writes:

> *"...the professional corporations are far from anti-bureaucratic; they themselves are bureaucratic mechanisms with the function of enforcing monopolistic policies...a process in which the professional as technician or expert was caught up in the bureaucratic machine, as one of its creatures" (1972: p. 15).*

It is Johnson's belief that a profession is not an occupation, rather, it is a means of controlling an occupation. In addition, Johnson asserts that professionalisation is a historically specific process, which some occupations have undergone at a particular point in time, rather than a process that all occupations are expected to undergo due to their

'essential' qualities. When discussing institutions and institutional control, Johnson asserted that:

> *"[There] are aspects of institutionalised forms of control which vary not only in association with changes in the content of knowledge and skills associated with an occupation, but also in response to emerging social problems and needs which are to a large extent the product of changing power relations...'professionalism' being one... professionalism, then, becomes redefined as a peculiar type of occupational control rather than an expression of the inherent nature of particular occupations" (1972: p. 45).*

Johnson concluded by stating that the social conditions necessary for occupational control were in decline in the early 1970s. Therefore, the power of the professions will continue to decline.

Larson studies the historic process of professionalisation, emphasising how economic advantage for occupations was attained by restricting the supply of practitioners and striving for a position of public respect and influence (Freidson 2001: p. 6).

Professions were described by Larson (1977) as being social products and articulated how she saw "professionalisation as the process by which producers of specialist services sought to constitute and control a market for their expertise". Larson (1977: p. 14) asserted that professional work cannot be detached from everyday life and that professional work is a commodity, an intangible service. She suggested that professionalisation is a deliberate strategy to obstruct the free movement of labour and induce or accentuate social inequality:

> *"I see professionalization as the process by which producers of special services sought to constitute and control a market for their expertise. Because marketable expertise is a crucial element in the structure of modern inequality, professionalization appears also as a collective assertion of special social status and as a collective process of upward social mobility. In other words, the constitution of professional markets which began in the nineteenth century inaugurated a new form of social inequality" (Larson 1977: pp. xvi-xvii).*

Larson was interested in the external consequences of professionalism that extended to professions as a whole. She asked what professions got out of professionalism and how. In her book, The Rise of Professionalism (1977), Larson gave an interpretation of the modern professional phenomenon in Anglo-American societies, which questioned the evolutionary implications of functionalism and its neglect of historical diversity (Larson 1990). In her 1990

paper, Larson reported that it was less productive to work towards a general theory of professions than it was to think of questions which go beyond the professions, and address the larger and more important theme of the construction and social consequences of expert knowledge. Rather, it should be seen as a complex programme of research instead of a readily usable and unproblematic concept (Larson 1990). At the time of writing, Larson expressed that the model or image of professions which were held, and that which was found in social science, emerged from both social practice and from an ideological representation of social practice. Larson suggested that the "image of profession…implicitly accentuates the relation between professional privilege and the market" (Larson 1977: p. xvii). Larson saw professions as a historically specific phenomenon. Larson asserted that the distinct models of status closure which exist, 'alerts us to the fact that profession is always a historically specific concept' (1990: p. 30). She suggested that a 'profession' is:

> *"…a name we give to historically specific forms that establish structural links between relatively high levels of formal education and relatively desirable positions and/or rewards in the social division of labor" (Larson 1990: p. 30).*

Larson perceived professions as a necessary part in any theory of the modern state (Larson 1990). In her analysis of professions, Larson built a historic narrative. She studied professions as interest groups linked to the class system of capitalist societies and analysed professionalisation as a "collective mobility project" in which a limited group of occupations

seek to improve not only their economic position but also their social standing and or prestige and to gain monopoly in the marketplace. When referring to her earlier work, Larson linked the partial phenomenon of professionalisation and its specific cases to the general restructuring of society in two exemplary instances of liberal capitalism:

> *"On the other hand, the analysis of different professional projects clearly indicated that they all shared the goal of creating a protected institutional market for services or for the work of individuals whose competence also had to be institutionally demonstrated" (Larson 1990: p. 24).*

In her analysis, Larson (1977) described professionalisation as an attempt to translate one order of scarce resources into another 'special knowledge and skills' into 'social and economic rewards' (Larson 1977):

> *"…professions are situated at the middle and upper levels of the stratification system…outside and above the working class…the fact remains that individual professional status is still undeniably a middle-class attribute and a typical aspiration of the socially mobile children of industrial or clerical workers" (Larson 1977: p. xvi).*

Larson explained that monopolistic and standardised prediction of professional producers is a necessary 'step in the march toward market control' (Larson 1977: p. 17). The structure of the professional market, Larson notes, is determined by the broader social structure which shapes the social need for the given service. Thus, the need for a 'commodity' determines the size of the market (Larson 1977). According to Larson, professions emerging themselves with a developing market social order had to create first hand a market for their services and gain special status for their members to give the respectability (Larson 1977).

Larson wrote in relation to monopoly or the control over access to the credential, which linked to the protection of scarcity as an integral part of the concept of professionalisation:

> *"In societies that value specialized expert knowledge and are also structurally equal, scarcity or monopoly have two kinds of interdependent rewards: opportunities in markets of services or labour…status and work privileges in an occupational hierarchy including bureaucratic position…one of these benefits is the professionals exercise of his or her specialist functions. Autonomy…is justified in principle by the professions claim of possessing a special and superior knowledge, which should therefore be free of lay evaluation and protected from inexpert interface" (Larson 1977: pp. 30-31).*

In relation to organisations, Larson illustrated that with the exception of medicine, no other profession controls a complex organisation, such as a modern hospital with a technological base and advancement with new and highly skilled specialisations (Larson 1977: p. 38). Larson affirmed that all professional or professionalisation phenomenon must be theoretically linked to the social production and certification of knowledge in relation to the social project of professional reform, which is also detailed as the most significant resource in the professions presentation to the public (Larson 1990).

Larson used Foucault's work in relation to knowledge, power and control of the production of discourse. Larson referred to Foucault's different procedures for controlling discourses. She detailed Foucault's basic exclusionary procedures, including the exclusion of the production of discourse, the distinction between reason and madness, the opposition between truth and falsity. Larson suggested that "professions can be distinguished by the nature and the structure of their discursive field" (Larson 1990: p. 38).

From a symbolic interactionist point of view, Larson stated that professions contain the actual traces of all that professionals in theory claim to be. Larson suggested that whenever challenged, professionals and experts, individually or collectively, retrench behind boundaries of their discursive fields and retreat towards the protected core.

2.1.3 Jurisdictional Competition (power)

The boundaries or jurisdictions which professions occupy were of particular interest to Abbott. Andrew Abbott rejected the individualistic view of professions in favour of a systems approach; that is, a systematic view of the nature of relations between professions. Abbott maintained that professions exist within a system and that they are never seen alone (Abbott 1988: p. 33). He defined a fully formed profession as an organised body of experts who apply some particular form of esoteric knowledge to particular cases. These experts have elaborate systems of instruction and training together with entry by examination and other formal prerequisites, normally possessing and enforcing a code of ethics or behaviour (Abbott 1988: p. 4). Ethic codes served as a means of excluding outsiders (Abbott 1988: p. 5). His focus is primarily on the relation of occupations to each other in a division of labour with the forces influencing their jurisdictional boundaries establishing their official and social identities as well as economic fortunes (Freidson 2001). Abbott acknowledged that most authors perceive that professions grow thorough and follow a series of stages which they call professionalisation and that most talk less about what professions actually do than how they are organised to do it. Abbott described professionalisation as 'at best a misleading concept' as it concentrated on the forms rather than the contents of professional life and ignored who was doing what to whom and how (1988: p. 1). Legitimation justifies both what professions do and how they operate. In the first case, legitimation establishes that the results produced by successful professional work are culturally valued results. In the second case, legitimation establishes that results are produced in a culturally approved manner (Abbott 1988: pp. 184-5). Abbott explained that professions make up an interdependent system and that in this system each profession has its activities under

various kinds of jurisdiction. At times, it may have full control and at times it may control a subordinate group. Abbott suggested that jurisdictional boundaries are perpetually disputed both in local practice and national claims (Abbott 1988).

> *"Any occupation can obtain a licensure…or develop an ethics code…But only a knowledge system governed by abstractions can redefine its problems and tasks, defend them from interlopers, and seize new problems – as medicine has… Abstraction enables survival in the competitive system of professions" (Abbott 1988: p. 9).*

Professions develop when jurisdictions become vacant. Abbott stated that this vacancy may occur because they are newly created or because an earlier 'tenant' has left them altogether or lost its firm grip on them:

> *"If an already existing profession takes over a vacant jurisdiction, it may in turn vacate another of its jurisdictions or retain merely supervisory control of it" (Abbott 1988: p. 3).*

He went on to add:

> *"Legitimacy provides a central foundation for jurisdiction, and its absence provides a central line for attack" (Abbott 1988: p. 57).*

Abbott (1988) suggested that jurisdictional claims have three parts: (1) to classify a problem, (2) to reason about it, and (3) to take action on it. Using medicine as an example, Abbott illustrated these three parts using a medical consultation as an example, i.e., ' to diagnose, to infer, and to treat' (p. 39). Diagnosis assigns subjective properties to objective problems, diagnosis takes information into the professional knowledge system and the treatment brings instructions back from it. During the process of diagnosis, relevant information about the client is pulled together to form a picture of the client's needs. This picture is, then, categorised into an appropriate diagnostic category. Abbott 1988 described theoretically these three steps as three acts of profession practice (p. 40, p. 44):

> *"It is within this logic that tasks receive the subjective qualities that are the cognitive structures of a jurisdictional claim" (Abbott 1988: p. 40).*

Treatment failure makes jurisdiction vulnerable. Treatment failure can falsify the doctor's diagnosis. In some cases, there is only one chance to get it right. Doctors need to treat effectively to maintain their dominance (Abbott 1988). Interestingly, for the process of the three steps, and to enable the doctor to carry out the three steps without threat to their jurisdiction, Abbott described 'certain clients' as more attractive to professionals. He

suggested that middle class people, would make more attractive clients to physiotherapists due to the clients ability, on one hand, to pre-diagnose their own problems and, on the other hand, the capacity to understand their treatment in 'relatively professional terms' (Abbott 1988: p. 47). Admittedly, this account was written twenty years ago, but it is exactly this kind of client, with the exception of class characterisation, that are questioning doctors' clinical practice, decision making, diagnosis and treatment – the informed patient.

The academic knowledge system is referred to, as Abbott suggests, that it:

> *"…also provides new treatments, diagnoses, and inferences for working professionals…These effects are usually visible secondarily, through loss of practical jurisdiction although there are cases of dominant professions becoming dependent on other professions for new means of treatment and diagnosis. (Generally, as in the case of medicine and the pharmaceutical houses, joint control is worked out)" (Abbott 1988: p. 57).*

Abbott maintained that the actual conduct of professional work determines many of the parameters of interprofessional competition. He maintained that behind the world of professional work lies a rationalising, ordering system (Abbott 1988).

2.1.4 "Third Logic" Theory 1990s – 2000s

With the developments of theories of the professions, and the practical evolution and advancements of professions and indeed the markets, institutional and organisational contexts in which they existed, saw some commentators amend and or modify their initial concepts. One writer that has done this is Eliot Freidson (an example of this course is also illustrated earlier in the piece with Larson (1990) and her revision of her 1977 paper).

In his 2001 book, Freidson provided an analysis of professionalism. Freidson explained that he relied on many of Larson's concepts and insights. He described that he abstracted them into a model of interconnected institutions whose realisation depends upon the conjunction of a limited number of contingencies (Freidson 2001). Freidson also drawed on the work of Abbott for his analysis:

> *"[Abbott] does discuss the social, economic, any symbolic sources of challenge and support, as well as the significance of an occupation's particular of knowledge, but his concentration on jurisdiction leads him well past the conventionally defined professions to include many specialists who have attained considerably less privilege…" (Freidson 2001).*

Freidson described Abbott's analysis as rich and imaginative, connected with occupational jurisdiction, using an idiosyncratic methodology (Freidson 2001: p. 6). In relation to Abbott and Larson, Freidson acknowledged that his analysis 'cannot' be as rich.

In Professionalism, the Third Logic, Freidson (2001) tried to make sense of the changes which occurred in relation to the professions throughout the advancing industrial world in relation to the 'logic' of institutions. In his attempts to gauge this Freidson demonstrates that monopoly is essential to professionalism, which directly oppose it to the logic of competition in a free market, and how properties of professionalism fit together to form a whole that differs systematically from the free market on the one hand, and bureaucracy on the other. Freidson believed that monopoly, credentialism or expert authority cannot be avoided and that they are essential for the 'nurturance of specialised knowledge' (Freidson 2001: p. 208). For Freidson, the 'soul of professionalism' is the occupational control of work (Freidson 2001). Freidson stated:

> *"Monopoly and credentialism are the key elements of professionalism's economic privilege" (Freidson 2001: p. 198).*

Macdonald stated that "whilst one can certainly argue that the professions were part and parcel of a 'process of state formation' it is also the case that those of their actions which involved or impinged on the state were carried out for motives and with objectives which had nothing to do, consciously, with state formation" (Macdonald 1995: p. 119).

2.2 Boundary Work and Practices

Boundaries and practices are two elements of an institution. Institutions are comprised of regulative, normative and cultural-cognitive elements that, together with associated activities and resources, provide stability and meaning to social life. Many treatments of institutions emphasise their capacity to constrain and control behaviour (Scott 2008a: p. 48, 50). It is argued that boundaries and practices and boundary work and practice work are distinct but interdependent occurrences which operate recursively and are mutually reinforcing (Zietsma and Lawrence 2010). Boundaries can be mental, social, or physical. They exist throughout society and indeed throughout the world. There are many different types of boundaries, including social boundaries, ethical boundaries and work boundaries.

> *"The notion of "professions" originally emerged as a demarcation problem— i.e., a problem of boundaries—between "special" and ordinary occupations. The issue was whether professions should be defined by their particular knowledge base, as a particular phase in the development of occupations, or as a particular type of institutional organization giving practitioners control over access, training, credentialing, and evaluation of performance" (Lamont and Molnar 2002: p. 177).*

Boundaries outside of science are typically socially constructed, and as a function, they mark out limits. Sometimes boundaries can be absolute, such as laws or practices set out in law, or boundaries detailing physical limits such as land boundaries. On the other hand, very often boundaries can be described as grey and ever changing. Lamont and Molnar determined that boundaries have been associated with research on cognition, social and collective identity, commensuration, census categories, cultural capital, cultural membership, racial and ethnic group positioning, hegemonic masculinity, professional jurisdictions, scientific controversies, group rights, immigration, and contentious politics to mention only some of the most visible examples (Lamont and Molnar 2002).

Often boundaries are dependent on the setting. They can differ between cultures, organisations and units. They can also vary over time, for example. Abbott described boundaries as units. Typically, the most general notion of a boundary is as a distinction that allows the recognition of categories. Boundaries are described as the distinctions among people, groups, categories and objects (Carlile 2002; Lamont and Molnar 2002; Zietsma and Lawrence 2010).

Pharmacists operate within distinct boundaries as set out by various laws and policies that govern the remit of pharmacy practice. Within any one professional group, professions may share tasks, carry out a range of tasks permitted by their boundaries, or carry out tasks specific to a professional environment or professional role. For example, theatre and anaesthetic pharmacists in a hospital will carry out a different set of tasks to a community pharmacist.

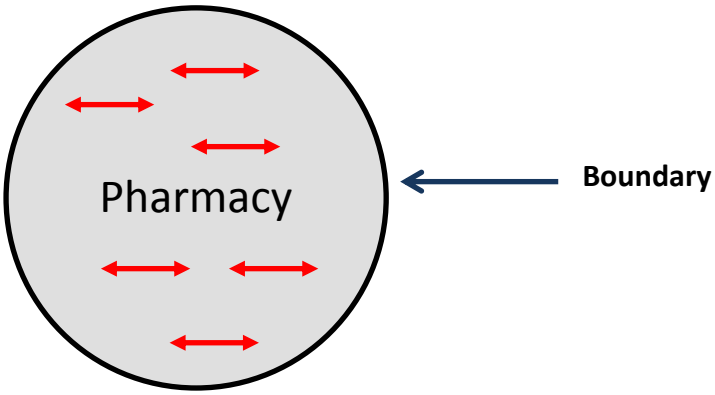


Figure 1: Pharmacy Work Sphere

Figure 1 represents the pharmacy profession and the professionals which exist and operate within the sphere. The bold line which encapsulates the red left right arrows, illustrates the boundary that pharmacists operate within. The red two-way arrows represent pharmacy groups/individual pharmacists who work within a more specific boundary remit. This remit will, typically, be governed by their employing organisation.

Zietsma and Lawrence (2010) described (and illustrated diagrammatically) a recursive, mutually supportive relationship between boundaries, practices, boundary work and practice work, and how this relationship has been found to underpin cycles of institutional stability, conflict, innovation and restabilisation:

> *"...boundaries and practices are distinct, interdependent features of groups that exist in a recursive relationship, with boundaries*

> *delimiting sets of legitimate practices, and practices supporting particular group boundaries... Although boundaries and practices work to stabilize each other, their relationship can also lead to significant change" (Zietsma and Lawrence 2010: pp. 9 – 10).*

This section will explore literature on boundaries and practices, specifically looking at boundary work and practice work in medicine and pharmacy. Examples of how these boundaries and practices are constructed, negotiated and maintained, reinforced and redefined will be drawn upon along with the shared routines and or activities that are guided according to the situation or boundary. Abbott's discourse around boundary work and jurisdiction and Zietsma and Lawrence's paper looking at institutional work and the interplay between boundary work and practice work will be drawn upon. This piece will go on to look at the transformation of pharmacy and pharmacists in the UK from traditional roles and practices to their current jurisdiction and boundary. More specifically, pharmacist non-medical prescribing[1] (NMP) as a case study will explore boundary and practice work theory.

> *"The literature on professions, science, and social knowledge illustrates exceptionally well the usefulness of the concept of boundaries as it is used to understand how professions came to be distinguished from one another—experts from laymen, science from*

[1] Non-medical prescribing is the term used to describe any prescribing done by a healthcare professional other than a doctor or dentist.

nonscience, disciplines between themselves, and more generally how systems of classification emerge to bring order in our lives" (Lamont and Molnar 2002: p. 177).

With regard to professions, it is important to bear in mind that this system of classification can be somewhat empowering as it creates jurisdictional monopoly. However, instead of bringing order, it could in fact be restricting and inhibiting for groups and or professions. With reference to the earlier discussion on professions, professions can be conceptualised in several different ways ranging from the macro level (including professional institutions, e.g., (bodies of knowledge, political roles, and professional associations) to the micro level (including professions working in day-to-day practice with distinct ways of working with distinct jurisdictional boundaries) and the processes of professionalisation or carving out legitimate areas of jurisdiction and market closure to professionalism as a way of being culture and identity.

Freidson suggested that the ideology of professionalism makes a case that expertise warrants special influence in certain affairs because it's based on sustained systematic thought, investigation, or experimentation. In the case of individuals, accumulated experience performing specialised work which required long and appropriate training (Freidson 2001: pp. 207-208). Abbott reasoned that the tasks of professions are to provide an "expert" service to human problems (Abbott 1988: p. 35). In his book, The System of Professions, Abbott put forward three basic arguments. That professions could not be studied individually but only within an interacting system, that a theory of professions had

to embrace not only culture and social structure but also intra-, inter-, and transprofessional forces, and that the development of professions would necessarily be a matter of complex conjunctures (Abbott 1993). Abbott proposes that a profession is a collection of turf battles[2], zones of action that are later yoked into a single defensible position in the system of professions. Yoking means connection of two or more proto-boundaries such that one side of each becomes defined as "inside" the same entity (Abbott 1995). For Abbott, professions develop when jurisdictions become vacant. He states that this vacancy may occur because they are newly created or because an earlier 'tenant' has left them altogether or lost its firm grip on them. Once a profession has been established, it has to maintain and defend its jurisdiction in order to remain a profession:

> *"The apothecaries …intended to use new powers obtained in 1748 to restrain the chemists and druggists from practicing pharmacy. The apothecaries could not however capture the whole field, and while successful in maintaining their position against the physicians, they gave ground on the other to flank pharmacists" (Carr-Saunders and Wilson 1933: p. 132).*

Abbott contends that:

[2] In defining 'turf', Abbott suggested that turf is a set of things to do (Abbott 1995)

> *"Legitimacy[3] provides a central foundation for jurisdiction, and its absence provides a central line for attack" (Abbott 1988: p. 57).*

He goes on to add:

> *"If an already existing profession takes over a vacant jurisdiction, it may in turn vacate another of its jurisdictions or retain merely supervisory control of it" (Abbott 1988: p. 3).*

Chemists and druggists worked to protect the professions interest and successfully argued for an exemption from the Apothecaries Act of 1815[4]. Chemists and druggists grouped as an occupational group, pharmacy, which established its organisation of pharmacists in 1841 (Anderson 2005; Carr-Saunders and Wilson 1933) which led to them, then, operating separately from medical practice. In 1843, The Pharmaceutical Society, received the grant of a royal charter (Carr-Saunders and Wilson 1933).

[3] Legitimation justifies both what professions do and how they do it. In the first case, legitimation establishes that the results produced by successful professional work are culturally valued results in the second case, legitimation establishes that the results were produced in a culturally approved manner (Abbott 1988, pp. 184-5).

[4] The term apothecary, often used between the 1600s and 1800s, does not refer to the chemist and druggist. It was used for individuals living in London who had passed the examinations of the Worshipful Society of Apothecaries of London, founded in 1617 (Royal Pharmaceutical Society of Great Britain 2013c)

Boundary work has been described as an effective ideological style which is used in protecting professional autonomy (Gieryn 1983). Boundary work is used by Gieryn to highlight the negotiated character of science, and is defined as:

> *"The discursive attribution of selected qualities to scientists, scientific methods and scientific claims for the purpose of drawing a rhetorical boundary between science and some less authoritative residual 'non-science" (Gieryn 1999).*

Gieryn argued that the demarcation of science from non-science allowed scientists to defend their intellectual territory and maintain an image of expertise, authority and credibility (Gieryn 1999). The literature presented the occurrence of occupation boundary disputes between professions and professionals in health care as common, although at first such disputes may not be obviously apparent (Abbott 1981; Allen 1997; Allen and Lyne 1997; Currie, Finn, and Martin 2007; Pickard 2009; Timmons and Tanner 2004). Boundary work often involves a profession working with people from another profession(s) as well as from other organisational units. This collaboration creates occupational boundaries. These occupational boundaries are established by the divisions between occupations and are often the result of professionalisation projects and strategies:

> *"…we can assume that recent jurisdictional boundaries will be altered by reassigning many now professional tasks to less qualified workers… this does not mean that professionals will be stripped of all*

> *their tasks, however, for some traditional ones are likely to remain part of their jurisdiction and newly invented ones based on new knowledge will probably added " (Freidson 2001: p. 209).*

Lamont and Molnar stated that boundaries are an essential "medium" through which people acquire status and monopolise resources (Lamont and Molnar 2002). In their 2004 paper, Timmons and Tanner suggested that professions who care for patients directly are held to have higher status than those which assist (Timmons and Tanner 2004). The medical profession is described as a dominant profession. It is consistently referred to as a profession that holds position of superiority and authority over other 'paramedical' professions having achieved monopoly (Abbott 1988 ;Abbott 1983; Abbott 1995; Dingwall 2008; Eaton and Webb 1979; Freidson 1970; Gieryn 1983). Abbott maintained that, specifically, medicine controls a complex division of labor [sic] in which a number of subordinate groups take their places. Abbott explained that:

> *"The control of subordinates in such occupations is largely an intraprofessional matter, meaning that jurisdictional battles between subordinates and superordinates are fought within the professional organizations themselves" (Abbott 1988: p. 82).*

For some time now, debates around the sphere of work of the medical profession and the control that other professions have led to discussions and questions around the decline in

medical hegemony. Collins (2007) suggested that doctors have professional status partly because traditional professions are associated with higher socioeconomic levels of society.

In an occupational setting, Wikstrom (2008) illustrated, that boundary work, is undertaken by the members of an occupational community who are trying to increase their influence among other groups already recognised for their status and power. Such members, almost by definition, lack similar status and power and yet they work alongside these other groups in a collaborative situation (Wikstrom 2008: p. 61).

As part of the modernisation of the NHS, a number of key policies on non-medical prescribing have been introduced. The views set out by Abbott are particularly relevant when considering non-medical prescribing and the expansion of the pharmacist's role and how this expansion affects other healthcare professions. The 'new' tasks carried out by pharmacists are tasks traditionally carried out by doctors. Non-medical prescribing (prescriptions written by nurses and pharmacists, for example) is described as easing the burden on doctors and improving patient access. However, it also brings to the fore significant questions about the changing social organisation of healthcare work. Abbott's concept and, indeed, this scenario involving non-medical prescribers and doctors unmask jurisdictional struggles and boundary disputes between professions. Previous work around pharmacist prescribing suggested that pharmacists are, in fact, reluctant to 'encroach' on medical territory and that the expansion and development of the role of the pharmacist is

purely to make better use of the skills that they already possess as pharmacists (Gilbert 1998; Weiss and Sutton 2009). Collins stated that:

> *"...professions may arrive at compromises and share jurisdiction, as occurs between psychiatrists and psychologists" (Collins 2007: p. 108).*

The boundaries or jurisdictions which professions occupy were of particular interest to Abbott. In his work, Abbott explained that many professions are actually doing similar things and that they are often competing with each other for particular tasks.Abbott describeed this as competing (or struggling) for jurisdiction. In his paper, 'Things of boundaries', Abbott continueed to use his ecological approach to examine the profession. He argued that professions constitute an open, ecological system in which individual professions exist in interdependence. They compete with one another for jurisdictional monopolies, thereby constituting a constantly changing system of professions. Using Abbott's work around jurisdictional claims, prescribing can be seen as an area of jurisdiction previously under full jurisdictional control of the medical profession with recent actions by the state affecting professional control. Abbott suggested that diagnosis, treatment, inference, and academic work provided the cultural machinery of jurisdiction. In order to claim jurisdiction, society must recognise its cognitive structure through exclusive rights because jurisdiction not only has a cultural structure but a social structure too (Abbott 1988: p. 59). This competition usually assumes the form of disputes over jurisdictional boundaries, i.e., it is waged to redraw the social boundaries between professions (Lamont and Molnar 2002: p. 178):

> *"...it is wrong to look for boundaries between preexisting social entities. Rather we should start with boundaries and investigate how people create entities by linking those boundaries into units. We should not look for boundaries of things but for things of boundaries" (Abbott 1995: p. 857).*

Collins (2007) explains that Abbott changes the focus of the study of the professions from the usual analysis of organisational structures of existing professions to an analysis of the work that professions actually do (Collins 2007: p. 108). Abbott maintains that professions exist within a system and that they are never seen alone (Abbott 1988: p. 33). Abbott, in his 1988 book, defends the principle that professions are organisational structures possessing many internal components and divisions of labour. He goes on to describe it as an interdependent system or structure and that jurisdiction is not exclusive (Abbott 1988: p. 86). He defines a fully formed profession as an organised body of experts who apply some particular form of esoteric knowledge to particular cases. These experts had elaborate systems of instruction and training together with entry by examination and other formal prerequisites, normally possessing and enforcing a code of ethics or behaviour (Abbott 1988: p. 4). Ethic codes served as a means of excluding outsiders (Abbott 1988: p. 5). His focus is primarily on the relation of occupations to each other in a division of labour with the forces influencing their jurisdictional boundaries establishing their official and social identities, as well as economic fortunes (Freidson 2001). Abbott acknowledges that most authors see (or assume that) professions grow through and follow a series of stages which

they call professionalisation and that most talk less about what professions actually do than how they are organised to do it. Abbott describes professionalisation as 'at best a misleading concept' as it concentrated on the forms rather than the contents of professional life and ignored who was doing what to whom and how (Abbott 1988: p. 1). Abbott contends, however, that it is commonly agreed that a profession is an occupational group with some special skill (Abbott 1988: p. 7).

Abbott explains that the professions make up an interdependent system and that, in this system, each profession has its activities under various kinds of jurisdiction. It may have full control over the profession or , at times, control a subordinate group. Abbott contends that jurisdictional boundaries are perpetually disputed both in local practice and national claims (Abbott 1988). The ability to clearly define a profession's role and practices is a key way of mataining legitimacy and defending professional boundaries:

> *"…the clarity with which professional borders are defined towards other professions may affect the jurisdictions vulnerability. Under some conditions, clarity is a good defense…the academic knowledge system of a profession generally accomplishes three tasks – legitimation, research, and instruction- and in each it shapes the vulnerability of professional jurisdiction to outside interference" (Abbott 1988: pp. 56-7).*

Nevertheless, Abbott maintains that a profession is always vulnerable to changes in the objective character of its central tasks (Abbott 1988: p. 39).

Task sharing is easily accepted by professions when work is delegated or performed on instruction from a dominant professional. In the case of pharmacy, pharmacists have been 'diagnosing' minor ailments and prescribing medicines for countless years:

> *"When aspirin is selected (from a range of other drugs) by an 'expert' sanctioned to interpret its appropriateness for a specific individual, this commonly available drug has the potential to be symbolically transformed into a medicine" (Harding and Taylor 1997: p. 554).*

Pharmacists advise doctors around prescribing, pharmacology, pharmacokinetics; they are medicine experts. Nevertheless, pharmacists do not have complete autonomy. They do not have full and complete control over the product (the drug):

> *"The major problem which prevents pharmacy from stepping across the line of marginality is its failure to gain control over the social object which justified the existence of its professional qualities in the first place" (Denzin and Mettlin 1968).*

Medicines are offered in a range of outlets. These include the internet, in corner stores and supermarkets, and most often by people who are not pharmacists and have no training in medicines or knowledge of medicines. Eaton and Webb illustrate:

> *"It can be argued convincingly that pharmacists have always carried out 'clinical' activities in retail pharmacy, and that clinical pharmacy is therefore nothing new. Yet retail pharmacists have achieved little by way of status and authority that would normally accompany such activities" (Eaton and Webb 1979: p. 85).*

Pickard, making reference to Fournier (2000) suggests:

> *"The assemblage of institutions, experts and practices that comprise the state, moreover, is subject to continuous shifts in line with changing discourses, indicating that the construction of both a professional grouping and its claim to expertise is an 'achievement... rather than... a discovery'" (Pickard 2009: p. 264).*

Abbott (1995) discusses sites of difference, boundary extension and 'proto-boundaries'. He suggests that locally random sites of difference become proto-boundaries only when they line up into some kind of extended opposition along some single axis of difference. Thus, it is possible to have two kinds of people who do some task and find that difference lining up

into a systematic difference across many work sites or across several types of institutions. As an example of this difference, Abbott used the kind of boundary that emerged between systems analysts and programmers in the 1970s and 1980s:

> *"...It appeared and reappeared independently in organization after organization. In this case, we have an extended set of boundary points that began to take on a special reality by virtue of the precedence of one or a limited number of types of difference. The names were conveniences to describe the boundary, which emerged well before there was any really systematic social reality to the entity "systems analysis" or "programming." It is rather that a dimension of difference--in this case over how one approaches a computing problem--emerges across a number of local settings to produce a proto-boundary" (Abbott 1995).*

This extension of boundaries is also a demonstration of how boundaries shift from sphere to sphere. More specifically, this occurrence is evident in the emergence of non-medical prescribing by pharmacists, nurses, and other allied health care professionals:

> *"[the academic knowledge system] provides new treatments, diagnoses, and inferences for working professionals…These effects are usually visible secondarily, through loss of practical jurisdiction*

> *although there are cases of dominant professions becoming dependent on other professions for new means of treatment and diagnosis. (Generally, as in the case of medicine and the pharmaceutical houses, joint control is worked out)" (Abbott 1988: p. 57).*

Abbott states that boundaries between professional jurisdictions tend to disappear in worksites, particularly in overworked worksites (Abbott 1988: p. 65). Often medical practitioners, for example, delegated their work to subordinate positions in the division of labour. This is particularly evident in the literature as it illustrates the blurring, crossing, spanning, and the borrowing of boundaries and the shedding of 'dirty work'. These types of processes are frequently used in the negotiation of boundaries.

Eaton and Webb illustrate that an attempt to gain status may result in pharmacists doing more 'dirty work' for medical practitioners for relatively few gains:

> *"The pharmacist may gain in status vis-a-vis other paramedical workers, he may even gain the medical practitioners' tacit affirmation that he is better equipped to make decisions about drugs than the hospital nurse or the general practice receptionist, but in essence relations with the medical profession may be little changed. Thus the threat of territory encroachment has been effectively controlled by*

> *officially delegating work which gives some increased status to pharmacists without detracting from the overall position of the medical practitioner" (Eaton and Webb 1979: p. 85).*

The problem here, however, is that, defining work roles exists through the threat that a profession experiences when this shift in labour division is formally and lawfully acknowledged, even though the actual division of labour in reality is different to what is implicitly expressed and or expected. Thus, the threat to dominance or the perception of boundary encroachment for dominant professions is heightened with the legislative rules and extension of boundaries and the modification of jurisdiction. Abbott states, "Legally established jurisdiction comes slowly and endures forever" (Abbott 1988: p. 64). This is particularly true in the case of non-medical prescribing as it is not going away.

In line with the NHS modernisation agenda and the governments focus on competent working and utilising the skills that workers already possess, there has been a shift of boundaries, which is clear in the NHS. An early example of this is in the 1970s where the role of ward pharmacists extended to participation in ward rounds and direct contributions to patient care (Ellis 2005: p. 135). These various shifts in tasks and expansion of roles and boundaries have now been formally recognised thorough a series of policies and acts which have been implemented, in many cases grounding them legally. Some examples of these changes include Pharmacy in a New Age Project (PIANA), Pharmacy in the Future, Pharmacists Prescription amendment policy, and A Vision for Pharmacy in the New NHS.

In the case of pharmacy, there are a number of different types of pharmacists including primary care pharmacists, community pharmacists (once known as retail pharmacists), hospital care pharmacists, industrial pharmacists, regulatory pharmacists, academic pharmacists, and veterinary pharmacists. Pharmacists today can be found in a number of different settings including in supermarket and community or high street pharmacies (independently owned shops or large multiple chain pharmacies), in hospitals and on hospital wards, doctor's surgeries, walk-in centres, in the pharmaceutical industry, and at universities. Nonetheless, pharmacists tend to work in one of two areas, community pharmacy (the most common) and hospital pharmacy. Pharmacists are experts in drug therapy and are often referred to as the most accessible healthcare professional. No appointment is needed to see a pharmacist and more often than not patients can be seen in a matter of minutes by a pharmacists (Department of Health 2003a, 2003b, 2008b; Jesson and Bissell 2006). In a news release, the Royal Pharmaceutical Society of Great Britain claimed that perceptions of community pharmacists by patients are that of a trusted healthcare professional, but there is lack of understanding around the broader role of pharmacists (Royal Pharmaceutical Society of Great Britain 2007). This lack of understanding regarding the role of the pharmacist is not limited to patients. Research has shown that this lack of understanding or confusion is also experienced by other healthcare professionals, including doctors and nurses.

The scope of frontline pharmacy practice has expanded from its earlier role and is now more diverse than it ever has been. The Nuffield report suggested that community pharmacists

future professional role should involve greater collaboration with other healthcare professionals and greater involvement with the public (Nuffield 1986).

Over the last twenty years, non-medical prescribing (then called nurse prescribing) has been a noteworthy item on the health agenda. One of the first references to non-medical prescribing was in the 1986 Cumberlege Report (Cumberlege 1986) which proposed nurse prescribing. Julia Cumberlege was requested to undertake a review of community nursing. One of the main recommendations to come out of the review was that nurse prescribing should be introduced in order to *improve the quality of care provided* in the community. Improving quality of care is a rhetoric that has carried through the last 25 years and is still a key aim for healthcare and non-medical prescribing. Under the wider heading 'New Roles', Cumberlege (1986) wrote a section entitled 'Power to prescribe' which set out some findings of the investigation and the justifications for change:

> *"...We recommend that the DHSS should agree a limited list of items and simple agents which may be prescribed by nurses as part of a nursing care programme, and issue guidelines to enable nurses to control drug dosage in well-defined circumstances. Detailed medical protocols should be drawn up with general practitioners which encourage community nurses within strictly agreed limits to vary the timing and dosage..." (Cumberledge 1986: pp. 33-4).*

The implementation of these recommendations and expanding prescribing rights took over 10 years to be realised and were first seen when district nurses and health visitors were given limited prescribing rights in the late 1990's. As such, prescribing rights have now legally been extended to other health professionals and extended even further to that recommended in the Cumberlege Report. Thus, prescribing and supply of medicines has progressed and now other allied health professions can prescribe medicines. Supplementary prescribing[5] was extended to physiotherapists, chiropodists/podiatrists, radiographers, and optometrists in May 2005 (Department of Health 2006a).

[5] Supplementary prescribing is a three party care group where a patient specific clinical management plan (CMP) or 'care plan' (Royal Pharmaceutical Society of Great Britain 2009) is devised and agreed between the independent prescriber, the supplementary prescriber (the pharmacist or nurse, for example) and the patient whose care is being managed (Courtenay and Griffiths 2004; Crown Report 1999; Department of Health 2005)

Chapter 3: The Evolution of the Pharmacy Profession

Pharmacy was once one of Great Britain's fastest growing areas of healthcare. Pharmacists are trained to be experts in medicines. Pharmacists are involved with medicines at every step of the way, from their development in the laboratories to their distribution in the community and in hospitals (Department of Health 2008; Royal Pharmaceutical Society of Great Britain 2009; RPS 2013). This section aims to follow the development and evolution of pharmacy over the years, going back to the role of apothecaries, druggists and chemists as far back to the 15th century. Working right through and looking at how these roles have evolved and adapted and came to be pharmacy and pharmacists in the current day. This piece will pay particular attention to community and hospital pharmacy. This section will examine the journey of pharmacy as an occupation and the changing roles of pharmacists and pharmacy:

> *"For some, the relation between professions and their work is simple. There is a map of tasks to be done and an isomorphic map of people doing them. Function is structure. But the reality is more complex; the tasks, the professions, and the links between them change continually. To some extent, these changes arise beyond the professional world. Technology, politics, and other social forces divide tasks and regroup them. They inundate one profession with recruits*

while uprooting the institutional foundations of another" (Abbott 1988: p. 35).

3.1 Pharmacy and Pharmacists: The Evolutionary Journey

The history of pharmacy goes back to traditional pharmaceutical experts, known as apothecaries. Operating under the apothecaries were chemists and druggists, a diverse group of pharmaceutical practitioners (Crellin 1967). Apothecaries often kept a shop for drugs and spices but also sold other retails items which were not drugs, items such as tobacco. 'Apothecary' is the historical name for a medical professional who formulated and dispensed drugs to surgeons, doctors and patients. This role is now largely performed by pharmacists. In addition to the tasks carried out by a pharmacist, historically, apothecaries offered general medical advice and a range of services that are today performed solely by other specialist practitioners, such as surgeons and midwifes. The role of the pharmacist has changed somewhat as Abbott and Crellin explained that long before the 1858 Medicinal Act, physicians, surgeons and apothecaries were all doctors. Bissell and Traulsen illustrated how the 16th century saw the forming of a Society of Apothecaries. This established the pharmacists' dominance over medicines, while physicians possessed control over prescriptions (Bissell and Traulsen 2005). In the 17th century, the apothecaries were able to become general medical practitioners, who took less of an interest in pharmacy. Then, the only difference between physicians, surgeons and apothecaries were the class of patients that they saw and treated (Abbott 1988; Crellin 1967):

"The physicians treated the upper classes, the surgeons some fraction of the middle classes, and the apothecaries the remainder of the middle and the entirety of the lower classes" (Abbott 1988: p. 77).

Now however, the roles of medical and health professionals have changed noticeably. The nineteenth century saw the British pharmacy undergo key changes (Crellin 1967). Over time, chemists and druggists grouped as an occupational group, pharmacy, and operated separately from medical practice. Chemists and druggists worked to protect the professions interest and successfully argued for an exemption from the Apothecaries Act of 1815. Roles are now specifically categorised, and the division of labour is officially determined by various laws, policies. Professional associations and professions work within their designated, identifiable and exclusive jurisdiction.

The Royal Pharmaceutical Society of Great Britain was the professional and regulatory body for pharmacists in England, Scotland and Wales, responsible for leading the profession and ensuring the highest possible standards of individual professional practice (Department of Health 2008; Royal Pharmaceutical Society of Great Britain 2007). The Pharmaceutical Society of Great Britain was founded in 1841 by a group of London chemists and druggists (Wallis 1964). It was not until 1988, that the Queen agreed that the title 'Royal' be granted

to the pharmaceutical society and from the society has been formally known as the Royal Pharmaceutical Society of Great Britain[6].

A pharmacist is referred to as an expert in medicines and how medicines work. Pharmacists work according to legal and ethical guidelines and are typically involved in all aspects of the preparation and use of medicines, from the discovery of their active ingredients to their use by patients. In addition, pharmacists also monitor the effects of medicines, both for patient care and for research purposes. Pharmacists also have to be registered with the General Pharmaceutical Council (GPhC) to practice as a pharmacist. Pharmacy is a relatively small profession with 46,310[7] pharmacists on the GPhC register membership in 2011, This was a drop from 50,664 (-8.6%) in the previous year and in fact the lowest number since 2002 (Hassell 2012; GPhC 2012a). Practicing pharmacists are split between various types of pharmacy practice.

As health professionals, pharmacists were described as a 'significant untapped resource' for delivering accessible services to the people who need them most. As such, the approach to the regulation of pharmacists must be similar to that for other clinical professions, in a way that safeguards patients and the public and supports the strategic development of high quality pharmacy practice. It is set out in the white paper, that there will be the establishment of a new professional regulator, the General Pharmaceutical Council. The

[6] The Royal Pharmaceutical Society of Great Britain ceased to exist in relation to regulation of the profession in 2010. This was as a result of government policy – Trust, Assurance and Safety – regarding healthcare professional regulation, prompted by the failure of professional regulation following a series of incidents concerning various healthcare professionals (Rodgers, Dewsbury and Lea 2010).

[7] of which n=6,662 were non-practicing pharmacists

General Pharmaceutical Council (GPhC) has replaced the Royal Pharmaceutical Society of Great Britain as the regulator for pharmacists, pharmacy technicians and pharmacy premises from 2010. As part of these reforms the government has sanctioned opportunities now available to pharmacists to become prescribers, to develop special interests in defined clinical areas or to practise as consultant pharmacists. Changes in education and training that will help to ensure that pharmacists have the clinical competencies to deliver the types of services needed in the future (Department of Health 2008).

In Great Britain, to attain the MPharm qualification and to register as a pharmacist, a four year undergraduate course has to be undertaken or one year of pre-registration training following the pharmacy degree. There are currently 29 schools of pharmacy in universities throughout the United Kingdom. Various university course overviews explain that the aim of the four year course is to furnish students with:

> *"…knowledge and technical ability, developing personal and professional skills and nurturing an ethical and caring outlook, all of which are necessary for this important profession" (University of Nottingham, date unknown, accessed 2012).*

In the past, a large proportion of the established undergraduate course was largely scientific in nature, focusing on how medicines were developed and how they worked. Today, pharmacy is firmly grounded in science but the degree course also covers social and

behavioural skills needed to understand people's beliefs and attitudes to taking medicines (Anderson 2005). Ongoing developments in Pharmacy training and the preparing of new pharmacists can be witnessed in various training programmes including the Modernising Pharmacy Careers Programme and the General Pharmaceutical Council pre-registration manual (Smith and Darracott 2011; GPhC 2011):

> *"This review is based on a modern vision of how and when pharmacists can, and should, make their significant contribution to patient and public health and safety, to ensure that more people use their medicines more effectively more often, and to reducing the possibility that those medicines will cause harm" (Smith and Darracott 2011).*

Historically, the role of pharmacists have evolved from the apothecaries in the middle ages. The role of the pharmacist in modern society has continued to change over time and the role of the pharmacist and pharmacy profession is continually under examination. In many ways, the role of some pharmacists now shares some similarities from where it started in its early origins in the middle ages. For example, patients consulted apothecaries for medical advice and apothecaries prescribed drugs (Hunt 2005). The roles of pharmacists changed from the traditional roles of apothecaries. The pharmacist's role has shifted in recent decades to practices. The focus of the pharmacist's role has shifted from the compounding of medicines to ensuring their safe and effective use by providing information and advice

and for some pharmacists, even prescribing. The same way in which there is now an emphasis on consulting pharmacists for advice (Anderson 2005; Taylor 2005; NHS Choices 2009, 2010). Pharmacists transform objects, drugs to medicines – social objects (Hibbert, Bissell, and Ward 2002):

> *"…in more recent years, and particularly over the last decade, universities have responded to changes in educational requirements as the public and employers have demanded more clinical involvement from pharmacists" (Department of Health 2008).*

There are a number of different types of pharmacist including, primary care pharmacists, community pharmacists (once known as retail pharmacists), hospital care pharmacists, industrial pharmacists, regulatory pharmacists, academic pharmacists and veterinary pharmacists. Pharmacists today can be found in a number of different settings including in supermarket and community – high street pharmacies (independently owned shops or large multiple pharmacies), in hospitals and on hospital wards, doctor's surgeries, walk-in centres, in the pharmaceutical industry and at work in universities. However, pharmacists tend to work in one of two areas, community pharmacy, the most common and hospital pharmacy. Pharmacists are experts on drug therapy and are the most accessible healthcare professional. No appointment is needed to see a pharmacist and pharmacists can often be seen in a matter of minutes (Department of Health 2008; Jesson and Bissell 2006). In a news release, the Royal Pharmaceutical Society of Great Britain claim that perceptions of

community pharmacists by patients are that of a trusted healthcare professionals, but there is lack of understanding around the broader role of pharmacists (Royal Pharmaceutical Society of Great Britain 2007).

The scope of frontline pharmacy practice has expanded from its earlier role and is now, more diverse than it ever has been. The Nuffield report suggested that community pharmacists future professional role should involve greater collaboration with other healthcare professionals and greater involvement with the public (Nuffield 1986). Early tasks of pharmacy, includes services related to traditional tasks such as drug grinding, compounding and dispensing medicines. In community pharmacy, it also includes more patient centred, less technical, modern services that relate to health care. Pharmacists play an increasingly key role in providing quality healthcare to patients. Working in the various settings, community, primary care and hospitals; pharmacists use their clinical expertise together with their practical knowledge to ensure the safe supply and use of medicines by patients and members of the public. The hospital pharmacist is part of a hospital team, typically providing, preparing and dispensing medicines normally to patients who are or have been treated in the hospital. They are responsible for the purchase, manufacture, dispensing, quality testing and supply of all the medicines used in the hospital. Hospital pharmacists advise medical and nursing staff on the selection and appropriate use of medicines, and provide help and advice to patients in all aspects of their medicines. They provide information about potential side effects and ensure that new treatments are compatible with existing medication (NHS Choices 2009). Community pharmacists are frequently described and seen as ‘shop keepers’ and dispensing factories, who experience

significant dissatisfaction (Hibbert, Bissell, and Ward 2002; Hughes and McCann 2003). Pharmacy has a long history of links with commerce, 'petit bourgeoisie' (Turner 1995), this view, and the stigma attached to it, taints how pharmacy is viewed as a profession today. There has been a clear effort to move away from the 'shopkeeper' image of a pharmacist (although the image still exists (Hughes and McCann 2003)). For some pharmacists, Pharmacy Automation has changed the way they work. The Pharmacy Automation dispensing system, a robot, is said to enable the better utilisation of pharmacy staff skills. This is because the robot enables the pharmacist to spend more time on patient care. It is now part of practice for some pharmacists to prescribe medicines, run specialist clinics and carry out Medicines Use Reviews (MURs). The pharmacy profession has developed radically and developments include new roles for pharmacists such as:

- Pharmacist non-medical independent prescribing (pharmacists who obtain the supplementary or independent prescriber qualification can prescribe within their competences)
- Pharmacist non-medical supplementary prescribing
- Pharmacists with special interests (PhwSIs) for example diabetes, pain management, drug misuse
- Consultant pharmacists (four main elements include, expert practice, research and innovation, education and professional leadership)
- Pharmacists registered as defined specialists on the United Kingdom Public Health Register
- Community pharmacists developing local clinical services

(Department of Health 2008)

Some of the services and tasks now carried out, that make up these broader roles include:

- Clinical services
- Supervising the preparation of any medicines (not all are supplied ready made-up by the manufacturer)
- Reviewing medications for safety and efficacy
- Dealing with patients
- Public health advice
- Medicines use reviews (MURs)
- Providing drug information to patients and other health care professionals
- Smoking cessation services
- Supervised methadone
- Needle and syringe exchange
- Responding to patients symptoms
- Advice and counselling around minor ailments[8]
- Minor ailments schemes
- Contraception services
- Chlamydia screening
- Free blood pressure testing

[8] Pharmacies can help with a range of common conditions and minor injuries, such as aches and pains, uncomplicated cystitis, colds and minor ailments. Including bugs and viruses minor injuries, tummy troubles, women's health, skin conditions, allergies, children's problems (NHS Choices 2009, NHS Choices 2010).

- Free diabetes screening
- Incontinence supplies
- Pregnancy testing

In addition to the expanded services and tasks, pharmacists still prepare and dispense medicines on prescription (POM) to the general public as well as pharmacy only medicines (P) and non-prescription medicines. The de-regulation of medicines from prescription only medicine (POM) to over the counter (OTC) has also had a sizeable effect on pharmacy practice as medicinal products from more therapeutic classes allows the pharmacists scope to manage more conditions without having to refer patients to a medical practitioner (Britten 2001; Hibbert, Bissell, and Ward 2002; Rutter 2009). The deregulation of medicines has been viewed by some doctors negatively. The deregulation of medicines reduces the range of medicines over which doctors have exclusive control, and thus reducing a doctors clinical jurisdiction (Britten 2001).

Professions and professionals are said to have derived from medieval or ancient origins. A number of scholars including Larson, Freidson, Abbott, Wilensky, Caplow and Parsons have studied professions and there are a number of different interpretations of what a profession is for instance ‘traits’, ‘power’, ‘power and knowledge’. Nevertheless, a profession is generally recognised to be related to a work organisation or a group of experts with a special skill or monopoly of knowledge; self-defined and socially necessary (social function) and accepted. It is understood that professions exist in a system, thus, they are interrelated

and never seen alone (Abbott 1988). The nature of professions is that they are necessary and adapt to the needs and demands of society. The earliest professions include law and medicine. These professions portrayed themselves a special, and have maintained power and knowledge, handing down knowledge and values. Abbott states that the first development of professions was in the nineteenth century:

> *"In England, the merging of apothecaries with surgeons and physicians, the rise of the lower branch of the legal profession, and the appearance of the surveyors, architects, and accountants signaled [sic] the change" (Abbott 1988: p. 3).*

A profession includes a central regulatory body – which ensures standards of individual members and has a code of conduct/ethics. A profession holds and displays values, attitudes, behaviours, language and jargon. Abbott states that the tasks of professions are human problems amenable to expert service. Problems which maybe problems for individuals such as sickness or problems for groups such as auditing (Abbott 1988). Professions develop when a jurisdiction becomes vacant or has shifted. Once a profession has been established, that said profession has to maintain and defend its jurisdiction in order to remain a profession.

The profession of pharmacy is a long debated subject. Denzin and Mettlin argued that pharmacy was an occupation or an incomplete profession (Denzin and Mettlin 1968). Over

the years, it has been suggested that pharmacy has under gone professionalisation, re-professionalisation and de-professionalisation (de-skilling) in different ways (Wilensky 1964; Denzin and Mettlin 1968; Birenbaum 1982; Nuffield 1986; Edmunds and Calnan 2001; Dimitra et al. 2012; Roche 2014). As mentioned earlier, chemists and druggists worked to protect the professions interest and successfully argued for an exemption from the Apothecaries Act of 1815. Chemists and druggists grouped as an occupational group, pharmacy, and now operate separately from medical practice. It has been argued to that pharmacy has a conflict of some of the features of a profession.

Pharmacists are referred to as a subordinate occupation/profession, quasi professional (Denzin and Mettlin 1968; Edmunds and Calnan 2001). Amid the discussions and debates that surround the professionalism of pharmacy and pharmacy as a profession, over centuries, there have been many attempts to professionalise and re-professionalise pharmacy. A small but significant example of this exists in the rebranding of 'retail pharmacy' to 'community pharmacy' in an attempt to move away from the image of a pharmacist as a shopkeeper (Hibbert, Bissell, and Ward 2002).

Edmunds and Calnan suggested that:

> *"Community pharmacists, especially retail ones, feel that they are facing threats of further deskilling and to their livelihoods. The rise of*

the supermarket pharmacy has been particularly important to the present deskilling process …" (Edmunds and Calnan 2001: p. 950).

The main aim of the RPS are to lead, support, develop and represent the profession of pharmacy as a body akin to a medical Royal College (Royal Pharmaceutical Society of Great Britain 2013b). In response to these assertions around pharmacy, over the years, the RPS and the government have made attempts to develop and define the role of pharmacy further. A range of policy documents and initiatives have gone toward determining the current role of pharmacists. Some of these include the Nuffield report, choice and opportunity, pharmacy in a New Age (PIANA), Choosing Health Through Pharmacy, The NHS Plan, Pharmacy in the future and Pharmacy in the New NHS. The National pharmacists association (NPA) and the Royal Pharmaceutical Society of Great Britain are united in their aim to have professional recognition of pharmacists (Edmunds and Calnan 2001). Mark Simmonds, Shadow Minister of Health, speaking at a pharmaceutical event in May 2009 said:

"…community pharmacists are often the first point of contact for patients before they visit the GP. Yet despite being highly trained and skilled − and prominently located in the heart of their communities − they are not being used to their full potential by the NHS" (O'Hanlon 2013).

A Vision for Pharmacy in the New NHS and Our Health, Our Care, Our Say: A New Direction for Community Services, are more recent steps toward the defining of pharmacy roles. The evolution of pharmacy has not gone unchallenged. Reactions of doctors and so on, raise questions and concerns around boundary encroachment and a challenge to the medical professions autonomy and dominance[9].

Over recent years, the role of the pharmacist has undergone significant changes. Most significantly are the non-medical prescribing and the legislative changes in 2003 and 2006 that have enabled this. The medical profession have raised various concerns and issues with non-medical prescribing and independent prescribing in particular. However, non-medical prescribing has been happening in pharmacy for many years and it is in fact –gone full circle to the pharmaceutical practitioner's role in the Middle Ages. There has been the development of new roles, as mentioned earlier. On the whole, given that the nature of professions is that they are necessary and adapt to the needs and demands of society, the journey of pharmacy is not indifferent to that which is traditionally expected of professions and way in which professions behave.

For pharmacists in

Health 2000a, 2003a, 2003b, 2008a, 2008c, 2010a; Royal Pharmaceutical Society of Great Britain 2009). Some of these include the Nuffield report, choice and opportunity, pharmacy in a New Age or PIANA, Choosing Health Through Pharmacy, The NHS Plan, Pharmacy in the future and Pharmacy in the New NHS. One of the most significant developments came over 10 years ago.

Royal Pharmaceutical Society of Great Britain (RPSGB) and their 1995 Pharmacy in a New Age approach set out a long-term strategy for the future of pharmacy and the expectations of imminently changing professional roles. The Pharmacy in a New Age set out to develop and to think about what was necessary to achieve such change. Pharmacy in a New Age enlisted the profession in the process of mapping and achieving its own aspirations and Pharmacy in a New Age involved the whole profession in the wider debates. One of the strategic aims of Pharmacy in the New Age concerned the management of prescribed medicines. The particular aim here was for pharmacists to be professionals of choice to provide effective advice and support to all patients taking prescribed medicines including those with unusual or complicated medicine regimens. Aligned with the developments propelled by the Cumberlege report and the nurse lobbying, the RPSGB set out a definition of supplementary prescribing that was subsequently submitted to and later accepted by the Department of Health.

During the Pharmacy in a New Age journey, came the 1998 Report on the Supply and Administration of medicines, the Review of Prescribing, Supply and Administration of

Medicines which states “the law should be clarified to ensure that health professionals who supply or administer medicines under approved group protocols are acting within the law” (Crown Report 1998). The subsequent Review of Prescribing, Supply and Administration of medicine (1999), saw the conventional role of a range of health professions change and the role of the pharmacist transcend beyond that of preparing and dispensing drugs. As stated earlier, the 1999 Crown Review of the Prescribing Supply and Administration of Medicines set out a proposed new framework for the prescribing, supply and administration of medicines. It was suggested that prescribing responsibilities should be extended beyond the traditional model of medicines use to professional groups other than doctors and dentists. Ministers agreed on the implementation of supplementary prescribing. In May 2006 a new category of prescriber was launched, the ‘independent prescriber’. This role is an extension of the supplementary prescriber. The term independent prescriber was redefined during the Government’s consultation on proposals to introduce independent prescribing by pharmacists. Independent prescribing, as per the Department of Health (DoH) working definition is:

> *“Prescribing by a practitioner (e.g. doctor, dentist, nurse, pharmacist) responsible and accountable for the assessment of patients undiagnosed conditions and for the decision about clinical management required, including prescribing. Within medicines legislation the terms used is ‘appropriate practitioner’” (Department of Health 2006b).*

An independent prescriber is permitted to prescribe any medicine in the British National Formulary (BNF) with the exception of controlled drugs for any condition (within the prescribers competence).

In the 2008 White Paper, 'Pharmacy in England. Building on Strengths – delivering the future', some major changes were announced. In addition to the usual role of pharmacists dispensing medications, pharmacists play an important role in promoting health and wellbeing. Significant developments in pharmacy and for pharmacist roles are explicit today in routine practice. Pharmacies already offer readily available professional advice – without an appointment – on self-care and the safe use of medicines and, increasingly, services that identify potential health problems (such as health screening) and support healthier lifestyles (such as stopping smoking and weight loss programmes). The Pharmacy White Paper (Department of Health 2000a, 2003a, 2003b, 2005, 2006a, 2008a, 2008b, 2008c, 2010a) goes on to highlight how the work of pharmacists and their jurisdictions will change further.

As health professionals, pharmacists have been described as a 'significant untapped resource' for delivering accessible services to the people who need them most. As such, the approach to the regulation of pharmacists must be similar to that for other clinical professions, in a way that safeguards patients and the public and supports the strategic development of high quality pharmacy practice. The White Paper, Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century, signalled the intention to establish a new independent regulatory body for pharmacy, called the General Pharmaceutical Council (GPhC) (Department of Health 2008a, 2008b). As a result of the

Government's decision to separate the regulation of health professionals from the professional leadership bodies the GPhC was created. This means the transfer of the existing regulatory functions of the Royal Pharmaceutical Society of Great Britain (RPSGB) to the GPhC. The General Pharmaceutical Council will replace the Royal Pharmaceutical Society of Great Britain as the regulator for pharmacists, pharmacy technicians and pharmacy premises from 2010, and is currently in the process of changeover (Candlish 2010). The 2007 White Paper stipulates that the regulatory body must be independent of Government and have full regulatory control (Rivers 2009). The draft Pharmacy Order 2009 sets out the obligations and powers of the new council. As part of these reforms the government sanctioned opportunities making it possible for pharmacists to become prescribers, whereby they could develop special interests in defined clinical areas or to practise as consultant pharmacists. There were also changes in education and training that will help to ensure that pharmacists have the clinical competencies to deliver the types of services needed in the future (Candlish 2010; Department of Health 2008b).

Non-medical prescribing, as a result of the Crown report and as set out in the White Paper is a relatively new phenomena. One of the main aims, as stated earlier was to increase patient access and choice, whilst also working towards the reprofessionalisation project of pharmacy practice:

> *"Pharmacist independent prescribing and supplementary prescribing are important steps towards increasing people's access to medicines,*

making better use of pharmacists' skills and helping to improve patient care" (Department of Health 2008b: p. 95).

The 2008 White Paper suggests that, "as the demand for healthcare rises, and the complexity of therapeutic interventions (including medicines) increases, the demand for pharmacists' specialist skills in patient-centred pharmaceutical healthcare will grow markedly" (Department of Health 2008b: p. 90). This growth is evident and sets to continue. With the implementation of new legislation and policies, the role of the pharmacist has evolved dramatically from the traditional pestle and mortar and the making and compounding of medicines. Within the profession of pharmacy there still remains considerable scope for professional development. These developments and changes are now being through the implementation of the GPhC and also seen in the proposed new standards outlining how pharmacists will be trained in the future. The outcome of the GPhC consultation process will set out the changes within the landscape of the pharmacy profession and academia (Candlish 2010). These adjustments will change the role of the pharmacists from the very beginning – the first stages of joining the profession.

3.2 Pharmacy Professions and Professionalisation

Professions and professionals will be considered and particularly pharmacy as a profession and its several attempts at becoming and being recognised as a profession and its attempts at professionalisation and re-professionalisation:

> *"When in 1815 the apothecaries became entitled to registration as medical practitioners in Great Britain, there were more repercussions throughout the pharmaceutical world than would have normally have been expected from so simple a development in the evolution of a profession" (Wallis 1964: p. v).*

In modern day society, a professional undergoes specialised training, a profession possesses a central regulatory body – which ensures standards of individual members and has a code of conduct/ethics. A profession holds and displays values, attitudes, behaviours, language and jargon. Abbott states that the tasks of professions are human problems amenable to expert service. Problems for individuals such as sickness or problems for groups such as auditing (Abbott 1988). As mentioned by Abbott, professions develop when a jurisdiction becomes vacant or has shifted. Once a profession has been established, that said profession has to maintain and defend its jurisdiction in order to remain a profession.

In Great Britain, pharmacy, throughout history, has been shaped by the social, political and economic context in which it has existed and these frameworks have largely shaped what pharmacy is and how it is practised (Anderson 2005: p. 4). Pharmacy is concerned with all aspects of the preparation and use of medicines, from the discovery of their active ingredients to how they are used (Anderson 2005: p. 3). It has been claimed that pharmacy has a conflict of some of the features of a profession. Namely conflict between altruism and the fact that pharmacy is a business which advertises and also, the way in which

remuneration exists within pharmacy and the ‘commercial trappings’ of pharmacy (Hughes and McCann 2003). Therefore, the decision to prescribe certain drugs could be guided by the cost of a drug or other interests which the pharmacist holds.

Over the centuries and to the current day there have been various debates around pharmacy and its classification and how it is viewed as either an occupation or a profession. Pharmacy as a profession is a long debated subject. Denzin and Mettlin argued that pharmacy was an occupation or an incomplete profession (Denzin and Mettlin 1968) and Goode referred to pharmacy as a semi-profession (Goode 1969).

Etzioni explained that semi-professional organisations are more concerned with the communication and to a lesser extent, the application if knowledge. Their professionals are less likely to be guaranteed the right of privileged communications, and they are rarely concerned with matters of life and death.

Goode (1969) suggested, JETBT1 0 0 1 72.54

Denzin and Mettlin illustrated that:

> *"Pharmacy and optometry, for example, have the same minimum period of training and probably the same degree of specialization and abstract knowledge…the trained optometrist may legally diagnose…and prescribe…while the trained pharmacist may not; the optometrist is clearly moving much closer to professional autonomy while the pharmacist is firmly subordinated to medicine" (Denzin and Mettlin 1968).*

Nevertheless, over the years, it has been argued that pharmacy has under gone professionalisation, re-professionalisation and de-professionalisation (de-skilling). Pharmacists have continues to be habitually referred to as a subordinate occupation or profession, quasi professional, and an aspiring occupation (Denzin and Mettlin 1968; Edmunds and Calnan 2001; Etzioni 1969; Freidson 1970).

Pharmacy has undergone a series of functional changes. From its establishment as profession, pharmacists have often been referred to as "overtrained" for what they do and "underutilised" in what they know (Eaton and Webb 1979: Department of Health 2000a, 2003a, 2003b, 2008a, 2008c, 2010a; Royal Pharmaceutical Society of Great Britain 2009).

More recently there have been changes in pharmacy regulation and practice to equalise this deficit or imbalance:

> *"...nineteenth century British apothecaries and surgeons emphasized what they had in common with physicians, while physicians emphasized what was different…since the dominant professions are superordinates, exclusionary strategies are the most prevalent" (Abbott 1988: p. 67).*

Freidson uses pharmacy as an example of an occupation:

> *"…which provided services related to healing and which, if unregulated, could in fact become healing consultantships competitive with physicians' practices. The services of many such occupations are useful to the physician and necessary to his practice, even if dangerous to his monopoly" (Freidson 1970: p. 47).*

However, non -medical prescribing has been happening in pharmacy for many years and it has in fact gone full circle to the pharmaceutical practitioner's role in the middle Ages:

> *"When the apothecaries made their successful advance into the field of the physicians, they began to concentrate upon the compounding and prescribing of drugs" (Carr-Saunders and Wilson 1933: p. 132).*

There has been the development of new roles, as mentioned earlier:

> *"…we can assume that recent jurisdictional boundaries will be altered by reassigning many now professional tasks to less qualified workers… this does not mean that professionals will be stripped of all their tasks, however, for some traditional ones are likely to remain part of their jurisdiction and newly invented ones based on new knowledge will probably added " (Freidson 2001: p. 209).*

That said I'm not sure what this means in relation pharmacist (and nurses) as they are not taking over the task, merely overlapping. Also in the case of pharmacy, medicines knowledge is their key expertise and knowledge area so it can be argued that they are gaining an area or task which their competence has always allowed them and that they are fully capable to do.

As Anderson illustrates:

> *"The pharmacist is society's expert on medicines, and in recent decades, the focus of the pharmacist's role has shifted from the compounding of medicines to ensuring their safe and effective use by providing information and advice" (Anderson 2005: p. 3).*

The Government has driven to extend the roles of non-medical healthcare professionals as a means of increasing access to healthcare for patients. On the whole, given that the nature of professions is that they are necessary and adapt to the needs and demands of society, the journey of pharmacy is not indifferent to that which is traditionally expected of professions and the way in which professions behave. As Abbott highlights, "Legally established jurisdiction comes slowly and endures forever" (Abbott 1988: p. 64). This is particularly true in the case of non-medical prescribing as it is shows no sign of going away.

From the nineteenth century through to today, the concept of professions and what a profession is remains a topic of discussion. With the tag profession or professional, today, suggesting status and some kind of specialism. However, the use of the word profession and professional, is increasingly used as a more throw away term for example, 'professional shopper' or 'professional gambler'. With no For some, the acceptance of what a profession actually is and its roles have been referred to as outdated and inappropriate. The Royal College of Physicians (RCP) suggest that the traditional view of professions is outdated and that competence may be a more modern way to describe professionalism:

"The idea that a profession is a bounded group – bounded together by a discrete body of knowledge, a monopoly of service, autonomy over conditions of work, and a unique code of ethics – is outdated" (Royal College of Physicians 2005: p. 21).

3.3 Pharmacist prescribers: Prescribing, Changes and Pharmacy

Prescribing is a major clinical activity of the National Health Service (NHS). Traditionally prescribing medicine for human use was carried out exclusively by doctors and dentists. Medical prescribing in this context is to order the use of a medicine or other treatment. It is the primary intervention that most doctors offer to improve their patients' health (Maxwell and Walley 2003). Since the Medical Registration Act 1858, doctors in the United Kingdom have been furnished with the authority to diagnose, prescribe and management the care of patients as they deem appropriate (Bradley and Nolan 2008). During the century that followed, the roles of the health professions in relation to medicines have become well distinguished. Doctors prescribed medicines, pharmacists dispensed or supplied medicines and nurses administered medicines. This distinction has been maintained across these health professions, especially in secondary care, until relatively recently (Goundrey-Smith 2008). The process of prescribing can be expanded from the basic procedure set out by (De Vries et al. 1994) for the World Health Organisation (WHO) state:

"This process, and especially the verification step, ensures that the outcome is reliable. The same principles apply when you treat a

patient. First you need to define carefully the patient's problem (the diagnosis). After that, you have to specify the therapeutic objective, and to choose a treatment of proven efficacy and safety, from different alternatives. You then start the treatment, for example by writing an accurate prescription and providing the patient with clear information and instructions. After some time you monitor the results of the treatment; only then will you know if it has been successful. If the problem has been solved, the treatment can be stopped. If not, you will need to re-examine all the steps" (p. 7).

Over the years, changes within the health care sector have seen traditional roles of health care providers change noticeably. One of the most significant changes has been the evolution of non-medical prescribing. Non-medical prescribing is the term used to describe any prescribing done by a healthcare professional other than a doctor or dentist. Over the last 20 years or so, legislative changes have meant that prescribing by other health professionals has become legal and more widespread in the United Kingdom.

Legislation governs who can issue prescriptions. The Medicines Act 1968 is an act of Parliament, and regulations made under the act, forms the legislation governing the use of medicines, which is designed to protect patient safety. The Medicines Act 1968 was introduced by the Department of Health and Social Security (DHSS) following a review of legislation relating to medicines – prompted by the thalidomide tragedy in the 1960s. It

brought together most of the previous legislation on medicines and introduced a number of other legal provisions for the control of medicines (The Shipman Inquiry 2004). Medicines were made available to the public under rules set out in this legislation. The original 1968 Act described the traditional model of prescribing. In other words, a doctor (or dentist), assessed a patient and, if a medicine was necessary, they wrote a prescription. Generally, a pharmacist then dispensed the medicine to the patient against the prescription (Crown Report 1999; Department of Health 2006a). In the United Kingdom (UK), the Medicines Act 1968 governs the manufacture and supply of three types of medicine. The act defines the three categories of medicine as: prescription only medicines (POM), which are available only from a pharmacist if prescribed by a doctor or a dentist; pharmacy medicines (P), available only from a pharmacist but without a prescription; and general sales medicine which may be bought from any shop without a prescription (GSL). The Medicines Act 1968 was designed to ensure that effective products can be used safely according to the licensed indications (Crown Report 1999).

Prescribing rights have now legally been extended to other health professionals. The White Paper, 'Pharmacy in England. Building on strengths – delivering the future' announced some major changes for pharmacy and the NHS. In addition to the usual role where pharmacists dispense medications, pharmacists play an important role in promoting health and wellbeing. Pharmacies already offer readily available professional advice – without an appointment – on self-care and the safe use of medicines and, increasingly, services that identify potential health problems (such as health screening) and support healthier lifestyles

(such as stopping smoking and weight loss programmes). The white paper goes on to highlight how the work of pharmacists and their jurisdictions will change.

3.3.2 Wider Socio-Political Context

The change in prescribing policy and the particular course which has advanced is a considerably lengthy and multifaceted one. The history and some of the key events and policy changes are listed in the table below

Key dates	
1979	Eaton and Webb in their paper 'Boundary Encroachment', refer to the Pharmaceutical Society's evidence to the Royal Commission are proposals that retail pharmacists' ability to give advice on the treatment of minor ailments' be recognised, and that pharmacists should be able to 'prescribe' certain drugs at present reserved for prescription only (Eaton and Webb 1979)
1986	Neighbourhood Nursing – A Focus for care (Cumberlege report)
1986	Nuffield Report
1989	The First Crown report advocates nurse prescribing for district nurses and health visitors
1992	Legislation to enable nurse prescribing
1994 - 1996	Pilot site for district nurse and health visitor prescribing
1996	District nurses and health visitors to prescribe from a limited nurse formulary
1997 - 1999	Crown Review – Review of Prescribing, Supply and Administration of medicines Final report March 1999
1998	DOH introduced the Nurse Prescribers formulary for District Nurses and Health Visitors in England
1998	A Report on the Supply and Administration of Medicines under Group Protocols
1999	The Second Crown report. Review of Prescribing, Supply and Administration of Medicines

April 1999-March 2001	Roll out of District Nurse and Heath Visitor prescribing
2000	Law changes to allow Patient Group Directions (PGDs). A written instruction for the supply and administration of a licensed medicine or medicines (POM) in an identified clinical situation, where the individual may not be individually identifies before presenting for treatment (not prescribing)
2000	The NHS Plan ➢ Modernising the NHS ➢ Patient centred services ➢ More flexible ➢ Improved access ➢ Better use of resources ➢ Challenge existing roles
2000	Pharmacy in the future. Stated prescribing rights would be given to pharmacists to make better use of clinical skills
2001	The Health and Social Care Act 2001; Legislation changes to enable supplementary prescribing for nurses and pharmacists
2001	A spoonful of sugar – Medicines management in NHS hospitals
2002	MLX284: Proposals for supplementary prescribing by nurses and pharmacists and proposed amendments to the prescription only medicines (human) order 1997
2002	The Royal Pharmaceutical Society of Great Britain Pharmacist Prescribing Task Group. First report, Supplementary prescribing by pharmacists
2002	University courses EF nurses
2003 - 2004	Combined courses for supplementary nurse and pharmacist prescribers
2005	Legislation to enable supplementary prescribing for physiotherapists, radiographers, podiatrists and optometrists (AHPs)
2005	MLX 321: Consultation on proposals to introduce independent prescribing by pharmacists
2006	Legislation to enable Independent prescribing by pharmacists, all medicines and all conditions
2006	Nurse prescribers extended formulary discontinued – extended formulary nurse prescribers can now prescribe licensed medicines including some controlled drugs
2008	Independent prescribing for optometrists
2012	Changes to the Misuse of Drugs Regulations 2001 relating to nurse and **pharmacist** independent prescribing of controlled drugs (Misuse of Drugs (Amendment No.2) (England, Wales and Scotland) Regulations 2012 (Statutory Instrument 2012/973)). From 23 April 2012 pharmacist independent prescribers can prescribe, administer and direct others to administer, any controlled drug in Schedule 2, 3, 4 and 5 for any medical condition, except cocaine, dipipanone and

	diamorphine for the treatment of addiction. They can prescribe, administer and direct others to administer cocaine, dipipanone and diamorphine for treating organic disease or injury (GPhC 2012b)
2012	Changes to the Misuse of Drugs Regulations 2001 relating to **nurse** and pharmacist independent prescribing of controlled drugs (Misuse of Drugs (Amendment No.2) (England, Wales and Scotland) Regulations 2012 (Statutory Instrument 2012/973)). Current restrictions are removed to enable nurse independent prescribers to prescribe any controlled drug listed in schedules 2-5 for any medical condition within their competence, except diamorphine, cocaine and dipipanone for the treatment of addiction (nurse independent prescribers are able to prescribe other controlled drugs for the treatment of addiction) (Department of Health 2012)
2013	Now or Never: Shaping pharmacy for the future. The Report of the Commission on future models of care delivered through pharmacy

Table 1

Following this, district nurses and health visitors have had limited prescribing rights since the late 1990's. Significant for nurses in was the 1989 Report of Advisory Group on Nurse Prescribing. In 1996 was the implementation of district nurses and health visitors to prescribe from limited nurse formulary. It was agreed that these prescribing rights would eventually be extended to other healthcare providers.

Pharmacist prescribing was pioneered in the United States of America (USA), its origin going back as early as 1972. Its implementation was driven by the necessity to improve health care delivery. California was the first US state in which pharmacists roles were officially expanded. In 1972, the Health Manpower Pilot Projects initiated cross-training students of allied health professions beyond their legal scope of practice. In the USA there are two models of pharmacist prescribing, dependent prescribing authority and independent prescribing authority. Tonna, Stewart, and McCaig (2008) explained that the extent of the pharmacist prescribing authority depends on whether the setting the pharmacist is practicing in is within the remit of state or federal law. In 2007, 43 states had sanctioned various collaborative drug therapy management pharmacist prescribing and pharmacist independent prescribing including California, Washington, Arkansas, Florida, Kansas, Mississippi, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas and Washington (Kalorama Information 2007; Tonna, Stewart, and McCaig 2008). Other Countries who practice non-medical pharmacist prescribing include Canada, New Zealand and Australia (Hoti, Hughes and Sutherland 2011). Each country practicing non-medical prescribing has their own drivers for this change and subsequent benefits. These include; improving health care delivery, to address medical staff shortages in remote geographical

areas improve services for specific patient groups, ease of patient access to medicine, making the best use of pharmacists skills and competencies (Emmerton et al. 2005; Kalorama Information 2007; Kondro 2007; Pharmaceutical Society of Australia 2009; Tonna, Stewart, and McCaig 2007, 2008). In terms of pharmacist prescribing in Europe, the UK is somewhat ahead in terms of its development and implementation and is used very much as a template which other countries are adopting.

For pharmacists in the UK, the lead up to their changing job role and the progression to prescribing has been an ongoing process. One of the most significant developments for pharmacists was The Pharmacy in a New Age project. The project continued until early 1999. Pharmacy in a New Age considered underlying issues in pharmacy and drivers for change. The Royal Pharmaceutical Society of Great Britain and their 1995 Pharmacy in a New Age approach set out a long-term strategy for the future of pharmacy and the expectations of imminently changing professional roles. The Pharmacy in a New Age set out to develop and to think about what was needed to achieve such change. Pharmacy in a New Age enlisted the profession in the process of mapping and achieving its own aspirations and Pharmacy and involved the whole profession in the wider debates. One of the strategic aims of Pharmacy in the New Age concerned the management of prescribed medicines. The particular aim here was for pharmacists to be professionals of choice to provide effective advice and support to all patients taking prescribed medicines including those with unusual or complicated medicine regimens. The Royal Pharmaceutical Society of Great Britain set out a definition of supplementary prescribing that was subsequently accepted by the Department of Health.

In 1997 the Government started a consultation process. This process was chaired by Dr June Crown, and led to a complete review of the prescribing, supply and administration of medicines (Crown Report 1999). The review grew out of a desire to make greater use of the skills and experience of the various professions working in primary and secondary care and to determine in what circumstances non-medical health professionals could undertake new roles with regard to the prescribing, supply, and administration of medicines. Non-medical prescribing is interpreted as an enhancement of pharmacy roles and the changes were needed to reflect the emerging needs in modern clinical practice.

During the Pharmacy in a New Age journey, came the 1998 Report on the Supply and Administration of medicines, the Review of Prescribing, Supply and Administration of Medicines which states "the law should be clarified to ensure that health professionals who supply or administer medicines under approved group protocols are acting within the law" (Crown Report 1998). The subsequent Review of Prescribing, Supply and Administration of medicine (1999), saw the conventional role of health professions change and the pharmacist transcend beyond that of preparing and dispensing drugs. The 1999 Crown Review of the Prescribing Supply and Administration of Medicines set out a proposed new framework for the prescribing, supply and administration of medicines inside and outside the NHS. The review recommended that, in order to develop services around the needs of patients and to make best use of professional expertise, prescribing responsibilities should be extended beyond the traditional model of medicines use to professional groups other than doctors and dentists. Following public consultation and advice from the Committee on Safety of

Medicines (CSM), Ministers agreed on the implementation of supplementary prescribing. Ministers decided that supplementary prescribing would be initially introduced for nurses and pharmacists, with the view to extending this further to other healthcare professionals in the future.

3.3.3 Non-Medical Prescribing

Developments in non-medical prescribing are evident across the world as policy-makers seek to reform healthcare services in the interests of enhanced service efficiency, greater user satisfaction and continuing clinical and patient safety. Non-medical prescribing aims to enable patients easier access to medicines that they require. The benefits for patients here is an avoidance of a delay in receiving medicines, a reduction in the amount of unnecessary appointments, reduced risk of hospitalisation and faster recovery. Non-medical prescribing permits appropriately trained pharmacists and other health professionals to make the best use of their skills and competence whilst adhering to and further improving clinical safety.

In the UK, the NHS Plan set out plans to reconfigure traditional professional hierarchies to create more flexible team working with a focus on improved access to patient-centred care. The Government strategy for pharmacy was published in 2000, Pharmacy in the future – implementing the NHS plan. This document stated that patients' needs would be better met by some pharmacists being able to prescribe for them directly. In addition to extending prescribing responsibilities, the Crown Review (1999) also proposed that, following diagnosis by a doctor or dentist, responsibility for the clinical management of some patients,

including prescribing, could be passed to another health professional. The necessary legal framework to enable the government to extend prescribing responsibilities of other health professions was subsequently included in section 63 of the Health and Social Care Act 2001 (Department of Health 2006a).

Following formal consultation, in April 2003, supplementary prescribing for nurses and pharmacists was introduced. Non-medical prescribing is the vehicle which allows this. There are two main forms of non-medical pharmacist prescribing, supplementary prescribing and independent prescribing. Nolan and Bradley state that Crown, in 2006 maintained that the aim on introducing non doctor prescribing was to improve health outcomes for patients (Nolan and Bradley 2008).

In order to become a non-medical prescriber, a specific training route has to be followed. In order to prescribe, one has to attain a post-graduate practice certificate in supplementary and or independent prescribing (Basey 2009). A Pharmacist Independent Prescriber must be a registered pharmacist whose name is held on the membership register of the Royal Pharmaceutical Society of Great Britain, with an annotation signifying that the pharmacist has successfully completed an education and training programme accredited by the RPSGB and is qualified as an independent prescriber (Department of Health 2006a). Pharmacists should have at least two years experience practising as a pharmacist in a clinical environment, in a hospital or a community setting, following their pre-registration year after their graduation (Basey 2009; Department of Health 2006a; Department of Health 2006b).

The set training programme has at least 25 taught days and at least 12 days learning in practice. In addition, there is an element of self-directed study. the courses are examined in a variety of ways and usually involve two methods of assessment, which can include Objective Structured Clinical Examinations (OSCEs) written exams, vivas, essays in addition to developing a satisfactory portfolio (Basey 2009). Upon successful completion of the supplementary training, the student is awarded a Practice Certificate in Prescribing. In addition to the supplementary training, pharmacists can chose to undertake a conversion course where they can work towards becoming an independent prescriber.

3.3.3.1 Supplementary Prescribing (SP)

Supplementary prescribing (SP) then referred to as "dependant" prescribing was one of the recommendations made in the report on the Review of Prescribing, Supply and Administration of Medicines (Crown Report 1999). The year 2003 saw the introduction of pharmacist and nurse supplementary prescribing. Since 4th April 2003, it has been legal in England for registered pharmacists to train and practice as prescribers (Department of Health 2006a; Department of Health 2005). Supplementary prescribing was extended to physiotherapists, chiropodists/podiatrists, radiographers and optometrists in May 2005 (Department of Health 2006b). The Crown Review asserts that its overriding principle is at the very least, maintain and preferably enhance patient safety. In addition the changes need to also bring about demonstrable benefits to patient care as well as being cost effective (Crown Report 1999). Supplementary prescribing, is a three party care group where a patient specific clinical management plan (CMP) or 'care plan' is devised and agreed between the independent prescriber, the supplementary prescriber (the pharmacist or

nurse for example) and the patient whose care is being managed (Royal Pharmaceutical Society of Great Britain 2009; Courtenay and Griffiths 2004; Crown Report 1999; Department of Health 2005). The care plan outlines a full range of medicines including unlicensed and controlled drugs that the supplementary prescriber can prescribe, however, these medicines must be within the supplementary prescribers area of competence (Basey 2009; Cooper et al. 2008a; Cooper et al. 2008b; Courtenay, Carey, and Burke 2007; Crown Report 1999; Department of Health 2006b). Typically, the kind of patients who were intended to be managed in this way were patients with long term conditions such as diabetes, asthma and hypertension for example (Cooper et al. 2008a).

3.3.3.2 Independent Prescribing (IP)

In May 2006 a new category of prescriber was launched, the 'independent prescriber'. This role is an extension of the supplementary prescriber. The term independent prescriber was redefined during the Government's consultation on proposals to introduce independent prescribing by pharmacists. An independent prescriber is permitted to prescribe any medicine in the British National Formulary (BNF) with the exception of controlled drugs for any condition (within the prescribers competence).

When the government introduced pharmacist prescribing, the intention was to improve health services and patient care by enabling patients to have quicker and more accessible service for patients and easier access to the medicines they need without compromising patient safety. In doing so, increasing patient choice with regard to access to medicines, and

in turn It was anticipated that non-medical prescribing would make use of the best skills of the health professionals knowledge and expertise; consequently contributing to the introduction of more flexible team working across the NHS (Department of Health 2006a).

In the white paper, 'Pharmacy in England. Building on strengths – delivering the future', some major changes were announced. In addition to the usual role where pharmacists dispense medications, pharmacists play an important role in promoting health and wellbeing. Pharmacies already offer readily available professional advice – without an appointment – on self-care and the safe use of medicines and, increasingly, services that identify potential health problems (such as health screening) and support healthier lifestyles (such as stopping smoking and weight loss programmes). The white paper goes on to highlight how the work of pharmacists and their jurisdictions will change.

As health professionals, pharmacists were described as a 'significant untapped resource' for delivering accessible services to the people who need them most. As such, the approach to the regulation of pharmacists must be similar to that for other clinical professions, in a way that safeguards patients and the public and supports the strategic development of high quality pharmacy practice.

Yet, other claims suggest that the drivers for the development and implementation of non-medical prescribing are linked to the shortage of doctors that was apparent in the 1990's

(Baird 2003). In addition, it has been suggested that non-medical prescribing has been developed to ease the burden on doctors and reduce junior doctors working hours. The rationale for non-medical prescribing is continually referred to as easing the burden on doctors and improving access to medicines. In a National evaluation of the new community pharmacy contract (Blenkinsopp et al. 2009), there are number of services that outlining the Department of Health's objectives of the Community Pharmacy Contractual Framework (CPCF). One of these objectives outlined being:

> *"Reducing demand on GPs and other primary care staff, for example through repeat dispensing, supplementary prescribing and pharmacist led clinics, for example for people with diabetes" (Blenkinsopp et al. 2009: p. 2).*

June Crown (author of the 1999 Crown report), whilst speaking a lecture at the University of Bath, maintained that non-medical prescribing by stating that the purpose of the Crown report was to make better and more appropriate use of nurses and pharmacists and that non-medical prescribing did arise due to a shortage of doctors (Hobson 2008).

3.3.4 Benefits and Concerns of Non-Medical Prescribing

Since the implementation of supplementary and independent prescribing there have been various evaluations and research carried out. Studies have looked at implementation of the

schemes and the new roles and the acceptability of changing roles for example, the where we are since the changes in prescribing, how the new roles have been adopted and consequent concerns by those working in the field. The most common focus in empirical research centres on the perception, experiences, and opinions of nurse and pharmacist supplementary prescriber and independent prescriber practitioners or trainees or those of doctors. These evaluations have looked at the early reports have shown that both supplementary and independent prescribing have enabled easier access to medicines to patients in hospitals and in the community (Basey 2009). Nevertheless, In spite of the developments of non-medical prescribing, there are relatively small number of prescriptions being written by pharmacist prescriber (Guillaume et al. 2008; Nissen 2009).

Patient safety is a recurring subject and concern that comes up in the debates around prescribing in general but it is particularly pertinent in the discussions around non-medical prescribing. These debates have raised important issues about notions of responsibility and 'safe prescribing'.

In policy, non-medical prescribing is described as easing the burden on doctors and improving patient access, however, we suggest it also brings to the fore significant questions about the social organisation of healthcare. Although non-medical prescribing may be interpreted as enhancing pharmacy roles, and even constituting a challenging to the dominance of medicine, research suggests that it remains shaped by the expectations of doctors and in areas of practice they willing concede responsibility (Bissell et al. 2008).

Although non-medical prescribing has little negative influence on patient safety (Bissell et al. 2003), it remains an integral issue in the negotiation of professional boundaries. For example, doctors' support for pharmacy prescribing is often based upon continued medical leadership, the use of strict protocols and appropriate levels of training in order to 'reduce risk'. The mobilisation of risk discourses can be seen as shaping inter-professional 'boundary work' for non-medical prescribing. Socio-cultural theories show how knowledge of risk can function to define shared identities and community boundaries, as well as risky 'others'.

Historically there were early concerns that doctors were over worked due to the long hours they work and as such, posed a threat to patient safety. In a reversal there are now debates suggesting that there are concerns that doctors, particularly junior doctors are a potential threat to their patients due to the vast reduction in their clinical working hours. In trying to alleviate some of the pressure and unburden doctors, it seems that the implementation of non-medical prescribing has triggered other debates.

3.4 Institutions, Organisations and Professions: Empirical Research

The professions function as institutional agents and individual professionals assume varying roles within their professional community and professions themselves adhere to an institutional model (Scott 2008a). When practices and boundaries in an organisation change or become challenged the impact of these changes directly affect the actors working in that organisation and the clients or customers it serves. The occurrence of such changes are particularly applicable and especially important for those who work in multidisciplinary

practices and or partnerships (Suddaby and Greenwood 2005). Battles over shared practice often denote institutional conflict. The aim of this short piece is to look at existing literature and empirical research and formulate research questions for further investigation. The proposed research intends to study institutions and organisations, locating the professionals, practices and boundaries within them whilst exploring how they change and are challenged.

Using non-medical prescribing and pharmacists as a case study, this paper will set out key areas that are considered important in the literature, which the proposed research will then examine. This piece will then set out the broad research questions that I will use to explore these areas. Prescribing is a major clinical activity of the National Health Service (NHS). Traditionally prescribing medicine for human use was carried out exclusively by doctors and dentists. The traditional model of prescribing saw a doctor (or dentist) who assessed a patient and, if a medicine was necessary, they wrote a prescription. Generally, a pharmacist then dispensed the medicine to the patient against the prescription (Crown Report 1999; Department of Health 2006a, 2006b). Initially nurses lobbied for the right to prescribe medicines. Some viewed this move as an encroachment of the jurisdiction of doctors and the proposal to extend prescribing rights was not accepted by all. Arguably, some nurses and other health care professionals had already been prescribing by proxy in their everyday working practice. The move to include pharmacists and a number of other health care professionals as prescribers followed years of lobbying and a subsequent change in the legislation. However, irrespective of the changes which have been sanctioned, resistance to the changes in practice and the shift in boundaries still endure through different actors who

object to the reforms. Within various pockets of the different professions, there has been and continues to be a tensions and conflicts. The areas of shared meaning that pharmacists have in common with doctors can also areas of conflict.

This empirical research will focus in on boundary and practice work to look at how professional relationships present; looking at the progressive erosion and reformation of boundaries with regard to professions and also institutions and organisations. The research study aims to examine the impact the shift in boundaries has on both professions (pharmacy, nursing and medicine) and its professionals (pharmacists, doctors, nurses) and the organisational forms in which they operate.

Boundaries and practices exist in many different forms and can be broken down and explored using various levels. These may include knowledge, practice, relationships, audience and discursive accounts. Boundaries and practices are two elements of an institution[10]. Blurring of boundaries or shifts in boundaries and practices come with institutional change (Suddaby and Greenwood 2005).

[10] An institution is any structure or system of social order and collaboration governing the behaviour of a set of individuals within a given community.

Within the limits that are set by boundaries, practices exist. A practice is described as something that people – individuals and groups do; shared routines, systems or customs (Krais 2006; Lawrence and Suddaby 2006):

> *"Human action is seen on a level of abstraction where social practice is reduced to norms, rules, laws, expectations, roles and rational calculations" (Krais 2006: p. 126).*

This research aims to concentrate on jurisdictional boundaries, boundary work and practice work (performed by pharmacists, doctors and other health care professionals) which are located within different organisational and institutional settings and forms; namely, different pharmacy practice settings, primary care, secondary care and community.

The study of organisations and institutions has been in receipt of much attention for many years by a variety of theorists including Greenwood, Hughes, Scott and Suddaby for instance. Institutions have been described as being comprised of a combination of pillars or elements. These elements are what Scott suggests institutions rest upon are regulative, normative and or cultural-cognitive pillars, all of which are symbolic in their nature (Scott 2008a):

> *"Institutions are comprised of regulative, normative, and cultural-cognitive elements that, together with associated activities and resources, provide stability and meaning to social life" (Scott 2008a: p. 48).*

Scott proposes that different theorists place different importance on different pillars. Scott describes sociologists and organisational scholars for example as stressing the centrality of cultural-cognitive elements of institutions – the shared conceptions that constitute the nature of social reality, while he suggests that economists for instance are likely to view institutions as resting primarily on the regulatory pillar (Scott 2008a).

Zietsma and Lawrence's paper which explores the interplay of boundary work and practice work, sets out a framework which they refer to as "*Boundary work, practice work and cycles of institutional stability and change*" (Zietsma and Lawrence 2010). Zietsma and Lawrence describe a recursive, mutually supportive relationship between boundary and practice work that underpins cycles of institutional stability, conflict, innovation and restabilisation (Zietsma and Lawrence 2010: p. 35):

> *"...boundaries and practices are distinct, interdependent features of groups that exist in a recursive relationship, with boundaries delimiting sets of legitimate practices, and practices supporting*

> *particular group boundaries... Although boundaries and practices work to stabilize each other, their relationship can also lead to significant change" (Zietsma and Lawrence 2010, pp. 9 – 10).*

This paper and indeed the diagrammatic frameworks are useful as they attempt to explain how boundaries and practices are challenged and defended by different actors in the context of the institution in terms of how the standing of the institution changes. However, Zietsma and Lawrence's diagram (Zietsma and Lawrence 2010: p. 209) suggests that it is merely outsiders that breaching boundaries and only insiders who are bolstering boundaries, however, I would express that these relationships and practices are much more complex than the diagram suggests, particularly when using this model in the case of pharmacists and non-medical prescribing practice. I would suggest that boundary breaching takes place among both outsiders and insiders and in the case of boundary bolstering, this happens among insiders and outsiders.

Taking characteristics used by Scott in his Three Pillars of Institutions theory and diagram (Scott 2008a) and Zietsma and Lawrence's diagrammatic framework which illustrates their theory on boundary work (Zietsma and Lawrence 2010), I intend to look at three areas (see below) to explore the impact of organisational and institutional changes in the National Health Service (NHS). Specifically in the settings listed earlier; and the shifts in practice and boundary work for pharmacists, doctors and health care professionals.

The blue arrows (see Figure 2 below) represent those 'boundary breaching'. In the Zietsma and Lawrence paper (2010), it is proposed that institutional conflict simply occurs between those who protecting the boundary of work and those outsiders who are trying to breaching it. This conflict however, I would suggest is more complex than the diagram conveys. In addition to the struggles set out in the Zietsma and Lawrence diagram and paper, between insiders and outsiders, there are the additional struggles which exist within the different professions and then again between those who have negotiated practice work (represented by the white and red arrows in Figure 2). Zietsma and Lawrence (2010) suggested that it is a case of winners and losers, between insiders and outsider, implying that all insiders and all outsiders are striving for the same collective ends. However, this is a simplistic notion, and it is essential to consider the different relationships that exist. Not only between different professions in different organisational and institutional settings, but also the relationships that are present between actors who share a profession and again the actors that share a profession but work in varying institutional and organisational settings (see Figure 2, red arrows).

Language is important in terms of identifying words and texts. Institutional vocabulary and the 'strategic' use of persuasive language is said to be a means by which shifts in institutional logic are performed:

> *"Persuasive language, or rhetorical strategy, is a significant tool by which shifts in a dominant logic can be achieved. Rhetorical strategies*

> *are the deliberate use of persuasive language to legitimate or resist an innovation by constructing congruence or incongruence among attributes of the innovation, dominant institutional logics, and broader templates of institutional change" (Suddaby and Greenwood 2005: p. 42).*

Language is used to define and redefine jurisdictions and practices. Suddaby and Greenwood in their research concentrate on the "arguments and language used to connect competing conceptions of the new organisational form" (Suddaby and Greenwood 2005: p. 36). Language can be symbolic and has been described as a social practice and culturally embedded. Looking at language and discourse will in this research will help to see to what extent it facilitates change or in fact prevents change. Suddaby and Greenwood (2005) stated that previous research proposes that:

> *"skilful and strategic use of language is a key means of initiating and directing change" (Suddaby and Greenwood 2005: p. 40).*

Legitimacy is described as a perception or assumption that action or an entity are desirable, proper or appropriate within some kind of socially constructed system, comprised of norms, values, beliefs and definition. Many commentators including Suddaby, Greenwood, Scott, Freeman, Suchman, Berger and Luckmann describe legitimacy as a crucial element in both

the creation and survival of new institutional forms. New organisational forms are said to have to acquire legitimacy. Zietsma and Lawrence propose that legitimised practices help to restabilise boundaries (Zietsma and Lawrence 2010). Examining how legitimacy is acquired, lost and kept for professions and individuals will help in exploring the negotiation of boundaries.

Knowledge and knowledge claims are a substantial part of boundary erosion and reformation. Knowledge, skill and expertise are key in jurisdictional defence. For, knowledge and skill – qualification – automatically suggests that a person or professional is endowed with the knowledge and skill to perform a particular or collection of particular tasks:

> *"...professions were more likely to claim that their practice was based on formal knowledge, to demand autonomy in their decision-making, and to adopt norms espousing a service orientation" (Scott 2008b, p.220).*

Scott suggests a social constructionist conception of the role of professions as:

> *"...a view that permits us to argue that the knowledge claims advanced by professionals can be both somewhat arbitrary and sincerely advanced, that professional jurisdictions can be contested*

and changing without being a simple matter of political clout, and that in many circumstances the advancement of professional interests is not inconsistent with attention to client welfare" (Scott 2008b: p. 221).

The knowledge which is held by individuals goes a long way into the translation of knowing what to do and actually doing it. However, what role or how important is knowledge in the negotiation of boundaries and in the defence of professional jurisdictions?

At the heart of these changes, disputes and struggles lies the individual professional. The interprofessional, personal and social identity that is held and the relationships that each individual has within its profession and or institution or organisation are extremely important in the context of professional and social interactions. The role and function of the individual in an organisation, in a profession, in a team, and their professional identity is what defines a professional and the tasks which they carry out. For this composition to change, or be compromised for better or worse can affect the way in which they see themselves, how other professions see them and importantly how the public recognise or view them.

For pharmacy and more broadly health care, looking at in this case non-medical prescribing, the multi levelled approach will be invaluable in understanding the processes in institutional

change. This is specifically due to the range of professionals who now have the opportunity to prescribe and the way in which their role impacts on and works alongside others. This change in dynamics is distinctive in that of institutional change and multidisciplinary partnerships and multidisciplinary practices. Using the three areas noted above will enable the data to be analysed at the micro, meso and macro level. Looking at these levels will not only complement the themes but will also help to contribute to conversations on and around organisations, institutions and professionalism, particularly where actors struggle to make sense of changes to practices and shared tasks.

3.5 Pharmacist Non-Medical Prescribing: Research Development

Pharmacy is one of Britain's fastest growing areas of healthcare. In their various roles, pharmacists are involved with medicines at every stage, from the development of drugs in the laboratories through to their supply in the community and in hospitals (Department of Health 2008a; Royal Pharmaceutical Society of Great Britain 2009). Pharmacists have historically supplied medicines to patients and this responsibility remains a key part of their role. For example, pharmacists sell and supply over the counter medicines and dispense prescription only medicines. This dispensing of prescribed medicines comes not only from fulfilling prescriptions as filled by the doctor, but now also includes prescriptions from other health care professionals, including pharmacists themselves. For community pharmacists this was set out in the Pharmacy Contract and was a Contract that contained three different service levels, which included Essential, Advanced and Enhanced and Local Services (Blenkinsop et al. 2009; Carroll, Hewiton and Carroll 2010; Sharpe 2012). These services outline the different tasks which pharmacists are able to do (see Chapter 2.2).

This PhD research project investigates the professional roles and boundaries for health care professionals with specific reference to pharmacists and changes in the non-medical prescribing. Namely

The published annual reviews of the Pharmaceutical Register show that the number of pharmacist independent prescribers rose sharply and in 2009, there was 1,108 independent prescribers and 1,471 supplementary prescribers on the Royal Pharmaceutical Society of Great Britain Register. Of these individuals, 688 were competent as both supplementary and independent prescribers. Almost half (46.0%, n=381) of the independent prescribers who provided details on their main job (n=829) held their main job in hospital, just under a third (31.0%, n=257) in primary care and a fifth (21.1%, n=175) held their main job in community. The remaining 1.9 per cent (n=16) held their main jobs in academia or other pharmacy, for example at the Department of Health (Allen 2009). In 2010, the Royal Pharmaceutical Society of Great Britain Register Analysis data analysis shows that there were 1,545 independent prescribers and 1,451 supplementary prescribers on the register. Of these pharmacists, 802 are catalogued as being both supplementary and independent prescribers. From 2009 to 2010, there was an increase of 437 (39.4%) in the number of independent prescribers but there was a net decrease of 20 in the number of supplementary prescribers; this(p)-4(rt)-4(h)-4Sm(p)-45 arsmmu bery

It is evident from the literature (see Chapter 2) that the role of the pharmacist has evolved over a number of years, and in the last 20 years, the tasks which a practicing pharmacist routinely carries out has shifted somewhat. This shift is also communicated within the published Pharmaceutical Register data.

The research is set within the health care arena and more specifically in National Health Service setting. The working relationships within healthcare notoriously involve complex human interactions that cannot be studied in simple terms (Anderson 2010). In order to develop the research further, I applied a combination of features from Scott's Three Pillars of Institutions model (Scott 2008a) and Zietsma and Lawrence's diagrammatic framework (Zietsma and Lawrence 2010). I intended to look at three areas (as listed earlier) to explore the impact of organisational and institutional changes in the National Health Service (NHS), specifically in practice, community and hospital settings as mentioned earlier; and the shifts in practice and boundary work for pharmacists, doctors and health care professionals. The diagrammatic adaptation illustrates how (see Figure 2).

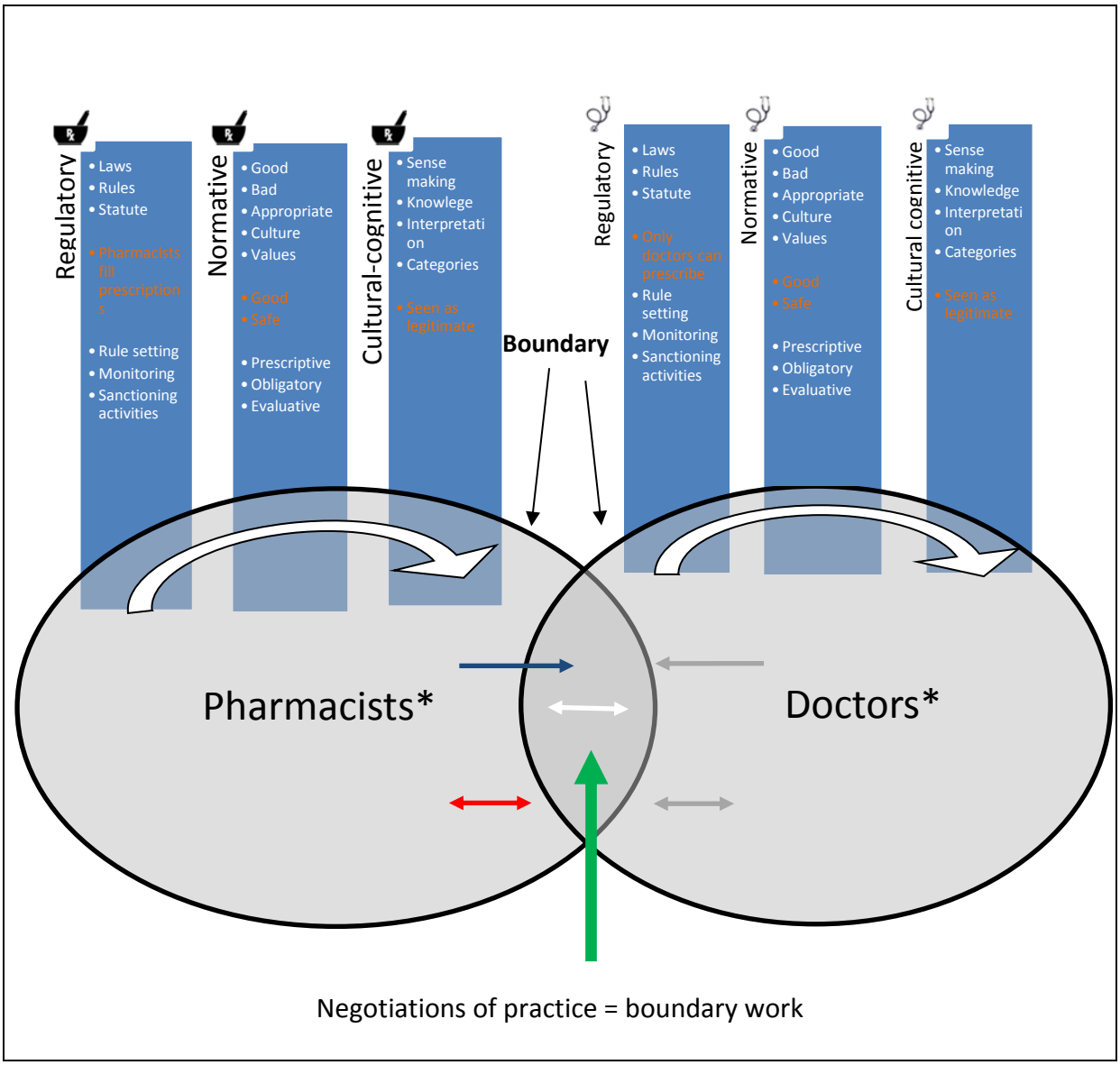


Figure 2: *The boundaries between doctors and pharmacists and the application of the Three Institutional Pillars. This illustrates how there is an overlap which comes with changes in the boundary and shared and or redistributed tasks.*

I initially began to develop this diagram as I tried to make sense of the different aspects of the interactions and the role of the pharmacist with others. In this diagram, doctors and pharmacists have been used as examples to illustrate how two professional groups interact.

The use of doctors and or pharmacists is interchangeable and is used here only because prescribing was once exclusively carried out by doctors, hence the task sharing element. In theory, any professional group who interact or have undergone or are in the process of redistribution of tasks or task sharing could be substituted here (the stared profession*) and have their own profession specific characteristics applied to the three defining pillars. The way in which the arrows behave in theory remains the same. The blue arrows (see Figure 2) represent those professionals from their particular professional group who are 'boundary breaching'. Zietsma and Lawrence (2010) propose that institutional conflict simply occurs between those who are protecting the boundary of work and those outsiders who are trying to breaching it. This conflict however, I would suggest is more complex than the diagram conveys. In addition to the struggles set out in Zietsma and Lawrence (2010) diagram and paper, between insiders and outsiders, there are the additional struggles that exist within the different professions and then again between those who have negotiated practice work (represented by the white and red arrows in Figure 2). Zietsma and Lawrence (2010) suggest that it is a case of winners and losers, between insiders and outsider, implying that all insiders and all outsiders are striving for the same collective ends. However, this is a simplistic notion. It is essential to consider the different relationships that exist between not only different professional groups but also different professionals who exist in different or overlapping organisational and institutional settings. In addition, the relationships that are present between actors who share a profession and again the actors that share a profession but work in varying institutional and organisational settings (see Figure 1; Figure 2,[red arrows]).

The focus of this research thus interested in the negotiations of practice and the boundary work that takes place (see the green arrow in Figure 2 and Figure 3) and the different relationships and conversations that occur possibly make this a success or hinder this outcome.

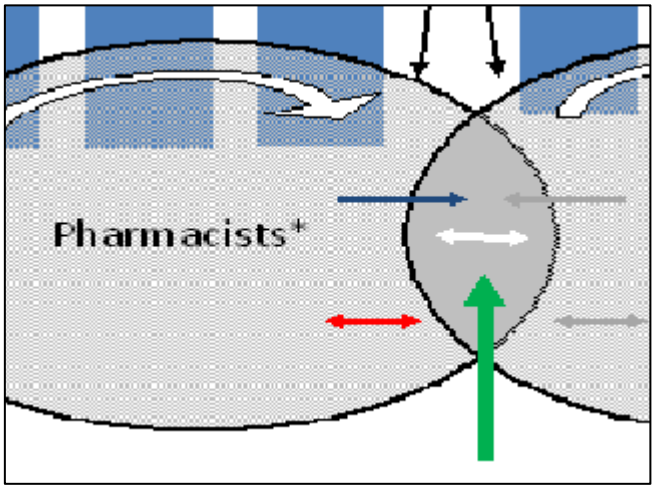


Figure 3: *Negotiations of practice – Boundary work takes place in the central area, indicated by the vertical arrow (green arrow).*

This research aims to identify any relationship between the distinct but interconnected areas as shown in the above diagrams (see Figure 2 and Figure 3). The arrows that represent the doctors in this case are greyed out. This is intentional. While I am interested in the perceptions and potential barriers associated with doctors or in deed other professions, primarily I am interested in pharmacists, their roles and how they get there. I am interested in the area that overlaps, specifically, the pharmacist's role within this domain. The overlap in this model refers to a renegotiation of practice. This renegotiation may be with the other professional sphere, the organisation or within a profession for example. This model is developed throughout this thesis.

Chapter 4: Research Methodology

4.1 Introduction

This chapter outlines the research methodology proposed for this study to achieve the objectives. Firstly, the research question and objectives are presented. A conceptual framework is outlined which then goes on to the methodological and philosophical position, the research design, sequence of data collection, the analytical process. Also presented are the justifications for the suitability of the chosen approaches. The chapter concludes with a discussion of the limitations of this study.

4.2 Research Question

With this broad area in mind and paying particular attention to some of the existing empirical research which looks at pharmacists and or non-medical prescribing (Savage, Blenkinsopp and Bennett 2011; Tann et al 2010; Bissell et al. 2008; Banks, Shaw and Weiss 2007; Buckley, Grime and Blenkinsopp 2006) it was decided that a qualitative approach would best suit both the target research population and also the aims of the study as qualitative:

> *"…data relate[s] to the social world and the concepts and behaviors of people within it" (Anderson 2010).*

Qualitative research involves broadly stated questions about human experiences and realties studied through sustained contact with people in their own natural environments, generating rich, descriptive data that enables their experiences and attitudes to be explored (Rees 1996; Dingwall et al, 1998). Qualitative research helps to understand how and, more specifically, why individuals behave in a particular way (Liamputtong and Ezzy 1999).

A number of research studies have sought to evaluate non-medical prescribing and the degree and frequency in which it is used and how acceptable it is to patients and the public (Bissell et al. 2008; Latter et al. 2011; Baqir, Clemerson and Smith 2010; Stewart et al. 2010; Hacking and Taylor 2010; Hobson, Scott and Sutton 2010; Cooper 2008a). This research sought to look at boundary work and explore how professional boundaries were negotiated in the context of current workplace changes that advocate enhanced skill and task sharing and multi-professional work. The research focused on boundary work, non-medical prescribing, and the role in the wider organisational context. The research centred on exploring how these relationships, whilst looking at the progressive erosion and reformation of boundaries and the impact it has on both professions and professionals. Pharmacy and pharmacists are the focus of this research.

To summarise, the research question aimed to develop theoretical and empirical knowledge on ***"How are professional boundaries negotiated in the context of current workplace changes that advocate pharmacist non-medical prescribing?"***

4.2.1 Research Objectives

The objectives of this study were:

1. To explore what is happening with pharmacist non-medical prescribing and discover pharmacists views of non-medical prescribing.

2. To identify issues/tensions in relation to pharmacists boundary disputes whilst undertaking their prescribing role.

3. To explore how professionals respond and adapt to changes in work roles and boundaries.

4. To explore the wider sociocultural and organisational factors that impact on pharmacist non-medical prescribing and boundary work.

4.3 Epistemological Position

The epistemological position is a personal and subjective one and it influences how research is performed and interpreted -what knowledge exists (ontology) and what are the possible ways acquisition of this knowledge can be achieved (epistemology). It is the theory of knowledge embedded in the theoretical perspective and, thereby:

“The research epistemology guides what you can say about your data, and informs how you theorize meaning” (Brap33a, ande: Tmdn.t

> *"…all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context" (Crotty 1998: p. 42).*

This research took the constructionist approach which is especially fitting because this study assumed the broad position that pharmacists and associated health care professionals hold in terms of knowledge, attitudes, expectations, beliefs about their roles, responsibilities, and practices and that these were meaningful components of the social world. Part of this research endeavoured to identify the current position for the pharmacists included in the study and the accurate reflection of reality in terms of boundaries, boundary work, boundary disputes, and boundary changes.

I take an interpretivist epistemological stance. This perspective focuses on individuals' experiences, their construction of understanding, perceptions, and interpretation of reality. In addition, interpretive methods grasp the meaning of social action in the context of the life-world and from the actors' perspective (Vasilachis De Gialdino 2009; Snape and Spencer 2004; Creswell 2007; Crotty 1998).

4.4 Methodology

The methodology is the strategy, the plan of action, the process or design lying behind the choice and use of particular methods and linking the choice and use of methods to desired outcomes (Crotty 1998). The choice of methodology used to answer any research question is rooted in the belief the researcher has about the reality of what knowledge exists (ontology) and what ways acquisition of this knowledge can be achieved (epistemology). I am interested in understanding the subjective knowledge and experience presented by pharmacists and other health care professionals. To understand and explore this area, this research uses inductive logic and is qualitative.

My research follows an exploratory and ethnographic methodology. Knowledge in qualitative research is constructed through the social processes of the researcher engaging with other participants in their studies. Qualitative research methods are linked to different visions researchers have of how social reality should be studied and what can be regarded as acceptable knowledge (Bryman 2004):

> *"The word qualitative implies an emphasis on process and meanings that are not rigorously examined, or measured (if measured at all), in terms of quantity, amount, intensity or frequency. Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is being studied, and the situational constraints that shape inquiry. They seek*

answers to questions that stress how social experience is created and given meaning" Denzin and Lincoln: p. 4).

With qualitative research, the research process changes as the researcher learns more about the topic and what they actually need to research rather than following a fixed process. Qualitative research is interested in the way in which the world is "understood, experimented, or produced" (Mason 1996: p. 4) by people's lives, behavior, and interactions (Strauss and Corbin 1990). Qualitative research does not produce statistical figures but is a complete description of the subject of research. Rees (1997) asserted that rather than presenting the results in the form of statistics, qualitative research produces words in the form of comments and statements. Its aim is to find out people's feelings and experiences from their own point of view rather than from that of the researcher. Therefore, qualitative research is the development of concepts which help us to understand social phenomena in natural (rather than experimental) settings, giving due emphasis to the meanings, experiences and views of all the participants (Pope and Mays 1995). The emphasis in qualitative research is focuses on, 'the perspective of those being studied rather than the prior concerns of the researcher along with the related emphasis on interpreting observations in accordance with the subjects' own understandings' (Bryman 1989):

"Qualitative research, while time consuming, is an excellent tool to investigate differences among cultures, genders, professions, and

geographic regions, to name a few. It provides a rich collection of information for the investigator" (Goodson and Vassar 2011).

Ethnographic inquiry is a qualitative approach that studies the cultural patterns and perspectives of participants in their natural settings where people live, work or socialise. Ethnography seeks to uncover meanings, process of actions and perceptions within the social context of the everyday world of the people involved in the research (Atkinson and Pugsley 2005). The aim of ethnographic research is to describe, analyse and interpret the culture of the participant to understand their beliefs, behaviours, practices, and language.

The researcher is immersed in the culture that they are observing, asking or interviewing and collecting data through fieldwork where extensive field notes are recorded to capture behaviour, orientation, cultural know-how, and cultural beliefs. Fetterman (2010) stated that:

"Ethnography is about telling a credible, rigorous and authentic story. Ethnography gives voice to people in their own local context, typically relying on verbatim quotations and a "thick" description of events" (Fetterman 2010: p. 1).

It is presumed that personal engagement with the subject is the key to understanding a particular culture or social setting. The scope of these projects can vary greatly, from studying an entire complex society to a single social situation or institution. Spradley (1990) suggested that the “beginner” would be wise to restrict the scope of his or her project to a single social situation so that it can be completed in a reasonable time. A social situation or institution always has three components: a place, actors, and activities (Spradley 1990).

Exploratory research is a methodological approach that is primarily concerned with discovery and with generating or building theory. Exploratory research is used to gain familiarity in order to find out what is going on where a problem has not been clearly defined and is flexible in its approach. The results of exploratory research are not usually used for decision-making by themselves, but they can provide significant insight into a given situation.

4.5 Methods

In order to produce knowledge to address the posed research question, qualitative techniques were used to gather data. Writing about health policy research and the use of qualitative methods, Murphy and Dingwall stated that qualitative research seeked to bridge the gulf between experimental situations and implementation in the community. The authors suggested that by examining how interventions and initiatives interact with the context, they can inform both practitioners and policy makers with the basis for informed judgments:

> *"...about the likely impact of developments, which have been demonstrated unequivocally to be beneficial under controlled conditions, once they are implemented in the complex, and sometimes messy, contexts that are typical of every day health care settings" (Murphy and Dingwall 2003: p. 46).*

A specific example of qualitative research in an organisation includes participant observations. The qualitative research methods utilised for this research were semi-structured interviews and non-participant observations.

The research involved collecting data via semi-structured interviews and data in the form of field notes taken throughout non-participant observations. In addition, each participant was asked to complete a one-page demographics sheet (see Appendix 1) whether they were taking part in either the semi-structured interviews or the observations.

4.5.1 Exploratory Interviews

Interviews have become an extensively used method for sociological research (Burgess 1990) and their scope ranges from tightly structured preconceived questions to more dynamic flexible conversations. Central to the interview is the idea that the spoken communication between respondent and researcher can reveal something of the world in

which the respondent inhabits and experiences. Exploratory interviews gather unique views, descriptions, and accounts of the respondent's experiences and places these within the wider social and interpretative context.

One-to-one, in-depth semi-structured qualitative interviews are the main method employed to collect qualitative data. The interviews were used to delve further into issues set out in the literature, to cultivate data specifically relating to pharmacists, and to explore the opportunities of pharmacists to practice as non-medical prescribers. I interviewed a sample of professionals for each case study, including pharmacists from hospitals, community and practice settings; medical doctors (consultants, GPs); hospital and community nurses; management and administrative staff and support workers. The interviews enabled me to explore further the experiences of non-medical prescribing from different stakeholder and professional perspectives.

Semi-structured interviews used a set of open-ended question and aimed to be flexible and interactive. The use of semi-structured interviews allowed the interviews to follow a more natural movement as they are more responsive and not prescriptive. Semi-structured interviews were a good method to collect data due to their flexibility and the ability to probe for further information during the interview. Silverman (2006) explained that interviews gain useful data as the method allowed me to probe for further information when important responses, areas, or themes emerged. Silverman (2006) went on the add that while Interviews are not only economical in terms of time and resources but they also

allow the researcher to explore people's attitudes and values, which the researcher would not have, necessarily, been able to observe or discern through other means (Atkinson and Hammersley 1994; Bryman 2004; Ritchie 2004; Creswell 2007; Fetterman 2010).

4.5.2 Face-To-Face Interviews

Participants were interviewed at a convenient setting of their choice. This varied from their work place location, the University of Nottingham, coffee shops. The aim was to provide a neutral, non-threatening environment that would help to promote a relaxed atmosphere and encourage the participant to tell his or her own story.

On the day of the interview (at the time/location, as arranged) informed consent was sought, along with minimal demographic information (age, time as qualified prescriber, setting working in).

The purpose and process of the interview was discussed with each participant at the consent stage and they were encouraged to ask any questions that they might have had. The participant's permission to record the interview using a digital recorder was sought at the consent stage. Participants were reminded that they were able to withdraw consent at any stage of the research process with no resulting consequences and they were reminded that if, for any reason, they felt uncomfortable to answer any particular question they could

opt not to answer it. Once consent had been given, I then turned on the digital recorder and the interview was initiated.

Once the interview had finished the digital recorder was turned off and that marked the end of the study for the participant unless they had agreed to take part in the non-participant observations.

4.5.3 Telephone Interviews

Four participants were interviewed by a telephone interview. This was to make it feasible in the few cases where the study period or the respondents work commitments would not have otherwise allowed. In doing so, this prevented the loss of some potentially rich data by preventing the four practitioners (from already small groups) from being excluded from the study for logistical reasons. Participants were approached and recruited with the same method used for the for face-to-face interviews. The only difference was that the participants, who were interviewed over the telephone, were sent the demographic sheet and the consent form electronically via email. These forms were, then, completed by the participant and emailed back to myself . The completed forms had to be returned before the interview could commence. On the day of the interview (on the day/time, as arranged) I telephoned the participant on the telephone number they provided. At the beginning of the telephone call, it was verified that the completed consent and demographic information form had been received.

4.5.4 Interview Schedule

The interviews followed a broad interview schedule (see Appendix 2) which was designed specifically for this research. Construction of the interview schedule questions was aided by literature review, field visits, and piloting.

4.5.4.1 Interview Schedule Development

From local knowledge of the hospital region and from established university contacts, I was able to use this knowledge and relationships to enlist the help of pharmacists. Three pharmacists from the local hospital and the university were, used to pilot and subsequently inform the development of the interview schedule.

A test run of an interview was conducted to trial the questions. Thorough notes were taken about the wording of the questions, how the questions were interpreted, and any other comments and suggestions that were put forward or any issues raised with the schedule's content. This process was used to help develop the interview schedule questions, which focused upon non-medical prescribing, but also enquired about other types of prescribing which have been reported in the literature, inter and intra professional relationships and interactions, and boundary work.

4.5.5 Non-Participant Observations

This phase of the field research involved detailed non-participant observations of pharmacy practice, which involved observing a pharmacist in their everyday setting doing routine practices or whatever they encountered during my time observing. Non-participant observation offers the opportunity to record and analyse behaviour and interactions as they occur. Non-participant observations allow experiences, actions, and events and so on to be seen through the eyes of the research without any construction on my part. Richie (2004) suggests that observations are:

> *"…a particularly useful approach when a study is concerned with investigating a 'process' involving several players, where an understanding of non-verbal communications are likely to be important…" (Ritchie 2004, p. 35).*

Being a non-pharmacist, interested in the work practices and tasks carried out, I attempted to understand the specialty more deeply. I aimed to illuminate the hidden areas of practice, that may not normally be discussed or referred to. I also wanted to ascertain the range of interactions and contacts pharmacists had during a typical working day.

I spent between two and a half weeks and a month undertaking non-concurrent overt observations at each site. The times observing varied between pharmacists due to their shift

pattern, for example, one pharmacist worked 12 hours a day, and the other two 8 hours. The pharmacist who worked 12 hour days was observed for the shortest duration, between two and a half weeks. Observations ceased when they became repetitive. Similarly, if the pharmacist had to do administrative tasks and requested not to be observed for that period, observations were cut short and resumed at the next arranged day. A maximum of 3 days per week was applied to the conduct of all observations carried out. No pharmacist was observed for more than 3 days[11] in a week.

Observations were conducted in both community and hospital settings. During my time observing, I took detailed field notes of observed interactions, practices, relationships, environments and also my thoughts and feelings in my observation journal (Wright Mills 1983). Field notes are a record of what is observed and is, ultimately, data. They detailed interactions and processes that make up peoples everyday lives and practices and are my understanding of the people and events that are the focus of the research. Field notes provided essential grounding for writing clear accounts of others and detailed the social and interactional processes that make up individuals everyday activities and practices.

Carrying out observations not only enabled me to observe first-hand the rich socio-cultural world of pharmacy practice which for some included the uptake of new prescribing roles. Observations allowed me to see how these roles were delivered along with any interaction with colleagues, other professionals and patients, but also the physical and spacial aspects

[11] A "day" is defined as the duration that the observed pharmacist was working on any particular day.

of the observed situations and practices (Gold 1958; Ellen 1984; Adler and Adler 1987; Allan 2001; Lewis 2004). Observations were undertaken in various clinical and nonclinical settings.

Non-participant observations allowed me to compile naturally occurring data. This is a method central to ethnographical research. Observation offers the opportunity to record and analyse behaviours and interactions as they occur and are also very useful when investigating a 'process' involving several players (Ritchie and Lewis 2004). As a researcher, participant observations allowed me to immerse myself in the research settings in order to get close to those studied as a way of understanding what their experiences and activities mean to them. Ritchie (2004) explains that the researcher:

> *"...joins the constituent study population or its organisational or community setting to record actions, interactions or events that occur. This not only allows phenomena to be studied as they arise, but also offers the researcher the opportunity to gain additional insights through experiencing the phenomena for themselves" (Ritchie 2004: p. 35).*

Disadvantages to using observations include the argument of 'reactivity'. That is, whilst being observed, people may act differently to what they normally would. However, for my research, observations allowed me first hand to get a better understanding of the culture of the work place and as such enable me to observe interactions as they occurred. To some

extent, these observations helped inform the interview questions. The data gathered from carrying out these observations also helped to illustrate the physical practicalities and any physical barriers (setting specific, access to consultation rooms) to carrying out the role of a non-medical prescriber and the extent to which, if at all any, the roles are different. For example, the observations in this study revealed inter-professional relationships and interactions.

It was not possible to generate an exact list of selected observational situations, groups, or interactions. In the ethnographic tradition, observational research is developmental and emergent through the research process. The purpose of both clinical and non-clinical observations was, therefore, to understand how individual pharmacists and staff groups work both alone and with each other, and also how they share information about prescriptions. A main focus of the observations was to see what the role of the pharmacist involves and how prescribing fits in with it. In addition, inter and intra-professional interactions and working together, communicating, and the sharing of information was observed.

On the day of the initial observation (at the time/location, as arranged) informed consent was sought at this time along with minimal demographic information (age, time as qualified prescriber, setting working in). The purpose and process of the observations was discussed with the participant at the consent stage and they were encouraged to ask questions that they might have about the research or the observations. Participants were reminded that at any point of the process they were able to withdraw consent with no resulting

consequences and that they only need to answer questions they feel comfortable to answer, if they were asked any questions by myself at any point of the observations. The consented pharmacist was the focus of the observations. Their interactions, tasks and activities were of importance and were monitored.

To support the processes of the observation and ensure the appropriate confidentiality and consent of patients and staff, a variety of different strategies were used to ensure that, as widely as possible, staff members and patients were informed beforehand where possible about the study irrespective of their direct involvement in observations. In terms of general awareness amongst staff, this included the distribution of Participant Information Sheets to clinical areas and staff department/staff room. The pharmacist on the day of the observations, as they moved through different work spaces and area, informed the pharmacy or medical staff team or those staff that they interacted with of my presence and my role there. When pharmacists had patient consultations, they asked them if they were happy for me to be present so to attain verbal consent where appropriate.

In the case of observing one-to-one clinical activities or consultations, such as undertaking physical examinations, private patient consultations, providing clinical care and where specific patient information or care was discussed, more formal procedures were used to ensure the confidentiality and consent of staff and patients. Specifically, both patients and staff were provided with appropriate information from the consented pharmacist (this was typically verbal although the patients were offered an Information Sheet should they wish

to have more information). Patients and staff were, then, asked if they consented to me observing. Where people agreed I observed the activity. Out of all the time spent observing, there was only one occasion where I was asked to wait outside of a consultation. On this occasion it was not appropriate to observe the interaction because the patient being reviewed on the oncology ward round was really quite ill.

It was very difficult to acquire informed consent from every single individual working within the site for the purpose of observations due to the level of activity and the amount of people in an area or moving between areas. For example, observations may not have involved just formal meetings or interactions but also more short-lived and fleeting interactions, for example, how staff members talked about their work when walking down the corridor, or during a weekly clinical meeting that I observed which had clinicians and pharmacists enter and leave throughout the entirety of the meeting. To provide information and consent to each individual who entered would have been somewhat disruptive and unfeasible. Approaching such situations for the purpose of consent would significantly disrupt the naturally occurring interaction as well as being impractical in the course of the study. In such cases, the selection and collection of such data relied upon the previous awareness measures and team briefings undertaken at the initial stages of the qualitative work package. The ethical basis for undertaking these observations was that research activities must respect the privacy and wellbeing of the persons observed, whether intended research participants or not. Unless those observed gave their consent to being observed, observational research would only be acceptable in situations where those observed would have normally expected to be observed in the normal course of their work

interaction. Using the medical meeting example, the meeting often had non-participant guests or observers present who had an interest in the scheduled discussion so being observed was not out of the ordinary here.

4.6 Recruitment

NHS Research and Development (R & D) approval was given by three NHS Trusts which allowed me to approach pharmacists in community and hospital pharmacy settings. Recruitment was carried out over a period of 14 months. During recruitment, through recommendations of other pharmacists, other health care professions were suggested to me. I had the opportunity to interview a small number of doctors, nurses and midwives. It was decided that I would include these people in my study as I felt that they would be able to add to the area, albeit from a different perspective of the pharmacist. The sample population recruited included professionals including hospital and community pharmacists working clinically and managerially, medical doctors (in both primary and secondary care), hospital and community nurses and midwives, and also management and administrative staff over two geographical regions as per NHS R & D and Ethical approvals.

4.6.1 Sampling

In qualitative research, individuals are selected to take part in research based on their first-hand experience of the phenomenon of interest. An opportunistic purposive and convenience sampling strategy was employed. Opportunistic sampling is a form of non-probability sampling (Polit and Hungler 1999; Barbour 2001). With this method of sampling,

the sample involves the researcher taking "unforeseen opportunities" as they arise during the course of the fieldwork (Ritchie, Lewis and Elam 2004). Dane (1990) suggests that the advantage of purposive sampling is that it allows the researcher to home in on people or events, which have good grounds in what they believe, will be critical for the research. Creswell (2007) stated that:

> *"The inquirer selects individuals and site for the study because they can purposefully inform an understanding of the research problem and central phenomenon of the study" (Creswell 2007: p. 125).*

The study was conducted with participants working in the community, primary and secondary care. These different work sites inevitably dictate different tasks and activities to be performed and so the different sites were included for a more rounded view of practice. The different tasks carried out and the ease or difficulty in which adapting and undertaking these tasks, both old and new, were explored.

For the purpose of this study, participants were included because they were pharmacists, practicing health care professionals, or support staff who worked in and around prescribing and had experience of medicines and/or the health service. Both pharmacists with the non-medical qualification and those who did not have the non-medical prescribing qualification were all included in the sampling for this study. The literature and the data around non-medical prescribing suggested that though pharmacists (and other health care professions)

who had gone on to gain the non-medical prescribing qualification did not reflect in the numbers of pharmacists (and again, other health care professionals) who used their qualification in practice (George et al. 2007). As the unbalanced representation was present in other professions, as well as pharmacists, and due to the shifting of tasks between professions to facilitate non-medical prescribing, I decided to widen the sampling frame to include other groups. Pharmacists remained the main focus, but I felt that in speaking to other professionals involved in the prescribing process, that potential or shared barriers and attitudes might be highlighted and would help in addressing and answering my research aims as it offered the potential to explore different working relationships and conversation[12].

Initially, participants were identified by gatekeepers (chief pharmacists and pharmacy managers) and established University networks (School of Pharmacy). Additional participants were identified using convenience, chain referral (snowballing) sampling. In addition to inviting people to the study via my own networking, I asked participants at the end of the interviews if they could suggest anyone whom I could invite to participate in my research. Some examples of people who put forward suggestions for recruitment include some people who suggested colleagues, others put forward people who they knew had a non-medical prescribing qualification, others were suggested as people who they met on the non-medical prescribing course.

[12] Interview questions asked were about pharmacists and their practice and also perceptions and attitudes towards and of pharmacists (see Appendix 2).

4.6.2 Pharmacists

Pharmacists and practices were approached for interviews and ethnographic observations by word of mouth, gatekeepers[13], other pharmacists, and established contacts from working on previous health service research studies at different Trusts (chain referral sampling snowballing). The chief pharmacist/pharmacy manager at corresponding pharmacies identified pharmacists (including themselves where appropriate). Potential participants were each sent or given a recruitment information pack by the chief pharmacist, pharmacy manager, or researcher. The information pack contained the study information sheet that provided details of both the interview and 1 72.024 512982o0aand

4.6.3 Doctors, Nurses and Support Staff

Doctors and nurses that work with the pharmacists were identified by the gate keepers, leads within the Trusts and practices, pharmacists and already established researcher contacts (chain referral sampling snowballing).

Eligible doctors and nurses who were recommended were invited to take part and given a recruitment pack by either myself, pharmacist/pharmacy manager or one of their colleagues. The recruitment pack contained the study information sheet and an invitation letter with a reply slip. Recipients who were interested in taking part in the study were invited to contact me directly with their expression of interest using the reply slip, email or telephone number supplied. In addition, potential participants were also encouraged to call me if they had any queries about the study. Upon an expression of interest, I personally then contacted the respondent with the contact information which they supplied and discussed their inclusion into the study, answered any questions and booked in a date, time and venue for the interview to take place.

4.6.4 Inclusion and Exclusion Criteria

The inclusion criteria for the semi-structured interviews were practicing pharmacists, practicing nurses and midwives and both general practitioners and hospital consultants. In addition, management and administrative staff and support workers were also included in the research. This included chief pharmacists, pharmacy managers, and general practice support staff. The research was concerned with individuals who were actively working in

their particular profession and had specific and relevant experience in the evolving healthcare system. Due to limited time and resources, the research exclusion criteria for the semi-structured interviews were non-practicing pharmacists, non-practicing nurses or midwives, and non-practicing doctors. Professionals who were non-English speakers were also excluded from the interviews.

Similarly, the inclusion criterion for the non-participant observations was that the subject had to be a practicing pharmacist.

4.6.5 Research Participants

The collective sample for this research consisted of 24 people who were recruited and interviewed between 2011 and 2012 (see Table 2 and Appendix 3). I did not feel that the number of interviews that I carried out would allow me to make any generalisations about their professions or role, however, this was never my intention.

Interview Sample	Total number	Number with NMP qualification[14]	Number using NMP qualification
Pharmacists	16	9	4
Doctors	2	n/a	n/a
Midwives	2	1	0
Specialist Nurse	2	1	1
NMP course lead (Nursing background)	1	1	0
GP receptionist	1	n/a	n/a

Table 2

Observation Sample; Pharmacist and setting	Total number	NMP qualification?	Using NMP qualification?
Community – chain multiple	1	No	n/a
Hospital – ward based	1	Yes	No
Hospital – clinic based prescribing	1	Yes	Yes

Table 3

[14] See Appendix 3

Only pharmacists were recruited for ethnographic observation part of the study. One observation was with a community pharmacist who worked in a multi-store chain (see Table 3). The other two observations were with hospital-based pharmacists. Although both pharmacists had the hospital setting in common, their work and roles were significantly different.

The number of observations carried out was low. In my research protocol and ethics application, I had stated that I hoped to observe between 3 and 6 pharmacists. The target sample size was not worked out statistically, rather, a modest number of participants were anticipated given the population being sampled. I had hoped that 3 to 6 observations would be carried out with at least 2 observations in each of the three settings, with the intention of continuing recruitment until saturation was reached or until time permitted. I contacted pharmacists through a range of means inviting them to take part in my research. Unfortunately, the majority of pharmacists declined to take part in my research, specifically, the observation element for a number of reasons including being “snowed under”, “unable to commit at this time”, and “not being practical”. Two pharmacists who had agreed in principle were unresponsive to emails and calls when trying to arrange the observations. I decided to included pharmacists who did not have a non-medical prescribing qualification as part of my observations.

The reason why I included a pharmacist without a non-medical prescribing qualification and who worked in community pharmacy was so I would have the opportunity to observe a

"typical" day of a community pharmacist. Observing this particular kind of pharmacist, enabled me – as a non-pharmacist to see the role of a pharmacist and consequent responsibilities. It also was useful as during my interviews, a number of pharmacists who had got their non-medical prescribing qualification were unable to use in easily in practice.

> *"We do know that a number of community pharmacists have completed the training but have not been able to prescribe as they have no link with a practice" Personal correspondence 2011*

In observing in an area that was unknown to me, helped me to begin to see where potential barriers might exist for pharmacists in community setting who wish to implement their non-prescribing qualification or undergo non-medical prescribing training thus generating useful data to enable to tackle my research question.

4.7 Management of Data

The Data Protection Act 1998 was adhered to for the storage of data gathered. Participant details obtained during the course of the study are stored securely and participant confidentiality was maintained at all times. Materials generated during the course of the study were stored in a lockable drawer and on a password protected computer with encrypted storage. In addition, computer folders containing patient data were also password protected.

Different types of data were stored separately both in individual computer folders and in a locked drawer to ensure that the data could not be linked back to the participant to whom it belonged. In order to further protect participant identity, participants' details were assigned a unique study number only meaningful to me. The participant study number was recorded on the consent/assent form that is, again, stored separately to the data. There is and will be no participant identifiers on the data file or the raw data. In addition, data analysis and presentation of material relating to this study ensures that all names of patients and places are removed or changed to ensure anonymity.

The audio−recorded interviews were transcribed verbatim and participant pseudonyms were assigned during transcription to protect the anonymity of participants. Transcripts were checked against the recordings for accuracy. The transcripts were, then, stored in NVivo 9 as source documents and analysed using thematic analysis. NVivo 9 was used for data storage, coding data, data retrieval, and to help organise data (Edhlund 2011):

> *"NVivo helps, analyze, manage, shape, and analyze qualitative data [sic]…It provides security by storing the database and files together in a single file…and it enables the researcher to easily manipulate the data and conduct searches. Further it can display graphically the codes and categories" (Creswell 2007: p. 167).*

I primarily used this software for the storage and coding of the various sources of the qualitative data that I had gathered through the fieldwork. This included storage of observation notes, interview transcripts, interview notes and reflexive notes. The software enabled me to store these on a computer in such a way that enabled easy retrieval and access, electronic coding, grouping and cross-referencing. The use of the computer software in no way lessened my active role as the researcher, as I was still required to analyse the data, read and re-read the data, assign codes, make selections and analyse the codes and themes from the data.

4.8 Data Analysis

The analysis of qualitative data should form an integral part of a complete qualitative research experience. It is a continual process as Coffey and Atkinson suggest that:

> *" ... the process of analysis should not be seen as a distinct stage of the research; rather it is a reflexive activity that should inform data collection, writing, further data collection and so forth. Analysis is not, then, the last phase of the research process" (Coffey and Atkinson 1996: p. 6).*

Since qualitative data is largely textual, statistical procedures were not applied. Literature suggested that the researcher bases their analysis on the personal interpretation of words

rather than the objective evaluation of probabilities (Boyatzis 1998; Braun and Clarke 2006). Much of what the researcher writes about when reporting results reflects what the participants have said. Nevertheless, effectively analysing qualitative data requires more than stating the content of an interview or conversation. The analysis should look for import

to thematic qualitative analysis using a constant comparative approach (Boyatzis 1998; Braun and Clarke 2006; Creswell 2007). The interview data was transcribed verbatim and was analysed manually using thematic analysis. Transcribing the interviews allowed me to develop an in-depth knowledge of the data, which helped to facilitate the identification of themes and categories. Thematic analysis involves working through the data systematically identifying, analysing, and reporting themes originating from the data (Boyatzis 1998; Braun and Clarke 2006).

Boyatzis described thematic analysis as:

> *"…a process for encoding qualitative information. The encoding requires an explicit 'code.' This may be a list of themes; a complex model with themes, indicators, and qualifications that are causally relate, or something in between those two forms…A theme is a pattern found in the information that at the minimum describes and organises possible observations, or at the maximum interprets aspects of the phenomenon… The themes may be initially generated inductively from the raw information or generated deductively from theory or prior research" (Boyatzis 1998: p. 4).*

In addition, the thematic analytical approach fits well with the qualitative data analysis package used in the present study (NVivo 9). NVivo allows large amounts of qualitative data

to be organised and stored in order to facilitate interpretation. A good code captures the qualitative richness of the phenomenon and may emerge from one or more original themes. A good coding and thematic scheme enhances the interpretation and presentation of the research, particularly, where the phenomenon under investigation is complex (Boyatzis 1998; Seale 1999).

Boyatzis (1998) describes a good code as having five elements:

- A label
- A definition of what the theme concerns (e.g. characteristics)
- A description of how to know when the theme occurs
- A description of any qualifications or exclusions to the identification of the theme
- Examples both positive and negative, to eliminate possible confusion when looking for a theme.

The unit of coding adopted is the basic segment of the raw data drawn from the transcript, "*that can be assessed in a meaningful way regarding the phenomenon*" (Boyatzis 1998: p. 63). In some cases, the unit of coding may represent a complete response to a single question, or it could be a part of a response to a single question. The response to a single question could incorporate more than one unit of coding and there could also be overlap between codes (for example, work place settings and boundaries). Individual extracts of data can be coded into as many different 'themes'. As such, an extract may be coded once,

twice, or coded multiple times as appropriate under different themes or codes (Braun and Clarke 2006).

Interview transcripts, interview notes, observation notes and reflexive notes were coded and analysed thematically. An iterative and in-depth analysis took place where I coded and analysed thematically the study data. The coded categories were derived inductively, obtained gradually from the data. This process began as soon as the first interview was complete. I transcribed each interview and these were each checked for accuracy against the interview audio recordings. I coded each transcript independently. The categories were developed iteratively as part of the analysis process.

Data analysis was an on-going process and was undertaken concurrently with data collection and systematic efforts to identify, check, and refine developing categories of data. Full and equal attention was given to each data item to identify interesting aspects of the data that may form the basis of repeated patterns (themes) across the data set. Notes were written manually on the text with words and quotes highlighted and underlined (in Microsoft Word and also on paper copies of the transcript). In addition, this process was repeated in NVivo (discussed below) where potential codes were further refined and nodes were created, collated, and relationships and patterns were mapped and ordered. Where relevant, the surrounding text data was also captured so that context was not lost when revisiting the codes and quotes (Boyatzis 1998; Bryman 2004). The development and refinement of themes and ideas occurred during this process. The process of the thematic

approach enables greater potential for involvement by my supervisors to engage with the data, as the themes and codes were able to be clearly defined and checked.

Regular supervision meetings helped to review the identified emerging themes and resolved any points of variance. By way of a validity check on these interpretative processes (Barbour 2001), the findings were discussed with my PhD supervisors. Advice and supervision was provided from members of the academic supervisors, both of whom have considerable expertise in these methodologies. In addition, an independent researcher based in the School of Pharmacy also reviewed my coding against a selection of anonymised transcript excerpts to check for agreement and variance among coded excerpts. This process did not alter my coding labels of the data. Rather, It provided me with the opportunity to discuss my findings and defend my coding.

The process of the thematic approach enabled me to have greater involvement in engaging with the data, as it enabled me to identify and define potential themes and codes. Themes were clustered to provide a conceptual structure or framework to the phenomenon under investigation. Each interview transcript was subjected to an iterative and in-depth analysis. Examples of some of the areas that were labelled and coded included behaviours, attitudes, and experiences .

Verbatim quotes and recurring ideas were listed independently to illustrate the labels. I then refined these labels. The labels were, then, further refined through a process of

discussion with my experienced academic supervisors. A detailed list of themes and sub-themes was generated from the resultant findings. Edhlund (2011) describes how once a code is assigned, N-Vivo places all statements with that same code into a separate file so that you can either consider the comment as part of the interview it came from or with other comments from other interviews that have the same coding or 'node'. Analysing all comments within the same code allows themes to be identified (Edhlund 2011). Gradually, themes were refined and renamed as patterns in the words and phrases began to appear, common to participant's discourses. Data that related to these themes were, then, grouped under their appropriate theme headings. Once this inductive process was complete, the emergent themes were compared to those themes identified within the literature review. This, then, helped to hone in on the themes as reported in the data chapters.

The observation field notes and reflective notes were typed up. I underwent an iterative process where observation notes were analysed systematically using the same process with the interview data, however, each observation transcript was analysed separately. Codes and themes were cross-referenced with interviews. This exercise enabled me to identify contradictions and similarities within the different themes, categories, and between transcripts.

The subsequent descriptions provided in the data chapters are my interpretation of the narrative and, therefore, could potentially be interpreted in a different way by another person. However, the verbatim extracts from both the interviews and the observations

endeavoured to provide evidence to support the thematic account and their inclusion providing a means of validation (Rose 1982):

> *"Where our interpretations move beyond the explicit data provided by individual respondents, we place great importance on ensuring that the building blocks used by the researcher in arriving at their interpretations are clearly visible to the reader…in our reporting, we take care to show how more abstract interpretations offered by research relate specifically to the data provided by study participants" (Snape and Spencer 2004: p. 21).*

It was not my intention to capture a "representative" sample. Rather, my aim was to include as many participants as I could who I felt would help me to answer my research question, hence purposefully selecting. The results from the data collection and analysis are presented in Chapter 5, Chapter 6 and Chapter 7.

4.9 Reflexivity

Reflexivity requires the researcher to be aware of their effect on the process and outcomes of research.

"…it is important to note…that researchers cannot free themselves of their theoretical and epistemological commitments, and data are not coded in an epistemological vacuum" (Braun and Clarke: p. 84).

It also involves the researcher to acknowledging the impossibility of being able to detach what you know from what you do and how you interpret.

4.9.1 Reflecting on the Methodological Approach

At the outset of the research, I adopted a largely qualitative ethnographic approach, where I aimed to explore the pharmacists world through inductive conceptualisations with the use of exploratory unstructured methods, the investigation of small numbers in greater detail; and the analysis of data through the interpretation of meaning and action (Atkinson and Hammersley 1994; Creswell 2007; Fetterman 2010). As a method of research, a range of techniques can be employed under this umbrella including my choice of methods, observations, and interviews.

The research developed a broad ethnographic approach and this approach has given way to more general qualitative methods with greater focus on individual perceptions, meanings, and behaviours. The main reason for employing this approach was the difficulty in accessing pharmacists for prolonged periods of time and, particularly, to carry out non-participant observations in various settings.

The general exploratory and descriptive aspects of the research continue along with the analytical aspects of the research, which have remained concerned with understanding perception, interpretation, meaning, and action. The analytical approach is discussed later on in the chapter.

I intended to carry out the observations and interviews with pharmacists who had the non-medical prescribing qualification as well as those that did not have the qualification given that they are the focus of the research. The reason for including pharmacists with and those without the qualification was to enable me to explore the rationale for the decision or consideration of the non-medical prescribing qualification. Having pharmacists with and those without the qualification was important in relation to the role of the pharmacist. I was also helpful as it allowed me to investigate the range of the perceptions pharmacists had in relation to the non-medical qualification and the subsequent impact or perceived impact on their role as pharmacists.

The number of pharmacists interviewed was greater than the number of other healthcare professionals and this was intentional. The Pharmacists were the focus of my research. The number of other non-pharmacist participants were not statistically calculated. They were included in my research as the opportunity arose to interview them and they worked with or alongside pharmacists.

> *"Sample size is a limitation of the ethnography method. The time required being involved in participant observation and conducting long interviews greatly limits the sample size. Unlike a scan sheet used for a common survey, ethnography is laborious and detailed in the collection of data" (Goodson and Vassar 2001: p.4).*

The number of pharmacists included enabled me to gather some rich data and allowed me to address my research aims. The final number of observations carried out was less than I had initially hoped. Despite sending recruitment flyers to LPCs for circulation and contacting pharmacists through local register lists and local contacts, the response was disappointing. I received over a dozen emails wishing me well but stating that individuals were unable to commit to being observed or that pharmacist were in the process of "change" and "uncertainty" so declined to take part in my observations.

As my research developed, the opportunity arose to speak to other health care professionals and support staff that interacted with pharmacists. Consequently, the interview sample group shifted to a more general inclusive group for the qualitative interviews, which expanded to include interviews with other healthcare professionals and support staff. They were included in the research to enable me to hear other voices and viewpoints of professionals working in a clinical environment. The primary focus remained on pharmacists and their roles. The interviews with nurses, midwives, doctors and receptionist focused on non-medical prescribing, the role of prescribing, and the perception

of and the interactions with pharmacists. The different participants were included as the accounts provided a glimpse of how pharmacists are perceived and showed how the role of other professionals are affected by pharmacists' non-medical prescribing, as well as the interactions these healthcare professionals have with pharmacists. This was interesting in terms of the negotiations of practice, roles and responsibilities, and also task sharing. It also allowed me to draw overall conclusions from the people that I spoke to and comment on how the views presented were similar or contrasted.

Although it was useful, it is also considered a limitation of ethnography as Goodson and Vassar (2011) illustrate:

> *"It is difficult to generalize with the ethnography method. When researching a certain culture, the results cannot necessarily be generalized to other populations. Because the results are based on the cultural responses, the outcome of the study cannot be applied beyond where the study was conducted" (Goodson and Vassar 2011).*

The final numbers of participants, particularly observation numbers were not what I had originally hoped or however, I feel that I collected a lot of rich data from the sample which I had access to.

4.9.2 Reflecting on the Research Role

It is important to recognise and acknowledge my background and perspective in undertaking this research….

> *"The researcher, too, has attributes, characteristics, a history, and gender, class, race, and social attributes that enter the research interaction" (Olesen 2000: p. 226).*

I am a researcher and I have done health service research and worked on clinical trials. I am not a pharmacist but I have worked with pharmacists in different capacities in my previous roles including working with clinical trial pharmacists, academic pharmacists and also interviewing community pharmacists about medicine adherence and pharmacy services. It is important to highlight these experiences as these encounters will have gone some way to affect and influence my interpretation throughout my research without losing rigor or credibility:

> *"Ethnographers are noted for their ability to keep an open mind about the groups or cultures they are studying. However, this quality does not imply any lack of rigor. The ethnographer enters the field with an open mind, not an empty head" (Fetterman 2010: p. 1).*

Creswell (2007) suggested that how we write as a researcher is a reflection of our own interpretation:

> *"…our own interpretation [is] based on the cultural, social, gender, class, and personal politics that we bring to research. All writing is "positioned" and within a stance. All researches shape the writing that emerge, and qualitative researchers need to accept this interpretation to be open about their writings" (Creswell 2007: p. 179).*

On a reflexive note, it is important to recognise my role within these different settings. It was the case that I was not involved in any of the tasks performed by the pharmacists nor with any interactions with patients or colleagues. I had a non-participatory role in the process of data collection and simply observed the pharmacists. I used natural breaks or the beginning or end of the observation days as an opportunity to raise questions. As a non-pharmacist, it was sometimes necessary for me to ask questions for clarity; probably due to my role as an outsider and the lack of technical knowledge that I possessed.

Fetterman (2010) suggests that ethnography is typically concerned with acquiring an 'emic' perspective on the social world: understanding the insider's point of view in order to account for the normative and ideological 'reality' of participants. Nevertheless, Fetterman (2010) points out that it is often necessary to first develop an 'etic' appreciation of the social

setting: to understand its structures, boundaries, relations and actions from an external perspective, within which the internal understanding can be implied. These considerations not only relate to the type of data obtained throughout the research process but also the relationship of the researcher to the social settings in which the research is carried out. For example, is the researcher seen as an insider or outsider?

Participant observations are a recognised and established feature of ethnography and qualitative research, yet its appeal in the research field can be variable. It can range from complete involvement in the social setting, where a specific role is assumed and the researcher becomes socialised into the group or culture, or observations can be more distant and external exploring the broader social patterns and structures. The variations in observational styles and field relations can depend upon the focus of the study, for example whether it is more concerned with the structural/material or the cognitive dimension of culture (Fetterman 2010). There have been several attempts to classify the role of the researcher during the fieldwork process (Gold 1958; Ellen 1984; Adler and Adler 1987; Lewis 2004) and, although primarily concerned with observational roles, it is necessary to consider their relevance to this study.

4.10 Ethics

Ethical approval for the study was issued from the National Research Ethics Service; Nottingham Research Ethics Committee 2 (REC Reference: 10/H0408/93). Research and

Development (R&D) approval was granted from Nottingham University Hospitals NHS Trust, Nottinghamshire County Teaching PCT and NHS Leicestershire County and Rutland.

4.11 Ethical Considerations

In addition to gaining ethics approval throughout conducting of this research, on-going attention was paid to a number of ethical challenges that arose after the design phase and in the field. Some of these included the issues of informed consent procedures, i.e., observational research carried out over multiple visits, confidentiality, and my role as the researcher.

For the observations, a pharmacist that was consented to the study completed a one-off consent form. However, due to the changing environment being observed and that the observations were carried out over an extended time frame, at the beginning of each phase of observations I reiterated the right of the pharmacist to withdraw from the study should they wish. Verbal consent was sought to ensure that the pharmacist was still happy to continue. During the course of the observations, where patient consultations were undertaken, the pharmacist took the lean in explaining my role and who I was and asked the patient for verbal consent to being observed. On one occasion, the pharmacist made the decision that I wait outside the room due to the patient being unwell. Verbal consent was dealt with case-by-case on an on-going basis.

Confidentiality was carefully handled due to the specific roles of participants in Trusts. A number of roles were unique in individual Trusts and areas so when referring to different cases or using examples offered by participants, extra care was taken in anonymising and removing any colleague, Trust or company names to adhere to confidentiality. For the same reason, this same care was taken when writing up and referring to observation data.

Ethics is also important with respect to the role of the researcher. This ranges from determining the researchers honesty and openness in the research methods chosen to the conclusions reached. The role of the researcher is also central in achieving valid results. It is accepted that data and inferences from the data are shaped by social and personal characteristics of the researcher when looking at data. It is impossible to remove yourself as a researcher altogether but it is argued that taking a reflexive approach can help when presenting the research process and results (Hammersley 2012).

Throughout the study, I maintained field notes recounting experiences of thoughts and ideas. This included handwritten notes reflecting on individual interview experiences, such as an interesting or challenging interview or observation. The reasons why interviews or observations were categorised as such was recorded. The notes were used to provide reminders of field experiences when undertaking the data analysis and reporting of results. This practice aimed to add validity to my conclusions by reflexively looking at the way the research was conducted and how circumstances may have differed and affected the research outcome.

4.12 Summary

This chapter has outlined the qualitative methods used to answer the research question and fulfil the aims. The value of the qualitative methods, as employed in this thesis, is described. I have endeavoured to provide a description of the process that I undertook in generating my data and how I engaged with it to identify and develop codes and themes which became my results. Data collected from in-depth interviews and observations was systemically analysed to develop themes and sub-themes from the data. The chapter illustrates how the data was produced and how it attempts to be valid, in that the accounts and subsequent findings are closer to the 'truth' for the participant's situation, circumstances and practices than data that might be gather using quantitative methods, for example. In addition, I have also provided justifications of decisions that I have made along with practices and processes that I have followed. The resulting data is presented and examined in the next three chapters.

Chapter 5: Pharmacists: Professionals in Practice

5.1 Introduction

This chapter presents the pharmacist's assessment of their role and occupational boundaries. Attention to these boundaries enables us to understand how and where they experience barriers to transforming roles and responsibilities that are considered to be outside their jurisdiction. In doing so, referring to how these boundaries and jurisdictions have altered and are still changing and where pharmacists see them as changing in current respective contexts. The participants in this research worked in

consider the boundary to be for their profession and subsequent practice. The implications of these boundaries for pharmacists and the profession of pharmacy in terms of professional and also service development are also considered.

5.2 Pharmacy Profession and Pharmacist Roles

Pharmacists in this study, when talking about their job, referred to '*pharmacy'* as a profession and their profession of choice. The data collected suggests that there is a link between a career choice; the profession which reflects pre-existing things with where they work which develops and specifies their role and context which is self-reinforcing.

> *R02: "I wanted to have a profession when I finished my degree that you know, that I'd be trained to do something and I enjoyed the, you know, the subject of pharmacy" Primary Care Pharmacist, GP Practice.*

The data suggests that there are different meanings attached to pharmacy and pharmacist roles. This includes aspects relating to a) technical work and tasks carried out, b) different relationships and c) knowledge held by pharmacists. For these pharmacists, the setting also governs quite significantly the opportunity or suitability for tasks to be carried out.

5.2.1 Pharmacist Roles

Pharmacists described how their roles traditionally, consisted of dispensing and ensuring the safe supply of medication. This narrative was shared by pharmacists based in both hospital and community settings. The majority of pharmacists were very clear that the main component of their role was that of a more technical, checking role and the supply of medicines, ensuring the accuracy and appropriateness of the medicines that they were to dispense.

> *R12: "[I] would help them [doctors] with the doses for individual patients, particularly if they're struggling. Also a big part of our role is checking prescriptions" Hospital Pharmacist, Lecturer in Paediatric Clinical Pharmacy.*

> *R05: "…prescriptions come in through the door, you dispense them as they come in or dispensers come in and you check them, obviously I do the final check and then you might have queries over the counter… When I do the final check I consider I'm concerned with the script more as a whole than when I'm dispensing" Community Pharmacist, Independent.*

Checking is described as a key component of a pharmacist's role. Pharmacists referred to this activity and the importance of it. This activity was important not only to ensure that the patient was getting the correct medication but also the check was beneficial to the doctors

and instances the pharmacists corrected errors made by the doctor before it could be an issue.

5.2.2 Core Duties

Core duties for the pharmacists are tasks that they do as standard and tasks that sit comfortably within the boundaries of their work. Community pharmacists recognised some differences between their role and those of pharmacists based in alternative settings. Overall however, pharmacists shared the view that they saw their role as checking and safeguarding, not only the patient, but also the doctor. This element of checking has been described as a pharmacist's "first duty". One of the pharmacists described part of their role as having to "police" what prescribers do in terms of using new drugs:

> *R07: "One of the things we've got to do is police what prescribers are to do in terms of using new drugs. Now the prescribers don't like that cause they want to play with all the new toys and if I've got to say "actually you can't play with that new toy" you get you know, "I'm an expert, I'm a consultant" blah blah blah and "I know best" and that's not a particularly nice conversation to have but at the end of the day you just say sorry you know, this is the Trust policy" Associate Director Medicines Management, Pharmacist, Hospital.*

Where errors were highlighted or queries arose, the pharmacists reported that they took steps to contact the prescriber to address any queries.

> *R12: "We find you know quite a lot of errors so we would always intervene and get those changed, usually by speaking to the prescriber and letting them know" Hospital Pharmacist, Lecturer in Paediatric Clinical Pharmacy.*

> *R09: "I don't know how to say this but if I ask them to write up some chemotherapy sometimes they won't, if they're not looking at it properly they might not write up quite up the right thing or not realise somebody is allergic to that" Paediatric Oncology Pharmacist, Hospital.*

Another pharmacist details times when the prescriptions are incorrectly written and they have to get in touch with the prescriber.

> *R05: "So it tends to be a case of, prescription not legally written or there's a problem with the actual medicine" Community Pharmacist, Independent.*

Although the pharmacists in this study worked across a range of settings, the pharmacists shared a number of working practices. On the whole, as a group some consensus was observed, as all of the pharmacists, including those who worked in a managerial role[15] described the core duties that they engaged in. Each pharmacist described having a series of core tasks, the common job that each of them performed. The recurring shared task was to check prescribing and to ensure that it was being carried out correctly. This activity is also in line with pharmacist's professional standards and also the pharmacy contract.

> *R10: "…as pharmacists let's face it we have core duties that we need to do and our first duty is to obviously professionally check and make sure that doctors are prescribing correctly" Theatres and Anaesthetic Pharmacist, Hospital.*

These tasks are universally performed by the pharmacists in this study irrespective of their job title or the setting in which they worked. The pharmacists who were based in the hospital setting, expressed that their role consisted of ensuring safe prescribing and looking after their respective wards or clinical areas. In each of these cases, they describe how they allocate their time. Doing what they describe as clinical work including, checking doctors prescribing, going around the wards, checking patient's prescriptions, 'sorting out' discharge medications, supplying medicines to the wards, doing drug histories, doing clinical interventions, working out drug and dosing calculations and giving doctors and nurses

[15] The Pharmacists who participated and worked in a managerial role still worked clinically. One pharmacist managed a hospital ward and the other pharmacist did locuming.

advice on prescribing and administration of medicines. That is essentially supplying medicines to patients and wards whilst working alongside a medical team.

5.2.3 Knowledge and Teaching

Some pharmacists in this study conveyed that sharing knowledge and teaching was seen as activities that were a key part of their role as a pharmacist. In ensuring accuracy and safe supply of medicines, pharmacists routinely communicated their knowledge with others and

> *R10: "it's educating them and saying well actually these errors have happened and we need to do something" Theatres and Anaesthetic Pharmacist, Hospital.*

As pharmacists impart their knowledge, they see educating doctors and other prescribers as a necessary part their role. Pharmacists refer to the transfer of their knowledge on medicines and prescribing as a critical component in healthcare and raising the standards of prescribing in general. The majority of pharmacists in this study regarded educating as an important activity and described it as a part of their role. However, the role that education had for different pharmacists varied. Some pharmacists described how education was a way of increasing or ensuring quality control. Pharmacists have described educating as a way to improve prescribing practice and ensuring safer prescribing. A number of pharmacists in this study described how they determined their experience as qualification enough to carry out

this task. Pharmacists here carved out and setting this activity within the boundary of the role that they performed.

> *R12: "I guess my qualifications if you like for teaching them say prescribing is actually having seen hundreds and thousands of prescriptions, and where things can go wrong and all of the errors that I pick up myself regular daily basis. I can pass all that kind of stuff onto them… that's where some of the teaching comes in is that I will show them examples of what can go wrong if a prescription is written in a similar, in a certain way or whatever so hopefully that knowledge then affects their practice" Hospital Pharmacist, Lecturer in Paediatric Clinical Pharmacy.*

This pharmacist legitimises what she does in practice concerning teaching and educating others through her extensive experience and contact with and knowledge of medicines, prescribing and prescriptions. The pharmacist's objective here is to impart her knowledge in such a way that she influences and enhances the prescribing practice of other prescribers. When this pharmacist talks about their "qualification", she does not refer to graduate or postgraduate study for example, rather they ground their knowledge in their everyday knowledge which has been amassed through experience. In addition to the checking aspect, educating and imparting knowledge is seen as within the remit of the pharmacist role for

some pharmacists. Interestingly, a number of the other pharmacists saw education and educating doctors as something that was a part of their job role.

> *R12: "Part of my role I see is an educational role really, particularly for the junior doctors who are only just learning how to prescribe to children so to actually take part of their role away I'm not sure how helpful that would be really" Hospital Pharmacist, Lecturer in Paediatric Clinical Pharmacy.*

> *R13: "the danger is that you lose communication with the doctors if you're doing all the prescribing. And I think … If I wasn't in this position and perhaps just going out on the wards on my own, yeah I could change a Salbutamol nebuliser to an inhaler but there's an issue there that we're not educating. Because, if we are discussing that with the doctors, we are educating those doctors to actually make those changes and therefore we are hopefully improving the standard of prescribing across the board" Consultant Respiratory Pharmacist, Hospital.*

This view was conveyed by pharmacists that worked in a teaching hospital environment. For pharmacists in the community setting, the way they picked up and dealt with errors or addressing problems were a little different. There was a clear element of coaching and

picking up errors but other pharmacists did not stipulate teaching or education as part of their role, even though this was something that they routinely did. The difference in the way this practice was described could be down to the different clinical setting and the difference in the way the pharmacists interact with the doctors and also the patients.

> *R15: "…it's necessary to have some knowledge. I mean it's, you need other parts, you need other sort of things in your armoury, it's no good having lots of knowledge if you can't impart that usefully to a patient…" Pharmacy Manager, Community, Supermarket.*

While this pharmacist refers to the role of knowledge, the focus is imparting it on the patient. For community pharmacists in this study, the interactions that involved communicating knowledge to doctors was in a reactive sense rather than being involved in any consultation. Pharmacists in the community typically see prescribing after the prescription has been written up for a patient. In another interview, a pharmacist described how in the dispensary it was not the place of a pharmacist to argue what should or shouldn't be prescribed or whether someone was competent to prescribe or not. Rather, it was their job, to check the prescription and ensure that it was legally filled. As a pharmacist, they checked what was prescribed in terms of age, weight, and 'so on' where appropriate. Once satisfied that the prescription was satisfactory the pharmacist supplied what was written up. Again, this type of occurrence was in the dispensary, in a similar environment to that of a community pharmacy. The prescriptions here reach the pharmacists at the point at

which they are presented to be fulfilled. Again, these pharmacists, like those in based in community do not play any part in the process of prescribing here. The prescriptions are written independent of the pharmacists thereby removing any potential for the pharmacist to contribute or influent prescribing. Accordingly, these pharmacists' roles are somewhat different to the pharmacists who work on their own wards or in specific clinical areas.

5.2.4 Barriers and Boundaries

Even though considered the experts in medicine and actually providing that final check before medicines were dispensed, the majority of pharmacists, working in both the hospital and community settings stated that they had faced barriers when communicating or advising on safe or more appropriate prescribing guidance.

> *R02: "you're deemed to be the experts in drugs and yet you have very little sort of autonomy on how to, to prescribe … sometimes you can tear your hair out when you see some of the prescribing" Primary Care Pharmacist, GP Practice.*

Occasionally the doctors or consultants were not pleased when their prescribing or medication of choice was challenged. In such instances, the pharmacists spoke of how they dealt with this situation and how they had to use particular techniques to communicate their recommendations.

R04: "…So I phoned that doctor and told him, and he said "oh that's fine, no problem at all. Give it, yeah, I knew that, just give it", so I said, "oh, fine, the only reason I'm ringing you up is the same thing happened to a colleague of mine and the patient died from an overdose"… hmm… "…because they were started on a too higher strength. So that's the only reason I'm checking, but if you're quite happy with that I'll make a note and that's fine…[clears throat]"."Can we change it to the lowest one please"…" Community Pharmacist and Store Manager, Community, Chain.

Pharmacists suggested that they used knowledge and legitimacy to convey point to doctors. Essentially, the intervention of the pharmacist is part of them carrying out their role in that they are providing that second or final check and that they are ensuring that medicines are prescribed correctly. Despite the widespread differences in pharmacy and in practice of pharmacists, despite the differences in additional services offered and performed by different pharmacists, the principle of what they do remains the same. At the heart of all that pharmacists do is medicines and the safeguarding of patients as well as the prescribers whose prescriptions and treatment they check.

In a few cases, these activities were not the core element of certain pharmacists jobs. For example in my cohort, there were pharmacists who only worked in the pharmacy unit a

couple of hours a week or pharmacists who undertook different roles. Despite this variance, pharmacists agreed that the checking function was one that was distinctive of a pharmacist's role and where a great proportion of a pharmacist's knowledge lay. The roles of pharmacists within this research was considerably varied (See Appendix 3).

Pharmacist's in this research suggested that a big part of their role was knowing their boundaries. This awareness could be viewed as particularly important where pharmacists move towards potentially extending their role and continue to carry out additional tasks and delivering further services. The pharmacists each had their own perceptions of their role and their boundaries. Some of the pharmacists commented:

> *R13: "you know, we are the experts in medicines. You know, I'm not a doctor, I'm very proud to be a pharmacist. I don't want to be a doctor. I think it's important that I understand the diagnosis, it's important that I understand the differential diagnosis but if I'm ever unsure about it I ask my colleagues to see the patient" Consultant Respiratory Pharmacist, Hospital.*

> *R02: "you've got to know your boundaries, now, I'm quite comfortable doing certain prescribing, I think I still find it quite stressful, I'm certainly not very comfortable about having to do, sort of examinations and stuff. I mean, obviously I was trained to do an*

abdo examination and it's sort of in my area but I by no means feel particularly confident and I can't really see any role of me doing that. And I, if I ever had a patient that came in and said 'I'm getting you know, sort of gastric pains' theoretically I do know how to do an abdo examination, I, I, wouldn't do it. I would go and get the GP" Primary Care Pharmacist, GP Practice.

Knowledge and knowledge claims are considered a substantial part of boundary erosion and reformation. In healthcare and medicine, boundaries are heavily entrenched in knowledge. For the pharmacists, knowledge, skill and expertise are key in jurisdictional defence.

R14: "I think that as a profession you would anticipate, because of their training and their background that they should have a deeper understanding of the prescribing process and what goes with it" Advanced Pharmacy Practitioner, Pharmacist, Hospital.

Generally, '*qualification*' automatically suggests that a person or professional is endowed with the knowledge and skill to perform a particular or collection of particular tasks. The knowledge which is held by individuals, typically determines what they are able to do which in turn, defines the boundaries that are operated within. Pharmacists in this study all described themselves as being aware of their boundaries and where they felt comfortable in practice. - carrying out the tasks is another way in which boundaries are unpacked.

5.2.5 Pharmacy Profession

Some pharmacists in this study felt that they struggled to make sense of their own professional identity or what it means[16]. Carr-Saunders and Wilson (1933) commented that it was problematic in defining a group as professionals. This analysis was to some extent reflected in the views of participants.

> *R15: "…it's just I think pharmacy is struggling for an identity at the moment really as to what it is. It's certainly no longer about making medicines…It was, it is still predominantly supply of medicines but I think the financial model is moving away from that and in doing so sort of making it difficult…to get an identity really". Pharmacy Manager, Community, Supermarket.*

> *R15: "that's the main concern about the profession really is that it's, it's not going to be a financially a worthwhile profession to be in possibly but the actual content of the job I'm still quite happy with, despite the, despite the change" Pharmacy Manager, Community, Supermarket.*

[16] This is discussed in more detail later in the chapter

easily done when they are allotted as obligatory more so than an optional route steered by the individual.

5.3 Professional Preference and Pharmacist Identity

Professional preference goes some way in steering the direction in which the pharmacist goes and subsequently the boundaries that pharmacists practice within. The data shows that clinical work was more historically associated with certain hospital pharmacists, particularly those based on wards. This research shows that the non-medical prescribing qualification and the different additional services being tasked to pharmacists in a range of different settings, more clinical work and clinical case management is being carried out by a range of pharmacists, not just restricted to one area.

Nevertheless, within the group of pharmacists, the majority of them specifically described themselves and others as being either clinically or patient orientated or having a clinical preference within pharmacy.

> *R10: "You come to a point in pharmacy where you think are you going to go managerial? Are you going to go more clinical and practical based? And I've always thought I'd be more practical rather than managerial and so I kind of saw that as the future. And I do*

believe that you know I think we should, you know it's becoming part of the degree" Theatres and Anaesthetic Pharmacist, Hospital.

The data indicates that pharmacists expressed preference in their practice area and identified themselves as being either clinical or managerial. Pharmacists described their role and career progression. Each pharmacist had made a conscious decision to follow one of these two distinct paths. The apparent division in pharmacist preferences was not restricted to setting. Pharmacists from each of the settings included in this research put forward this argument. Given the distinct differences in clinical and management pathways referred to, the margin within which a pharmacist's role lies can be said to be determined as a consequence of how they identify themselves and the subsequent choices that they make. The setting will then affect the tasks performed by virtue of the jobs set out in the respective settings in which they work.

5.3.1 Clinical Verses Managerial

Pharmacists who want to do work which is more clinical have deviated from what was their original settings and or work areas. This is true of both community and hospital pharmacists.

R02: "…through my [undergraduate] course knew that community was never going to be for me, I'd much prefer more clinical, but yeah, I suppose went and did a PhD and did a bit of

research and then I kind of, I think maybe primary care was the happy medium between community and hospital" Primary Care Pharmacist, GP Practice.

R16: "I effectively gave up a full time branch manager's position to do two things which have no permanence to them. So again that's another risk, but one that I was happy, well not happy to take but one that I was willing to take because I do definitely want to be a clinical pharmacist and I was aware that it was physically impossible to do both roles so if I was forced to choose" Community Pharmacist, Chain.

Both pharmacists here describe themselves as wanting to be clinical. For these two pharmacists the option to follow a 'clinical' pathway has influenced them in the choices that they have made with respect to where they will work and in what role. In order for them to evade these boundary restraints and to allow them to carry out the clinical role they desire, they have specifically opted to move settings and work within a distinct setting, in this case primary care. For R02, community pharmacy has a distinct boundary. This boundary is perceived to be a barrier; one that does not facilitate clinical working or tasks that this pharmacist describes as their ideal or preference. She states that she knew that community pharmacy would never to be for her as she had a preference towards more "clinical work". This is despite the on-going changes in community pharmacy that allow and promote increasing clinical services carried out by pharmacists. It would seem that for this

pharmacist, the clinical services here fall short of their requirements. The second pharmacist on the other hand describes herself as having two definite roles that her time is split between; community pharmacist and prescriber.

> *R16: "I work in the community so when I'm working as a pharmacist I'm working normally in shops… When I'm working as a prescriber, some of the clinics are pharmacy based, some are surgery. The main one is surgery based and another one is involved with the out of hours service, so I'm working with quite a big spectrum of different people but all kind of on the community side as opposed to the hospital side or research side" Community Pharmacist, Chain.*

This pharmacist demonstrates that while she had to give up her managerial job to follow a clinical path; she was able to follow a different route whilst remaining a community pharmacist, working in the community setting. While some of this pharmacist's clinical work is based in a GP surgery, there is still prescribing done which is community based pharmacy.

Pharmacists in this study shared in their preference to perform either clinical or managerial roles. However, they were somewhat divided by the perceptions that they hold about different aspects of pharmacy and the way in which they go about fulfilling their desired roles.

5.3.2 New Roles

As stated earlier, in recent years the pharmacy profession has developed radically and there are now increasing numbers of pharmacists with special interests, consultant pharmacists, specialist pharmacists, community pharmacists developing local clinical services and pharmacist prescribing (Department of Health 2008a). Alongside the occurrence of these revisions, roles for pharmacists have unavoidably seen the introduction of new tasks. Pharmacists state that there has been a move away from the perception held by other groups who viewed pharmacists as pill counters, amongst these changes in the roles which pharmacists fulfil, there remains much uncertainty as to what pharmacists actually do.

> *R17: "another barrier that is GPs' perceptions of pharmacist prescribers so that creates a huge barrier, so it tends to be pharmacists get to do the things that GPs don't want to do, which isn't necessarily the best use of a pharmacist. Or a GP for that matter" Community Pharmacist, Chain.*

The data suggests that this is the case more in the community and general practice setting as opposed to the hospital. That is not to say there are marked changes in roles among hospital pharmacists. This was demonstrated in one of the participant observations, where the pharmacist who was being observed did not go to the hospital pharmacy once for the duration of the observations. This particular pharmacist, who was a non-medical prescriber,

instead ran clinics and this was where the majority of her time had been spent. One pharmacist described how their Trust supported non-medical prescribing pharmacist but also was conscious that pharmacists needed to perform their "core duties":

> *R07: "…obviously we can't do that for everybody or we won't have anybody left to do the core duties" Associate Director Medicines Management, Pharmacist, Hospital.*

Some pharmacists referred to the expansion of the pharmacy role and the addition of other services as helping towards the defining of pharmacy and almost re-establishing it as a profession. One pharmacist felt that utilising new skills made the pharmacy profession more valid.

> *R16: "…It's got a long way to go but I think… we should be doing that and I think that makes me feel that my profession is more valid because it is a profession… in a more whole way than the way it was previously" Community Pharmacist, Chain.*

The suggestion that adopting new tasks makes pharmacy a more valid profession implies that those pharmacists who practice roles that have not been extended represent working as part of a "less valid" profession. Pharmacists articulate their pride in their profession,

however, they often contradict this by inferring that they have to adopt additional tasks or take on new roles to present an acceptable representation of their profession.

As outlined earlier, there has been a tremendous shift in the role, responsibilities and boundaries of the pharmacists in hospital, community and primary care settings. This move is not only evident in the policy changes that have enabled different tasks and jobs to be carried out by pharmacists, but this shift has been expressed in the data by each of the pharmacists (discussed further below).

However, some pharmacists ignore the fact that many of these tasks fail to realise the expertise that pharmacists have. That is, other much less qualified health care assistants or professionals for example could carry out these jobs, in this example auxiliary nurses or pharmacy technicians[17]. One pharmacist instead describes how pharmacy has changed and that the profession is almost grappling to establish its identity. This typifies Nancarrow and Borthwick's (2005) analysis, where they refer to changes and how such changes have implications for traditional workforce boundaries. Nancarrow and Borthwick (2005) suggest that there will be opportunities for others to move into vacated space. For example, the perceived threat of technicians who can check dispensing for example. Further perpetuating the argument that pharmacist's skills are underutilised[18] rather than changing this point.

[17] Although, pharmacy technicians do not typically work in such a clinical role, so as to administer an immunisation, the same could be argued for pharmacists and the change in role that they are fulfilling in carrying out such clinical tasks.

[18] Non-medical prescribing is described in policy documents and literature as a way of better utilising pharmacist's skills and improving patient's access to medicines.

All of the pharmacists spoke about identifying themselves as pharmacists and stated that they felt they represented pharmacy as a profession in their work. Pharmacists frequently spoke about what they aimed to achieve in the future. This was typically through accreditation and adapting their role in the future to accommodate their specialist interests and broaden the jurisdictions in which they work. A number of pharmacists suggested that this would or did require moving to an alternative job or new role.

> *R10: "she is regarded like a consultant at XXXXXX, she's so knowledgeable. But it's not really just the knowledge, it's like her patient contact. …she's obviously got the natural ability … but she is probably a show case for prescribing and pharmacists prescribing. Because, within her own field she is regarded by the consultants as amazing, she's regarded from patients as amazing they absolutely love her and pharmacy staff you know they do, you know she is what it should be basically" Theatres and Anaesthetic Pharmacist, Hospital.*

The above excerpt shows how a specific pharmacist has been spoken of and is held in very high esteem by her peers professionally and has also been referred to as 'amazing', and said to demonstrate what they believe pharmacy *should* be. This pharmacist, who is spoken of so highly, has become a non-medical prescriber in order to extend her role and endeavour to realise this ambition. In terms of changes in the profession, this highlights just what a

difference expanding your role can achieve and how far the boundaries of pharmacy have in fact expanded. Again, other data implies that pharmacists welcome the chance to become prescribers as a profession as a number of pharmacists stated that they believed it had a greater place in the future roles of pharmacists. Non-medical prescribing is one example of task sharing and task shifting. It is increasingly employed by pharmacists in attempting to develop their role. More interestingly though, is the fact that it is proposed that this particular example of a pharmacist is what "pharmacy should be". This further adds to the discussion around pharmacy being a lost or incomplete profession. This pharmacist (R10) essentially implies that pharmacy, as it is, is not as it ought to be.

5.4 Challenges to the Profession

Evidence of challenges to working in pharmacy were present in the data where pharmacists spoke about their futures they identified limitations of their role or the part their role plays in the wider context. A pharmacist manager commented that the profession of pharmacy was becoming less of a lucrative "industry" than it was previously. Expressing some of his concerns around the future of the profession, he explained:

> *R15: "I think it's a difficult question what defines pharmacies now … I suppose years and years ago it was their exclusive skill that no one else did was to produce the medicines, that's not, that's only done in sort of very specialised settings now. Especially with laboratories, 99% of pharmacists don't do that…And so it's a question*

of what is the role, so I suppose it then became you know safe supply of medication and advice relating to the medication. But then that, I think the way the remuneration is going now that isn't sufficient, so it's looking for these different roles that we can take on…" Pharmacy Manager, Community, Supermarket.

While pharmacists have had opportunities to provide a range of 'new' services, these services do not necessarily reflect the level of specialised knowledge or skill pharmacists possess in a lot of cases, for example, flu immunisations. Although this pharmacist and other pharmacists in the study, spoke about the development of 'new' roles, pharmacists describe how often they are carrying out tasks that are not always utilising their knowledge or potential in practice. In this respect, the development of new roles and tasks and the changes to pharmacy, almost act to represent boundaries in themselves as pharmacists are doing more and more tasks that do not maximise or exploit the skills that they have. While there are certain services that have been tasked to pharmacists which are said to make better use of their skills and knowledge, these typically require further accreditation which in turn come with a new set of practical issues. Despite the fact that these opportunities do exist, these are often not without compromise or their own difficulties.

Pharmacists successful in developing their individual roles, have had to push for the changes and expansion as the pharmacists describe that there is not any kind of standard or predetermined path.

R14: "it's very much down to the individual and the way in which they interact…with others that that depends upon how their role develops" Advanced Pharmacy Practitioner, Pharmacist, Hospital.

R08: "…you will find that only the most you know, tenacious and motivated pharmacists will find a way through to enable them to do it [use non-medical prescribing in practice]" Lecturer and non-medical prescribing lead, University and Hospital.

The data suggests that for the pharmacists, individual contractors lead their own role development and is not depicted necessarily a profession where career paths are developed purely from their participation in professional accreditation or activities. Pharmacists describe how after qualification, they struggled to convert their qualification into practice. In that sense, pharmacists have to be instrumental in working to determine what their 'profession' is and successfully developing their role. They have to endeavour to attain whatever it is that they desired from their profession. One pharmacist described attaining support in practice to assist role development "luck":

R02: "…but it is luck, it's a lot of luck finding a good practice that's very supportive of pharmacists and you know…" Primary Care Pharmacist, GP Practice.

The limitations and challenges that the pharmacists spoke about had a strong sense of pharmacy attempting to re-define itself. A number of the challenges that the pharmacists had with their profession was centred around developing their role and the ability to enact these roles successfully in practice. Pharmacy was described as less lucrative than it once was. In addition, pharmacists suggested that pharmacy and pharmacists were misunderstood. This misunderstanding of the role of pharmacists was described as a challenge as it resulted in limited opportunities for pharmacists to develop their roles for example. For pharmacists in this study, the challenges faced were often multi facted. Often down to a combination of factors including setting, role expansion, lack of understanding of the role of pharmacists and also money.

5.5 Economic Factors

Traditionally, the variation in the tasks that pharmacists have carried out in their routine work has been to a large extent influenced by the setting that they worked in. This variation in tasks is still evident today. Pharmacists in this research outline the different ways in which their work and roles are determined. A recurring contributing factor is money and variable economic pressures such as budgets and targets that greatly determine or Impact on many roles and tasks that are carried out by pharmacists.

R02: "I've got pressures to do cost saving work and the easiest way to do cost saving work sometimes is to do mass sort of audit work. Much more switching, quite mundane work. So I would have hoped that we could have moved away a lot more from that but as I say, [the] current sort of climate doesn't allow anyone really to do that" Primary Care Pharmacist, GP Practice.

Here, as for a number of other pharmacists, the work is guided somewhat by the demands of the economic pressures dictated by their work place – in this instance a GP setting. Pharmacists, often have to justify the money or funding that has been allocated for their employment and so in turn, they have to fulfil a range of tasks and services to validate their role within the workplace, even though these may not be tasks typically associated with pharmacists.

R16: "effectively what I'm doing for the surgery is that I'm helping them to achieve cost targets" Community Pharmacist, Chain.

The presence of funding and budgets or conversely the absence of said funds and budgets are prescriptive in the extent to which a number of changes can be made. For each pharmacist in this study, money, funding and targets were a common consideration.

Observation

07:45 am. The pharmacist signs on to the computer and checks his emails. He checks the store's performance via "Company Targets". Targets as store manager and targets as pharmacist. The check shows that this store was the "lowest in the area". The pharmacist comments that he has to make money for Mr XXXXXX. The pharmacist describes the "shop" activity as something that is a professional activity as you have to match products to the person. The pharmacist meets with the rest of the team before store opening and tell them that the figures show that the they are below target and that they need to increase sales this week.

Community Pharmacist and Store Manager, Community, Chain.

While pharmacy is concerned with medicines and their safe delivery to patients, there is a whole range of other factors which collectively affect the role of the pharmacist and the job they carry out. This is particularly true in the case of community pharmacists where there are a number of store or shop activities which operate as a business and are effectively there to make money. This is in addition to the core duties which are attributed to the role of a pharmacist.

5.6 Decision Making Process

Pharmacists felt that a significant part of their role was decision making. As mentioned earlier, pharmacists in the hospital setting saw themselves as involved in decision making and all of the hospital based pharmacists said that they had regular contact and communication with the doctors and medical team which they worked with and in each case. These were described as good interactions. I perceive that the difference, between community and hospital pharmacists is largely down to the setting. Whilst, the hospital pharmacists do tend to work closely with the doctor and the wider medical team, they essentially carry out very similar tasks to doctors with respect to these core duties which as pharmacy professionals, is required of them.

> *R02: "So quite often, as such I'm prescribing…and I'm generating the prescription, obviously I cannot sign it but, you know I've sort of made that clinical decision to do it and they've [the GPs] backed me" Primary Care Pharmacist, GP Practice.*

Other pharmacists who worked in community settings, also said that they saw their roles as checking prescriptions and ensuring safe and legal prescribing which includes contacting prescribers and making suggestions. However, these pharmacists interactions were somewhat different in that they first saw prescriptions at the point of dispensing, the relationships the pharmacists had with the doctors which they were checking was considerably different as they obviously had no part in the decision making process.

5.7 Boundaries in Context

Ambler (2003) suggests a more straightforward reason why general practitioners and community pharmacists have not developed a trusting and respectful relationship. That is simply that they don't know one another very well. While this is evident in the data, this does raise questions about how far pharmacists go, particularly community pharmacists, to get to know their GPs. There are often geographical and spatial separation to start with in any case but these are often further reinforced where either or both parties doesn't make attempts to get to know each other and what the other does or maintain a working relationship. When asked about their interaction with doctors, for community pharmacists this was often only done over the phone. When asked if the GP practice had reached out and invited the pharmacist to their practice to discuss things or to attend meetings, they had but the pharmacist did not have the time to spare:

> *INTV: "Have you ever been invited to like the GP practice to discuss things?"*
>
> *R15: "We have a couple of times …there's three practices at XXXXX Health Centre which is nearby… We've been to another practice there once as well so and been to XXXXXX at the Health Centre which is sort of nearby, so this over the last sort of five years there's probably been about four meetings I would say with local surgeries. I mean it's something, I suppose it's, it shouldn't*

necessarily be left to the doctors on their back. I mean I suppose we could possibly suggest something as well but we haven't really done much about arranging these things with the doctors. But it's something that, it's something that I suppose we're asked to do by our head office who say try and liaise as much as we can with the doctors but it's just a case of time" Pharmacy Manager, Community, Supermarket.

Despite attempts from surrounding practices and surgeries to engage with the pharmacist in this example, they have not really made any progress in doing so. Understandably though, the pharmacist did explain that time constraints were an issue despite being encouraged by "head office" to forge better relationships with the doctors but this wasn't necessarily translated into practice. This occurrence further contributes to the fact that doctors and pharmacists don't know each other well. Of course, this is not the case across the board, however, it does go some way to illustrating how this breakdown in communication occurs and how this potentially impacts on relationships and practice.

Nonetheless, this perception and lack of understanding can and more to the point is being slowly counteracted as this community pharmacist claims:

R16: "it's changed the way that patients view me … so I suppose it's promoted what pharmacists can do to the patient and it's also

promoted it to the other medical staff, it's shown that we can do things other than work in a pharmacy shop dealing with supply" Community Pharmacist, Chain.

Just having the opportunity of being able to show what she is capable of, this pharmacist is, within her role and the setting in which she works in, challenging preconceptions of what a pharmacist is and what they are supposed to do. As a result, this demonstrates the potential scope and depth of the role of community pharmacists which is often perceived as underrated and misjudged.

Despite hospital pharmacists working closely with consultants, there is still a lack of understanding of the role of pharmacists and the boundaries that they operate within. A hospital pharmacist explains:

R07: "I think we've tried very hard to get people to understand that pharmacy do not make up polices, so it's not pharmacy that decides we're not going to stock a particular product. We go through our therapeutics committee and that's chaired by medics. So if that group has made a decision, then its them that the consultant's who's annoyed should direct their anger towards rather than shouting at me or one of my staff" Associate Director Medicines Management, Pharmacist, Hospital.

The hospital pharmacist describes how the pharmacists role has been misunderstood. This hospital pharmacists stated that they would freely change and alter prescriptions should they notice errors or wrong dosing, despite often not being legally permitted to do so. Hospital pharmacists will challenge doctors' prescribing at the point at which this occurs should they be there at the time and they also offer advice and guidance, working out calculations and so forth. The difference, which is evident with the pharmacists in the community, is that they are not tangibly in a position to do this. The GPs' prescribing decisions tend to be made independently of any advice from others, unless specifically sought. Pharmacists in the community tend to flag up queries or errors as they present at the pharmacy counter. Community pharmacists are less prepared to make such changes to prescriptions, fulfil prescriptions or query doses and so on. Whether this is down to the legalities of what pharmacists can and cannot do professionally or due to not having the relationship that hospital pharmacists speak about having within their clinical areas. Legally this is not wrong, in fact, the community pharmacists made a number of references with regards to dispensing legally written prescriptions and the need to challenge doctors where necessary if a prescription was written incorrectly. The difference being, that this interaction is not necessarily as frequent or as informal as that described by hospital pharmacists. Even though the work carried out by pharmacists has evolved over the years, for all of these pharmacists checking prescriptions and maintaining safe prescribing still forms a large part of the pharmacist's job role.

5.8 Summary

The boundary for the profession of pharmacy was examined in this chapter. The chapter outlines different boundaries that pharmacists perceive for themselves and boundaries that pharmacists work within both collectively as a profession and individually. As a professional group, pharmacists now have the scope to perform a wider range of tasks and irrespective of the setting in which a pharmacist works, policy now allows for pharmacists to undertake a lot more clinical work – should they wish.

Independently, the role of each of the individual pharmacists was unique and distinct. While pharmacists had activities in common, no two pharmacists in this research carried out the same role. Even though there were a number of community pharmacists working in the same setting, any uniformity was hard to find. Similarly, for pharmacists from the same organisation, roles performed were starkly different. The roles among the pharmacists definitely had similarities in that there were tasks and duties that they might have held in common, typically the legal bounds of their professional conduct and core responsibilities as demonstrated in Scott's (2008b) Three Pillars. Nevertheless, pharmacy as a whole proved to be a very complex assortment of professionals with different interests, aspirations and freedoms to perform tasks and or practice in various ways. This is illustrated in Figure 4 below. Despite the fact that the pharmacists in this research presented as quite complex in terms of defining definitive boundaries of pharmacists, the overall opinion or impression of pharmacists was generally oversimplified or misunderstood. Even amongst pharmacists themselves when commenting on pharmacy or pharmacists in different areas or settings.

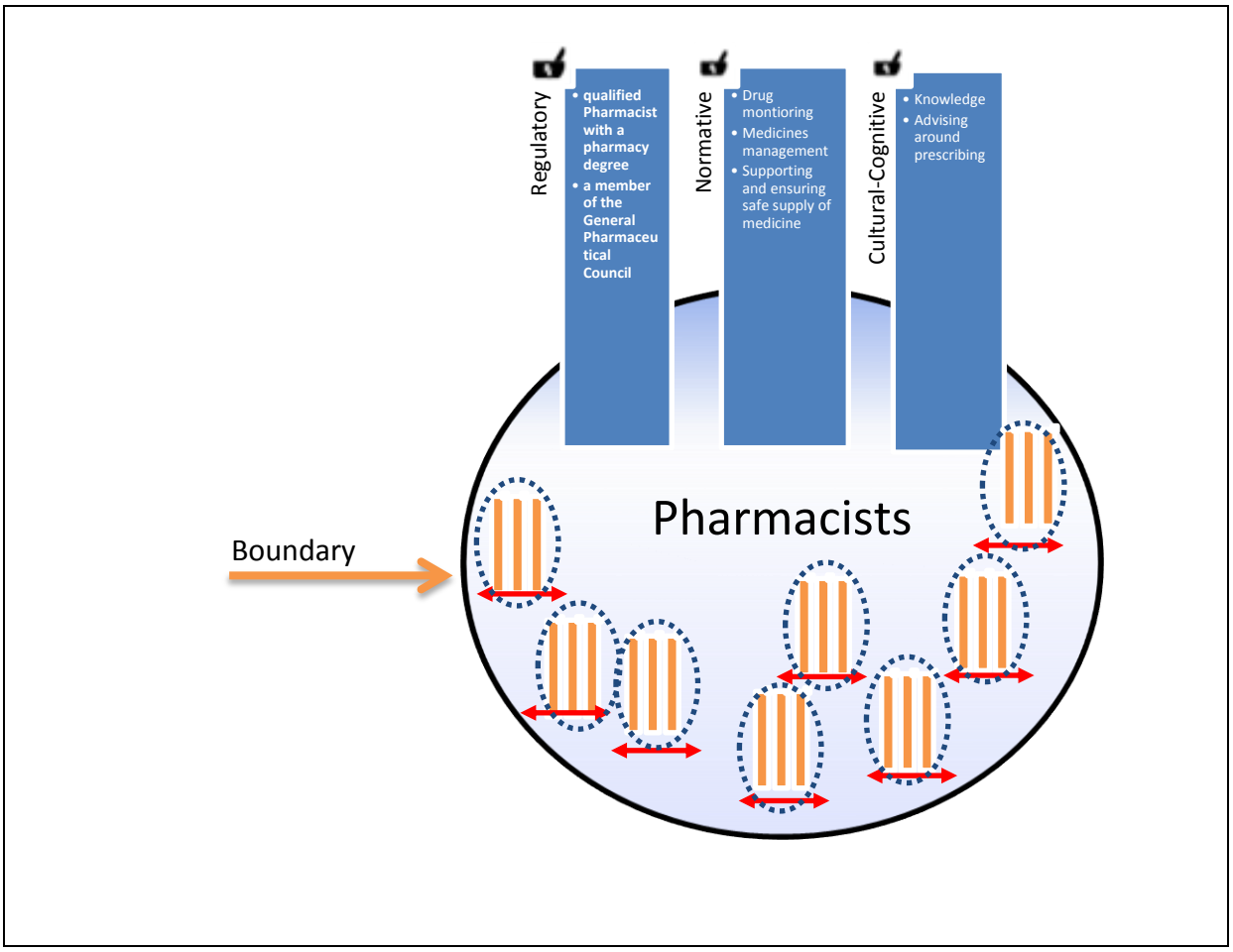


Figure 4: Pharmacy and Pharmacist Boundaries

Individually when working in their routine setting, the boundaries are re-drawn and setting and interest specific (as represented by the two headed arrows and *new* or individually defined pillars in Figure 4). The redrawn boundaries and re-defined jurisdiction which pharmacists work within, and the expanded tasks which pharmacists carry out or are qualified to carry out, somehow comes down to whether their employer allows or however this fits within the bigger picture of how these changes will or would impact on the other people who work to deliver a service over all. In this respect, the individual boundaries for

specific pharmacists aren't always fixed and can sometimes change. As demonstrated through the dashed line around the separate pillars within the wider boundary of the profession. Scott (2008b) comments that organisations require more than technical knowledge, information and material resources to survive and thrive in their social environments. Pharmacists described how they felt that taking on new roles and tasks was a move toward them feeling that their "profession" was more valid. This also related to earlier discussion in the literature chapter around legitimacy. Scott suggests that legitimacy is the perception that actions are desirable, proper and appropriate.

There has been the introduction of additional services which are offered and carried out by pharmacists under this re-defined boundary. Nevertheless, I think the most significant change has been with the increasing acceptance of and participation in non-medical prescribing. It is clear that non-medical prescribing practice varies somewhat between individuals, often determined by what they feel comfortable doing, what their organisation allows them to do and what their setting permits in terms of practice.

Whatever the setting in which the practitioner works or whatever preference individuals hold as professionals in the type of work they aspire to undertake, the implementation of non-medical prescribing presents a number of barriers and challenges. It does give the freedom or at the very least the opportunity to develop individual job roles and practices. In principle non-medical prescribing is said to utilise underused skills that pharmacists already have. It does seem sensible that for these roles to be enacted by pharmacists and for them

to get the most from the qualification, there needs to be an existing gap that the practitioner fills. Where someone is already fulfilling these tasks in practice or where the non-medical prescriber only feels competent or comfortable to do certain aspects of tasks, may create barriers in themselves, and in turn define what a non-medical prescriber is in that scenario.

The boundary that encompasses the profession is one which allows pharmacists carry out a range of tasks. Even though there is some resistance to pharmacists carrying out particular tasks or performing certain roles, pharmacists generally carried out work that went beyond that of the outdated view of the dispensing pharmacist or the pharmacist as a shopkeeper. The next chapter will look closer at the activities and tasks carried out by pharmacists and look at how the boundaries have changed and are being extended.

Chapter 6: Professional Boundary Expansion

6.1 Introduction

This chapter explores the ways in which the boundaries that pharmacists work within are expanded and also why these changes are occurring. The introduction of additional services has enabled transformations in the work which pharmacists are permitted to do and consequently seen the boundaries for some pharmacists have been seen to change. This is evident with the promotion of Advanced and Enhanced services and the continuation of non-medical prescribing in pharmacy. More specifically, this chapter examines how the prescribing role has altered or transformed the role of a pharmacist within the division of labour through task sharing and shifting and finally look at what impact prescribing has had on their professional identity as a pharmacist. Each participant was asked about non-medical prescribing and his or her prescribing role[19]. Pharmacists described their "prescribing role" as anything loosely related to prescribing. From OTC, to supply of emergency prescriptions. Unsurprisingly, prescribing and what prescribing means to pharmacists, their roles and pharmacy as a profession were areas that were referred to ubiquitously. Prescribing was considered an important practice for the pharmacists in a number of ways.

[19] Prescribing role here relates to pharmacists perception of thier prescribing role which they hold or any prescribing tasks which they perform, with or without writing a prescription. From over the counter, to discussions and communications with doctors around prescribing, to prescribing independently with a non-medical prescribing qualification.

6.2 The Future of Pharmacy

Non-medical prescribing was introduced in practice following recommendations from the second Crown Report. Non-medical prescribing was for quite specific reasons, namely the government recognising that pharmacists represented an underutilised healthcare group in the United Kingdom and so non-medical prescribing aimed to make better use of pharmacists skills (Department of Health 2005) (see earlier literature chapters). In practice, the reasons why and the ways in which people engage with non-medical prescribing varied. The pharmacists (both those with and those without the non-medical prescribing qualification) were asked what non-medical prescribing meant to them as pharmacists. These pharmacists were also asked why and how they decided whether to be a non-medical prescriber, or not if they had not done the qualification. Had they considered doing it and whether there was a reason why they had not pursued this. The responses to these questions were somewhat varied, yet when referring to the profession as a collective and what non-medical prescribing meant to the pharmacy there were various overlaps in the replies given.

A community pharmacist and store manager described non-medical prescribing and the adoption of similar additional tasks and services as the future of the profession of pharmacy. This pharmacist looked upon non-medical prescribing as a natural progression within the remit of a pharmacist's typical role. This pharmacist however, did not have the non-medical prescribing qualification. The notion of pharmacists being non-medical prescribers, was for the majority of pharmacists something that they saw as natural. In terms of the professions future, pharmacists saw non-medical prescribing as an activity or

an opportunity to work in a way that will assist in securing some stability in a profession which has been described as uncertain. One of the pharmacists suggested:

> *R04: "I think…[it's] the future of pharmacy, no matter what anybody says, you've got to get skills to keep the profession going otherwise we will become dinosaurs. Everybody else is getting all these extra skills everybody else is getting all these extra 'we can do's' and we'll just be left behind. Who's got more knowledge on drugs? Pharmacists or nurses? ... So why are nurses prescribing and pharmacists aren't?" Community Pharmacist and Store Manager, Community, Chain.*

In this example, the pharmacist expresses that non-medical prescribing is a different way in which pharmacists can add to their skill set and in turn "keep the profession going". This particular pharmacist gives their rationale for his view. Again, another reference to what the perceived vision is for pharmacy and the role which non-medical prescribing holds. "The future" of pharmacy is centred on the application of non-medical prescribing. Throughout this research, pharmacists spoke about the changes to pharmacy and the expectations of these changes. Amid various statements given by pharmacists, lack certainty in the profession's future. There is a strong feeling among the pharmacists in this research that non-medical prescribing has an instrumental role in securing the future of pharmacy. Much more than a qualification, it is viewed as an extension of the role of a pharmacist. Despite

extensive training that pharmacists have to undergo to qualify as pharmacists, the certainty of the profession is questioned and its future under scrutiny.

6.2.1 Ambition and Goals

Following on from the role that non-medical prescribing plays for professionals in practice, pharmacists spoke of the aspirations and ambitions they had when entering into pharmacy and where they had hoped both pharmacy and their careers would go. Entering into pharmacy was a choice made for a number of pharmacists, not because what pharmacy represented or offered at that point as a profession or a career, but the potential they saw in the profession as it stood. Propelled by foresight and potential rather than solely what pharmacy actually had to offer at the time.

> *R10: "I think there's a lot of scope for it and it's always something that I knew was going to be the future if that makes sense" Theatres and Anaesthetic Pharmacist, Hospital.*

> *R07: "when I was at university a long time ago it was an aspiration thing for pharmacists to be able to prescribe. I think it's really good for the profession that pharmacists can prescribe and I also think the same for nurses. It's another step forward in breaking down this barrier that medics are like superhuman and everyone else*

is some underling that does what its told" Associate Director Medicines Management, Pharmacist, Hospital.

Pharmacist R07 qualified 27 years ago and understandably began to study pharmacy some years before qualification. Even at that time, more than 25 years ago, prescribing is something that this pharmacist desired for the profession of pharmacy, an undertaking that he had hoped to do within his chosen profession.

6.2.2 Career Choices and Career Progression

Pharmacists were asked how and why they decided whether or not to become a non-medical prescriber. Individually, most pharmacists saw non-medical prescribing as a way to aid their practice and or develop their career. As mentioned earlier, a number of pharmacists described themselves as being clinically or patient orientated or having a clinical preference within pharmacy. Prescribing was described in terms of the act of writing a prescription and getting the patient to engage with the prescription, concordance and adherence, a vehicle to giving patients greater choice, a way of reducing patient waiting times, as a way to expand or develop a role, and it has even been described as "the future". Prescribing means different things to different people. There were a number of reasons why healthcare professionals who had embarked on the non-medical prescribing training chose to do the course.

R16: "I've always leaned towards the clinical side rather than the management side… You know there are the two paths and you tend to… naturally lean towards one or the other. And I've always leaned towards patient care more than management… As time went on I felt that I wanted to expand the role and so the opportunity came up to go on the course and I was very happy to take it." Community Pharmacist, Chain.

For this pharmacist and a number of others, the non-medical prescribing qualification was undertaken as an opportunity to expand their clinical role and to carry out more patient focused work, in their eyes, further developing their role as a pharmacist. Taking such a course enabled the pharmacists to define their skills in their preferred area of practice. Traditionally in pharmacy, as described earlier, pharmacists tended to work in community pharmacies or in hospitals predominantly checking and supplying medicines. The evolution of pharmacy roles, include pharmacists working in a more multi-disciplinary manner, in hospitals being not only in dispensaries but also ward based and working with medical teams. Non-medical prescribing is used as a gateway for the pharmacist to achieve extended autonomy by expanding their role further and facilitating pharmacists to use and build on the medicines knowledge which they already have.

R02: "quite often, when I have done sort of med reviews in the past as such I, I've, I've generated a prescription. I've made that

decision and my GPs have said, 'yeah I think that's a good idea' and signed the prescription. So, as such I wasn't legal to do that but when I'm doing audit work for example, it may well be that I have gone down this instance and recommend that this tablet gets switched to something else" Primary Care Pharmacist, GP Practice.

R13: "...you know as a pharmacist, you make so many recommendations to doctors to prescribe and you know that you're making, you wouldn't advise on something that was wrong… I think that for years as pharmacists we have been making these recommendations… Like I said you know you recommend a doctor to prescribe this, but there is this element that you're not taking full responsibility for those actions and I think it's good that we are [now]. You know if we're making those recommendations" Consultant Respiratory Pharmacist, Hospital.

While these pharmacists refer to their own practices and examples of how and why the think non-medical prescribing is a 'good idea', they also draw attention to boundary work. Although the pharmacists do point out that making changes and recommendations to drug prescriptions was something that they routinely engaged in, non-medical prescribing is important as it acts as a facilitator whereby the pharmacists are able to work outside the original boundaries that they held. Boundaries that did not always ensure that their

recommendations or prescriptions would be adhered to. In addition to speaking about the potential role for non-medical prescribing in their roles, the non-medical prescribing qualification empowers them and enables them to be more autonomous in their practice and service delivery.

Other reasons that pharmacists provided for embarking on the non-medical prescribing qualification include filling a gap in practice or service provision that had been identified by either them or their employer, for practical reasons to help with their existing job and or developing a job role and practices and for the pharmacist's own future professional development and or progression.

> *R02: "I've been doing the job quite a long time and… it will enable me to develop my role a little bit more… so I guess it's a job satisfaction and it's also just you know… the primary care trust will not exist in… less than 18 months' time. So, if I'm having to sell my services, then you know there's going to be lots of other primary care pharmacists. And you know lots of pharmacists now are prescribers, so I felt it was actually something that was probably quite sensible thing to do… it was basically an opportunity that I think will hopefully hold me in good stead for the future." Primary Care Pharmacist, GP Practice.*

Ahead of time, pharmacists describe how they were preparing for the anticipated changes that, at the time, the then Primary Care Trusts (PCTs) and the National Health Service (NHS) in general, were moving toward. A number of pharmacists said that they looked towards accessing the non-medical prescribing qualification as a sensible and strategic move.

> R02: " its seen to be doing something, its developing the role of the pharmacist really which you know again is kind of when the PCTs don't exist it's something that I think is quite important I think for pharmacists to be able to do" *Primary Care Pharmacist, GP Practice.*

Here, this pharmacist considered that they might have to "sell" their services and in essence, compete for roles in the future. This pharmacist took the course with the aim of setting up and running clinics and hopes that by successfully running clinics, the doctor whom she works with sees the value of the service and in the future invest in the services she provides. Undertaking the non-medical prescribing qualification for these pharmacists goes far beyond being able to simply write a prescription or prescribe medicine. Specifically, it is about the long term future of their job and career, giving them the opportunity to stand alongside others and compete for work and defend their professional jurisdiction and legitimise their knowledge and what they have to offer.

> *R02: "I don't know how primary care pharmacists will work. There will be a lot of private companies going round GP practices sort*

of saying we can come in and do this work for you and come in and be paid there sort of, sort of a sessional basis. I hope having this qualification will mean and I mean, that's why I'm very keen to get the clinics up and running, that GPs will see that there is a value in having someone that works with you" Primary Care Pharmacist, GP Practice.

The non-medical prescribing qualification[20] does mean that having been awarded you are legally *able* to write a prescription. Being able to do this means that pharmacists could not only hold or run clinics, but also, the non-medical prescribing qualification means that, in terms of the existing roles in which some pharmacists operate, being able to prescribe will facilitate them in carrying out their role more effectively.

R10: "I think it is the future. It seems silly sometimes when I stand with a doctor and say "Can you please prescribe this?" and you know it just feels like I should actually take responsibility for that if I'm going to, rather than a doctor signing his name to something that actually I've told them to prescribe" Theatres and Anaesthetic Pharmacist, Hospital.

[20] Both the independent and the supplementary non-medical prescribing qualification.

R07: "I mean basically I'd love to be a prescriber but it's about the time to do the course if nothing else. I mean, can I justify going on a 6 month course and having all this time? … when actually, what it will do will make it easier for me just to correct things and you know add the odd bit of frippery round the edge. I don't think I'm clinically active enough to justify doing it and I think it would be helpful for me, I think it would be helpful for the organisation because having to write to somebody and then someone to change it when they know a lot less about the medication than I do. It's not ideal but saying I'm going to spend x amount of XXX PT money getting trained I think is difficult to justify." Associate Director Medicines Management, Pharmacist, Hospital.

While there are undertones of uncertainty of the current standing of the profession, the future of pharmacy seems to be the direction of focus for a number of the pharmacists. Although there are points at which pharmacists seem to look at the profession as an abstract thing, the data shows that pharmacists hold a valuable role and many of the pharmacists in this research demonstrate how they have succeeded in challenging the boundaries and the role that non-medical prescribing has and can play in doing so.

6.3 Knowledge and Education

Pharmacists are experts in medicine and citing better use of pharmacist's skills is a rhetoric which is often applied when talking about NHS reforms and improving the services available to patients. Pharmacists have referred to themselves as the experts in medicine and have commented on to their knowledge and the power that this knowledge has. This utilisation of pharmacist skills actively challenges and further expands the existing boundaries as the fundamental knowledge and skills of the pharmacist that are employed are broadened. This argument has been used in defending the introduction and implementation of pharmacist non-medical prescribing for many years.

6.3.1 Ability, Competence and Legitimacy

When considering the boundaries of pharmacy and the way in which roles are changing, the one consistent and key thing for pharmacy as a profession here is the knowledge and the technical ability that they hold as a group.

> *R17: "You're able to interact with patients at a different level. You're able to bring a different skill to prescribing than medical prescribers… More of a pharmaceutical knowledge than medical prescribers [can]" Community Pharmacist, Chain.*

It is important to consider the significance thatknowledge holds for a profession in terms of it monopolising a service or aspects of service but the data illustrates that the pharmacists need more than knowledge alone (see Chapter 2 and Chapter 3).

> *R15: "you need other sort of things in your armoury, it's no good having lots of knowledge if you can't impart that usefully to a patient… I think someone who's got a limited knowledge could be a more effective pharmacist than someone who's got very extensive knowledge but doesn't have the communication skills." Pharmacy Manager, Community, Supermarket.*

The pharmacists still refer to themselves as the experts on medicines. Knowledge and medicines management were frequently raised when they were defending their profession and or competence to fulfil particular roles and practices. In the breadth of roles held by these pharmacists, knowledge was treated in different ways. Some used the knowledge they had to fulfil their role, checking and ensuring they flag up errors and or unsafe prescribing. Other pharmacists used their knowledge to carry out routine tasks such as over the counter prescribing, medicines use reviews and other activities undertaken by pharmacists and some pharmacists use their knowledge to educate others.

6.4 Task Sharing and the Redistribution of Tasks

The redistribution of medical work and the different use of skill mixes within health and the expanding of practices, roles and boundaries has been explored in a great deal of medical sociological research and writing (Pharmasist Prescribing Task Force, 2010; Charles-Jones, Latimer and May 2003; Eaton and Webb, 1979). Traditionally, prescribing was an activity exclusively carried out by doctors and dentists. Doctors prescribed medicines and pharmacists dispensed the drugs according to the prescription that the doctor had written.

> *R14: I think you could argue that perhaps pharmacists should have been the first profession to be non-medical prescribers. I also think that pharmacists are probably slightly more reserved and professionally cautious as well. That probably does have an impact on, they're not known for taking risks… The people who are non-medical prescribers tend to have developed in a speciality and so you are, or you are assuming that they have some competence within that speciality, and some clinical knowledge within that speciality but not necessarily in other therapeutic area… So it's not necessarily the prescribing per se, it's the interaction of co-morbidity and other medication. And from that point of view you'd hope and expect a pharmacist to have perhaps a slightly better understanding than, than a nurse or other healthcare professional because they understand the pharmacology of the other drugs that people are taking" Advanced Pharmacy Practitioner, Pharmacist, Hospital.*

A number of pharmacists felt that pharmacists collectively as a profession group, were best placed to prescribe given their knowledge of medicines and also the notion that they are considered to be cautious and meticulous. A number of pharmacists explained how they felt they were the most appropriate group to prescribe – aside from doctors, and that pharmacists should have got prescribing rights way before nurses. For the majority of pharmacists, they considered non-medical prescribing to be a good thing overall for the profession of pharmacy as a whole and saw it as breaking down existing barriers which are present within healthcare re-defining the boundary of pharmacy. Conversely however, the way in which pharmacists viewed themselves and their behaviours and disciplines were not mirrored by other professions.

> *R11: "…pharmacists tend to be very process driven about what's in the book and what's in the textbook whereas we are much less tied down to that because we know that's what's in the book is just what someone has written in the book based on what their experience has been" Consultant Neurologist, hospital.*

A consultant viewed this caution and fastidious approach as a barrier to pragmatic prescribing practice and suggests that the pharmacist's routines were down to limited patient experience. Again, this preconception or opinion of who or what pharmacists are, can be brought down to the limited contact that certain practitioners have with pharmacists. Their relationships and opinions are somewhat coloured by the interactions

that they have had with this group, and not necessarily a true representation of pharmacists ability or suitability to perform certain tasks and practices.

The data gathered indicate how pharmacists collectively expressed how they had undergone change and were actively trying to take on new tasks and acquire new skills. Throughout the research, the range of participants illustrate their rationale and motivations for engaging in certain practices, giving a sense of what they are doing, how this becomes practice and how they do it and also, why they adopt, change and take on different tasks.

In recent years pharmacists have been assigned numerous tasks and have subsequently taken on new responsibilities including paid services like the minor ailment scheme, smoking cessation and flu jabs (Department of Health 2008a, 2008c, 2010a).

> *R15: "Certainly additional services. When I first started working here there was no such thing as MURs, we weren't doing any of these paid services like minor ailment scheme, smoking cessation, flu jabs, all that sort of stuff, none, we didn't do any of that it was just pretty much the dispensing standard service… gradually these things have to come to the fore really. But minor ailments…that's got more extensive in terms of the range of products that we can supply now, before it was very basic. It's, yeah I'd say in the last seven years it has*

changed quite dramatically, we do an awful lot" Pharmacy Manager, Community, Supermarket.

There is no doubt that pharmacy continues to develop. There are various white papers and bills which set out how pharmacy is to remain progressing and growing as a profession (Department of Health 2000a, 2003a, 2003b, 2008a, 2008c, 2010a; Royal Pharmaceutical Society of Great Britain 2009). Some pharmacists are viewed as pioneers for other pharmacists to follow[21], working in new areas having expanded their roles, while others expressed their frustrations with pharmacy, identifying the need for pharmacists to further expand their skill base and services. Interestingly however, some of the tasks and jobs that pharmacists had been allocated were not deemed as especially skilled tasks.

R15: "it's looking for these different roles that we can take on… like health monitoring I suppose and other things would be things like flu jabs I suppose. We've just taken on all these roles which on their own aren't particularly skilled where some of the monitoring, glucose and blood pressure testing could be done by an auxiliary nurse" Pharmacy Manager, Community, Supermarket.

R16: "I mean we spent four years at university and then a year on the job learning about chronic disease management and then you

[21] See discussion below

spend a lot of time, if you're working in a shop you don't until very recently you don't spend a lot of time actually dealing with that" Community Pharmacist, Chain.

Task sharing can be a complex distribution of tasks and often, is an activity that happens amongst individuals and multiple professions. While it is easy to make the jump between prescribers taking on tasks performed by doctors, there are many circumstances, where task sharing happens at varying levels and stages.

One pharmacist asserts *appropriateness* of what it is they are competent or what they are prepared to do as a key consideration in the undertaking of certain tasks.

R14: "I think the key criteria is as it were appropriate patients because I wouldn't necessarily want to see every patient who was started on a particular drug because an awful lot of the routine patients can probably be dealt with by and seen by nursing colleagues… It's the more complicated polypharmacy, co-morbidity where there might be some more, or more complex patients who were, it's probably more appropriate" Advanced Pharmacy Practitioner, Pharmacist, Hospital.

This pharmacist bases their suitability and expectations in accepting certain tasks and equally redistributing certain tasks based on the expertise that they hold. Here, the pharmacist identifies their knowledge and strengths in order to justify the acceptability of taking on tasks, clinically appropriateness. This pharmacist proposes that more routine cases are more suitable for nurses and that they should see them and that he more complicated polypharmacy cases. This demonstrates how the pharmacist is assertive in assigning tasks suitable within their multi-disciplinary team. In addition, this example further draws attention to arguments around knowledge and legitimacy when it comes to carrying out tasks. It also highlights the more complex levels of interactions, practices and the different negotiations that transpire when such claims and decisions are being put forward and the way in which professionals then defend their jurisdictions based on their expertise.

The reason why professional's share tasks varied between the different groups and the different ways groups have to work together. As mentioned earlier, task sharing is seen in some cases as legitimising a profession or professional and their practice. In a number of cases, boundary expansion and the adoption of new tasks invariably means that other tasks, custom to their original roles are often redistributed or altered.

> *R16: "So originally when I embarked on the supplementary prescribing course, that was one thing that we talked about looking at in surgery. By the time I finished the course, the surgery were pretty well on top of that so I would have been possibly seeing a very,*

very small number of patients who were possibly serial non-attenders at the surgery… So we decided that that wasn't necessarily going to get the best value for the health boards who were paying for the clinics or for the surgery. Or from my point of view it wasn't going to really promote the role as well as it might. So, we had the meeting and looked at different areas that the surgery felt would be, were maybe untapped areas and might be more appropriate and more fruitful, and then I had to go and learn all about atrial fibrillation… And just up skill from that point of view… I also had to learn how to diagnose things… for the first time I was involved in diagnosing conditions, so seeing patients and sounding their chest and taking their temperature and you know looking in their throats and looking in their ears and things like that, so that was quite a big learning curve as well" Community Pharmacist, Chain.

Task sharing however, could also be interpreted as a simple way of re-asserting roles and or positions and making use of expert knowledge that is already held and redistributing tasks deemed non-specialist, thereby defending jurisdictions.

The majority of the pharmacists spoke about their belief that in order to uphold pharmacy as a profession, how they have to perform extra tasks and were in fact now doing more in practice than they ever did before in the roles which they were previously subscribed to.

This was particularly the case for community pharmacists and more specifically primary care pharmacists, when contemplating the changes to the PCT (at the time of interview) and the consequent competition pharmacists envisage between themselves and independent providers.

Pharmacists spoke about how they considered the emergence of new activities as a way to sell themselves professionally. Pharmacists taking on different roles or expanding an existing skill sets and roles represented employing these new activities. These opportunities enable pharmacists to utilise skills that they already have and thereby acts as a means of showcasing what pharmacy and pharmacists have to offer.

In the case of pharmacists showcasing their skills and exhibiting what pharmacists have to offer, this was of particular importance to pharmacists. For example, for pharmacists working as primary care pharmacists, due to the impending changes to how health care budgets are to be managed. Although this showcasing is not exclusive to primary care, given the changes it is something that is significantly important to the pharmacists who will be affected by the coming changes.

> *R02: "it's seen to be doing something it's developing the role of the pharmacist really which you know again is kind of when the PCTs don't exist it's something that I think is quite important I think for pharmacists to be able to do" Primary Care Pharmacist, GP Practice.*

R10: "like EP[22] prescribing… I think it's showing what pharmacy can do and it's, I think it's show piecing what pharmacy can do, because there's so much we can do as pharmacists. Project work, prescribing and it's selling that to people and once they see the results I think it will be, it will just take its own course if that makes sense" Theatres and Anaesthetic Pharmacist, Hospital.

This show piecing or showcasing of pharmacists capabilities ties in to a lot of literature around pharmacists and pharmacy as a profession making better use of their skills and or making their skills better understood. Members of the pharmacy profession in showcasing their skills; seek to communicate at what level pharmacists can work at and are capable of working.

6.5 Accreditation

Pharmacy contractors can provide services in addition to those traditionally carried out by pharmacists, once accreditation requirements have been met. Legitimising and validating their capacity to challenge and expand boundaries. Accreditation is a key part of the Pharmacy Contract whereby it enables pharmacists the opportunity to broaden the remit in which they work by permitting them, through appropriate accreditation, to work towards

[22] Electronic Prescribing involves the use of computer systems to facilitate the prescription, supply and administration of medicines. Electronic Prescribing (EP) systems are able to capture a full prescribing history for a patient in a transferable manner recently (Goundrey-Smith 2008: p. 1).

delivering extended services. This application however, is not always translated easily into practice.

> *R13: "as we know there's so many pharmacists who have got the qualification and haven't written a prescription. And I think that probably… raises up the pharmacist's expectations and then it's quite demoralising then if you can't use that qualification, because it's a hard qualification to do you know. It's you know, and unless you have a niche and are going to be able to use it then I think you know, what is the value of that. And I just think it's probably more demoralising for junior staff to do it" Consultant Respiratory Pharmacist, Hospital.*

A key element that is associated with better use of accreditation is developing good working links and relationships. This was expressed as being one of the central factors in accessing and utilising the different accreditation practices.

6.6 Collaborative Working

Multi-disciplinary working in health care is commonplace. The Pharmacy Contract states that pharmacists, working with doctors and other health professionals, have an important and expanding role in optimising the use of medicines and in supporting better health.

R02: "I don't think you can really under, undervalue the importance of having a really good relationship with your GP because certainly I have worked in other GP practices that I didn't really know them and, it it's much harder to try and do sort of extend your role and do more sort of interesting clinical work" Primary Care Pharmacist, GP Practice.

R14: "I have very good relationships with local GPs and increasingly they are prepared to contact me…if there are specific issues regarding individual patients" Advanced Pharmacy Practitioner, Pharmacist, Hospital.

Well established relationships are described as invaluable. The relationships between professions have proven to be invaluable for a number of pharmacists in enabling them to redraw their practices in a particular department or area. While a good relationship alone might not guarantee the development of a role or service, that support is necessary, especially in the cross boundary working.

In addition to the relationships that contractors have with the people that they work with and for, the data shows that the interactions that they have with their peers is also necessary in the development and enactment of their roles. Practitioners state that they

have learnt from what others have gone through and encountered in implementing the use of their non-medical prescribing qualification (see 6.3.1 below).

6.6.1 Perception of Pharmacists

This difference was recognised and touched upon throughout. There was a lack of understanding by pharmacists across the different settings about the roles and work they considered other pharmacists to do. The community pharmacists each stated how their contact with patients and doctors varied from hospital pharmacists. Emphasising that their role was largely working with the patients, the views held by some of the hospital pharmacists on community pharmacist and their roles were somewhat ill-defined.

> *R10: "I mean in hospital you work with the consultants and you're very much are involved in decision making whereas community pharmacist is just a checking role" Theatres and Anaesthetic Pharmacist, Hospital.*

> *R14: "And there is always generally a dialogue about a particular decision. I suppose from a nursing perspective I probably, or if there is a pharmacological justification for a particular decision… We'd probably try and have discussion with them about it" Advanced Pharmacy Practitioner, Pharmacist, Hospital.*

In this example the pharmacist R14, describes the setting as a key requirement for involvement in the decision making process. This makes some suggestion that being a community pharmacist, means that they somehow do not have or cannot make a valid input in the management of patient's medicines. Thus deeming their role as a *just* a "checking role". However, this affiliation with the medical team in hospitals that the hospital pharmacist (above) speaks about is not viewed this way in all clinical areas. The views expressed by a consultant, doesn't discriminate between pharmacists that work in the community and those that work at the hospital as he describes what he believes a pharmacist role to be.

> *R11: "…pharmacists, sometimes I ask them for specific bits of information and they're involved in dispensing medication and checking that it's the dose that I meant to write and that I haven't made a mistake with the prescription. So they're involved in that… Sometimes I'll ask the pharmacist to provide some information about a drug or about effects of a drug or stuff… Sometimes I'll need to ask them if, what they've got in stock if I want a hospital prescription. So what dosage of tablets they've got and how many milligrams in the tablets... They can calculate, I mean, as it is they round up or round down. Sometimes the junior doctors put the stupid dose like you know 1.253ml because they haven't bothered to round milligrams and mil*

things and some pharmacists will quite appropriately round up or round down" Consultant Neurologist, hospital.

This finding around roles and decision-making is nevertheless supported by published literature. Specifically, Ambler (2003) indicates that over the last 20 years there has been a mutual respect and professional trust between hospital doctors and pharmacists, born out of their closer professional working and shared decision-making. Ambler goes on to show that the same progress cannot be seen in primary care however as considerably less headway has been made. It should not however be concluded from this that in the absence of swift evolvement, pharmacists in primary care only fulfil or are only capable of fulfilling a checking role. This is certainly not the case and both literature and the study data illustrates otherwise:

R16: "a lot of people don't understand the difference between a pharmacist and the pharmacist prescriber with the extra qualification and extra skills. So for example I would be seeing people that had chest infections, throat infections, UTI. Things like that, and a lot of the time if they were offered an appointment to see me within a pharmacy setting the first comment would be "But I went in and asked for MAS treatment," you know the minor ailment service, "treatment yesterday at my community pharmacy and they weren't able to help." So they don't understand why I might be able to help

more than someone who works as a traditional community pharmacist and doesn't have the prescribing role" Community Pharmacist, Chain.

A lack of understanding around what pharmacists do in practice and the different services that they have to offer is often a barrier in itself. Among the participants in this research, the healthcare professions who do not fully understand the role and remit of the different pharmacists cannot be expected to fully engage with or support pharmacy services that there are available. Participant R16 illustrates how people confuse different services and do not recognise the variance in the remit of pharmacy practice. Of course, my research doesn't claim to be generalisable.

6.7 Prescribing in Practice

The pharmacists spoke about their personal experiences and opinions of both IP and SP. The majority of pharmacists favoured the independent non-medical prescribing qualification. Having this qualification confers further recognition on the pharmacist as an autonomous practitioner. It also allows pharmacists to be accountable and responsible not only for their prescribing decisions, but also their patient diagnosis and management. Both pharmacists describe being able to prescribe as taking full responsibility for recommendations which they suggest. The pharmacists illustrate throughout how they routinely put forward suggestions and recommendations for prescribing, and influence prescribing practice. For Pharmacists, being able to prescribe removes obstacles in that, for some pharmacists

communicating across practice settings, trying to manage patients found that these recommendations or suggestions were often overlooked and ignored by other prescribing members of their patient's health care team. In this case, being able to prescribe eliminated this obstacle.

6.7.1 Drug Monitoring

As part of their role pharmacists routinely monitor the drugs and doses which are prescribed. Pharmacists also customarily make recommendations, highlight errors and make corrections where deemed necessary. This was a process which involved tracking down the prescriber in hospital, phoning GPs in their practices or waiting to see the GP when available when working in general practice completing audits for example. With the introduction of pharmacist prescribing, non-medical prescribing allows responsibility for prescribing to be attributed to the pharmacist making the recommendations. This is something that many of the pharmacists in this research looked at as a positive thing and was welcomed.

> *R13: "Let's take full responsibility for those recommendations and put pen to paper" Consultant Respiratory Pharmacist, Hospital.*

Rather than making these recommendations and then leaving it with the prescriber to either accept the treatment suggestion or not, non-medical prescribing actually gives prescribers the opportunity to use their knowledge in a way in which they can follow

through and implement prescribing and drug therapy. In a number of cases, this expands the pharmacist's role in a way that supports their existing pharmacist practice but essentially redistributing their tasks. One pharmacist describes the benefit of non-medical prescribing in this instance:

> *R07: "…watching other people prescribe when actually what it will do will make it easier for me just to correct things and you know add the odd bit of frippery round the edge… I think it would be helpful for me. I think it would be helpful for the organisation because [I'm] having to write to somebody and then someone to change it when they know a lot less about the medication than I do" Associate Director Medicines Management, Pharmacist, Hospital.*

For others the act of signing a prescription created barriers. The act of actually filling a prescription form and signing is almost symbolic as it communicates something to the person completing the action (or writing the prescription) and to those around them (Cooper 2012). In this case, for these pharmacists filling and signing a prescription, gives them ownership of the decisions they make and legitimises their knowledge and contributions that previously were not always observed. The thought of actually filling a prescription and signing it, adds a different dimension to this responsibility. The act of signing the prescription forces the pharmacist to question and re-question what it is that

they have already confirmed that they know in a way that is not viewed to be the same for doctors. Pharmacist R07 illustrated this:

> *R07: "I'm not gonna speak out of turn here but because doctors have been doing prescribing for so long, I think that a lot of them regard it as not a particularly high level activity. I think they regard it as somewhere around about just transcribing something, they don't really see it as a very important activity. So, they don't kind of necessarily give all the thought that you or I would give if we were sat down to write a prescription. If it were me …I would I'd be so sure that I've got to spell the drug name right, I've circled the dose time, I would make sure that everything was absolutely perfect, not, oh well I've done 50 prescriptions already today I'm just gonna dosh up another one and run out the door. And I think there's a belief that if it's wrong, somebody will come along and tell me it's wrong. And non-medical prescribers, I don't have that because they've got this professional pride that they don't want to let the side down in terms of non-medical prescriber" Associate Director Medicines Management, Pharmacist, Hospital.*

Not only does this pharmacist speak about the importance of the act of writing and signing a prescription but he also describes how he perceives that the two professional groups view prescribing differently from his years of experience. He suggests that doctors are almost

indolent as they know that there will be checks done on the prescription before it is dispensed, lazy in terms of missing dose times off, misspelling drug names

and returns it to the patient for her to hand it in at the dispensary. The consultation soon ends.

Consultant Respiratory Pharmacist, Hospital.

When the consultation is over, R13 comments that she just changed a few things. She corrects a mistake the consultant made with the dosing and puts additional things that "the dispensing pharmacist will want to see" such as when the medication is to be taken, that for this particular drug it has been discussed, that an information sheet was given and also that this patient has folic acid. This example goes some way in illustrating the ways in which prescribing practice varies among different groups. This pharmacist commented that she knows exactly what the dispensing pharmacist would need to see, as she has extensive experience of being in that role. The requirements of prescribing and what is essential in terms of information to be recorded on a prescription is something that comes second nature to the pharmacist.

Despite the fact that of the 16 pharmacists interviewed, ten had undertaken the course and achieved their non-medical prescribing qualification, it was evident that having succeeded in getting the non-medical prescribing qualification that is was not an absolute that obtaining the qualification – directly translated into being able to use it in practice or prescriber status.

This “right” or “permission” to prescribe has proved to be somewhat problematic as after completion of this course, non-medical prescribers have often struggled to implement their qualification in practice. Only three of the ten pharmacists who are qualified non-medical prescribers were actually using their non-medical prescribing qualification[23].

6.7.2 Barriers and Challenges

> *R16: “when I set it up no one previously ran an atrial fibrillation clinic as a pharmacist from a surgery. So apart from anything else, I had to learn the computer system. I had to effectively become my own receptionist and set up documents. So, invites to patients, have a think about how I wanted to do it, how I would invite patients, what I would do with them once they arrived, how to make it not too big at the beginning because atrial fibrillation does kind of overlap with so many other diseases” Community Pharmacist, Chain.*

Pharmacists faced a number of barriers in different aspects of their everyday practice where non-medical prescribing was concerned. These ranged from barriers encountered when working with others, barriers imposed by their employers and/or the organisations who they worked for and barriers because of the changes in job roles that restricted the tasks that they could perform.

[23] By using their qualification, this refers to non-medical prescribers actually having their own prescription pad, seeing patients, and being able to write up prescriptions as necessary.

Often pharmacists in the community were faced with numerous barriers in getting queries addressed and also barriers when it came to them speaking to the prescriber. Gatekeepers, namely receptionists, were often perceived to be obstructive. In this sense, the pharmacists described how they had to legitimise their call before being put through to the prescriber and even after being put through to the prescriber.

> *R05: "The times that I've had to pull rank, …times when I've phoned the surgery and the receptionist is being a bit, how do I put it politely, just being rather difficult and I kind of … I say something like, there's an overdose for a child would you like me to dispense it? And then I get through. When…the receptionist is putting barriers I don't tend to say I'm the pharmacist I tend to use the importance of a prescription and to get to the doctor" Community Pharmacist, Independent.*

In this example, the pharmacist describes herself as having to exert some authority. Illustrating how she has to negotiate her way through the reception staff by legitimising and almost having to make the dispensing error presented before her sound more serious or as serious as it could be in order to get to speak to the prescriber and address the error which she had present in front of her. Throughout the study, pharmacists both in community and hospital settings who needed to speak to the GPs found that getting through to them could

pose a problem. A non-medical prescriber in the hospital also faced problems in terms of the GP not prescribing as she had suggested with patient of whom they shared care.

Participants spoke about the different setbacks that they had experienced. Different healthcare professionals detailed how they almost gave up or felt like giving up on implementing the qualification. Throughout the process of beginning their non-medical prescribing training until its implementation, pharmacists suggested that seeing the process through from actually getting the qualification to being able to use it in practice was the biggest challenge that they faced.

> *R 16: "I think the frustration is when people undergo the course and become qualified that then the next major, major hurdle is… finding a clinic that they can be involved in and want to be involved in. And then getting it up and running and to be honest, getting a clinic up and running is almost as big a learning curve and as big an amount of work as completing the course to become a prescriber." Community Pharmacist, Chain.*

> *R02: "Once you've got the qualification it's actually the setting up that's quite difficult because there isn't really any information unless you know" Primary Care Pharmacist, GP practice.*

In two cases, the barriers encountered were such that the pharmacists altogether abandoned trying to implement the use of their non-medical prescribing qualification. In one case the prescriber couldn't overcome funding issues and in the other, the prescribers role would change in such a way that there would be a gap in service delivery in that she would be unable to fulfil certain tasks if she were a prescriber and as such somebody else would have to fill the gap, however, this was not workable in practice.

Both these practitioners are pharmacists and in order to fully embrace the non-medical prescribing role they state that it would have meant that there would have had to have been some sort of compromise with respect to the job role which they typically performed as a pharmacist. In these examples, prescribing is not already an integral part of their daily or routine tasks. This subsequently presented as barriers for these pharmacists and it meant that the degree to which tasks would need to shift or be redistributed to allow them to prescribe, they would have to change job roles. Pharmacist R03 states that, upon failing to implement the changes that she had originally envisaged for her role and working practice, she has since changed her job role altogether. This pharmacist moved into a managerial role in order to progress her career. She was able to develop her role here in a way that she was unable to do with the obstacles that she faced trying to implement her prescribing role.

The different barriers were put down to a range of reasons including there not being a clear set up process for non-medical prescribers to follow, the practicalities of an individual

practitioners actual role or work changing, and the impact that that will have on their usual working routine and practice.

The three prescribers who spoke about the requirements of SP (R09, R10 and R14) all worked in the hospital setting, two of whom saw the patients on medical wards. The fact that the patients were ward based and had care and treatment packages in place, delivered by a wider care team, with specialist consultants and so on, imply that IP would not be something that would be necessary or practical. In addition, the suitability or ability for a non-medical prescriber to diagnose, manage and prescribe here is not demonstrated, as participant R09 speaks about not being able to understand and familiarity of the scans and the access to other results or tests that the pharmacist does not personally have access to.

> *R09: "I want to do it as a supplementary prescriber rather than an independent prescriber…I feel as an independent prescriber you're responsible for the diagnosis and I don't feel confident or comfortable with me, because I don't understand all the scans, all the blood films and things, you know I don't see them with my own eyes… I mean, obviously it's chemotherapy so it's a bit scary anyway. You need to make sure you do it right, so I would feel much more comfortable for the doctor to be responsible for the diagnosis, tell me which protocol they want to use and then I'd then take it from there and prescribe the chemotherapy" Paediatric Oncology Pharmacist, Hospital.*

This disparity determines the competence and the appropriateness of non-medical prescribing in action in these situations. The other pharmacist supplementary prescriber also held clinics again in a hospital setting. However, the nature of the drugs that he had to prescribe, at the time of interview[24] dictated that this was only possible through supplementary prescribing. Even though pharmacists in the hospital setting described their roles and how they work as part of a wider team, to enable these prescribers to work independently their role would have to change to some extent. By the very composition of pharmacy and the service that these pharmacists deliver, they are restricted in what they can do by definition of their everyday core pharmacist duties and skills. In addition, the impact that the shifts in work load and taking on new tasks or the redistribution of existing tasks create further issues in the practicalities for groups, in this case pharmacists, to adopt differing prescribing roles. More specifically, carrying out certain clinical tasks for example reading scans and determining treatment plans with GPs are not something that seems to sit easily within the knowledge base for these roles within this setting, i.e. the hospital setting. Thus suggesting that in this setting for non-medical prescribers, particularly for pharmacists their job and role would have to change somewhat to permit them to use their qualification. Particularly when it the fundamental diagnosis and decision about patient treatment and care sits with the doctor or consultant.

[24] There were changes in the prescribing of controlled drugs by non-medical prescribers after the interview had taken place

When describing their feelings around supplementary prescribing and their experience of it, most other references made to supplementary prescribing were negative or spoke about the restrictions or barriers that the SP qualification created or came with.

> *R13: "I was a supplementary prescriber before and that was rubbish, I didn't use it all…I really didn't embrace with the supplementary prescribing at all, it just didn't seem to fit at all. So when I became an independent prescriber it was much better" Consultant Respiratory Pharmacist, Hospital.*

> *R14: "…using supplementary prescribing, is rather, can be rather cumbersome…But for what I would, for the items I need to be able to prescribe at the moment that still is the only way of being able to do it…So it, it serves a purpose" Advanced Pharmacy Practitioner, Pharmacist, Hospital.*

> *R16: "The difficulty with supplementary prescribing I suppose from a GP's surgery is that if somebody comes in and defectively wants minor ailments treatment that I could do in any other setting, legally because of the prescription pad I can't, I can't give them Paracetamol which seems crazy" Community Pharmacist, Chain.*

Although these references to supplementary prescribing are not the most complimentary, there is no denying that supplementary prescribing serves a purpose and enables non-medical prescribers to prescribe where they otherwise would not be able to. When looking at the comments here, it again seems that the practice setting determines to a certain extent whether or not either supplementary or independent prescribing is more suitable. For some pharmacists, it appears that in a clinical ward setting, supplementary prescribing is the most suitable method of prescribing and for those working more independently, seeing patients in an outpatient clinic or where a patient is seen in primary or community setting, then independent prescribing seems to be preferential.

6.8 Summary

This chapter has explored different ways in which pharmacist roles have been expanded and if and why individuals perceive these changes necessary. The data shows that the redistribution of tasks, particularly task sharing between professions illustrate one of the main ways in which, in the case of pharmacists and pharmacy, boundaries are expanded. This expansion is in part down to both the changes in policy. For a number of the pharmacists in this research, these changes have transform the way they can work. This has resulted in changes in boundaries and jurisdictions.

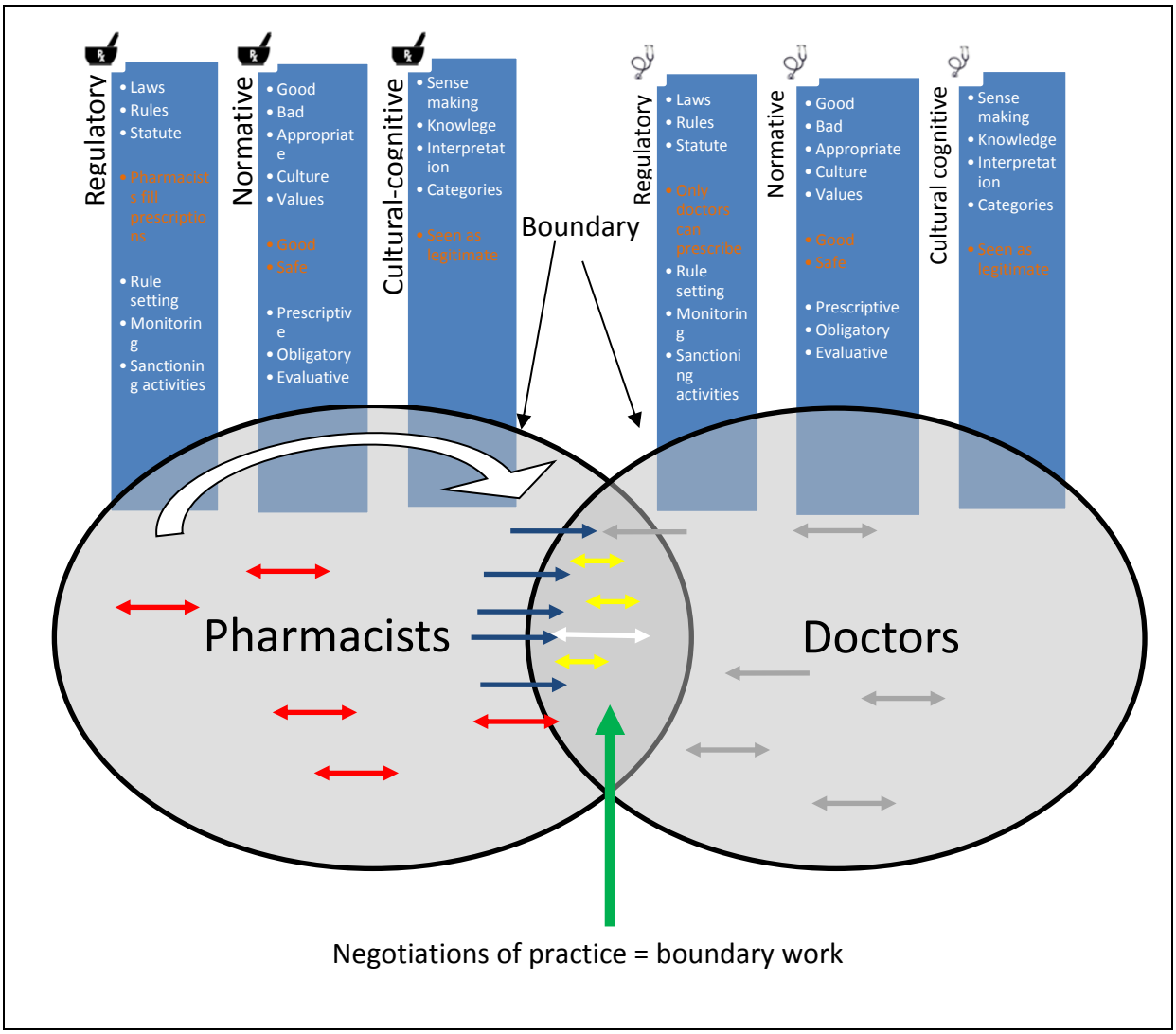


Figure 5: Jurisdiction and expansion of boundaries.

The main development here from the earlier Figure 4, is the move beyond self-identifying what a profession is independent of others The delivery of services by professionals invariably changes once that individual professional begins to interact with other professionals from the same profession (red arrows) and other groups (yellow arrows). The addition of the single horizontal arrows in Figure 5, illustrates the occurrence of different

actions and how occur and change when there are more than one profession working within an area. That is not to say that they share the same expertise as this is not the case, as demonstrated earlier. Nevertheless, different roles and different settings suggest and demonstrate varying levels of inter-dependence and different sets of negotiations in order to fulfil or develop a role or practice.

In what can be arguably seen as expanding their boundaries, pharmacists are in many cases actually reasserting their clinical expertise and actually performing roles which comfortably lie within their competence and knowledge bounds, rather than taking on "new" tasks. Even in this case however, this does encompass the development of roles in that undergoing these negotiations and demonstrating their value, is one of the ways in which pharmacy can be seen as reclaiming territory or practices that belongs to the profession.

Chapter 7: Enacting the Prescribing Role

7.1 Introduction

Taking a step back from the looking at the profession of pharmacy and what non-medical prescribing means to it and the working perspective; considering different interactions, inter-professional barriers and relationships that the practice fosters, it becomes important to look how the role of being a non-medical prescriber is enacted. In doing so, it is necessary to consider and to take into account the role of the different employing organisations as they constrain and regulate behaviours and the resulting formal rules and the roles in which they play in actually facilitating this or not and the professionals subsequent response.

Even though a number of health professionals have undergone non-medical prescribing training, the training alone does not enable them to use their qualification or translate it into practice in every instance (George et al. 2007). The data shows that a number of health care professionals have not used their qualification for a variety of reasons – as touched upon in the previous chapter. Some of these reasons will be explored in more depth along with looking at those professionals who have the qualification and have been able to use their non-medical prescribing qualification. There is a growing literature on non-medical prescribing and boundaries. This includes literature on prescribing pharmacists, inter-professional boundaries, non-medical prescribing in practice, collaborative prescribing, evaluations of non-medical prescribing and prescribing across geographical regions. Little work looks at the area in between. More specifically, the process of implementing the non-

medical prescribing qualification for the individual, the organisational setting and the role of the organisation or service provider in facilitating its implementation (See Figure 5). This chapter will reflect on these interactions, procedures and more importantly the subsequent responses of the individuals in embarking on their professional expansion.

7.2 Organisational Setting and Context

This research shows that participants consider there are a number of distinct reasons and motives that organisations have in supporting non-medical prescribing training and subsequent implementation and use of the qualification. One pharmacist explains part of her initial discussion around getting a Designated Medical Practitioner (DMP) on board to mentor her. An example whereby the pharmacist entered into her non-medical prescribing qualification as a 'condition' where upon comp he c g of h

R06: "…a lot of things I see historically would have gone to the GP before. So they want to support it. They want you to do it. They want you to do more and more and take more responsibility on without giving you recompense so the organisation would support that… that's what is a big annoying thing is that you are cheap GPs" Non-medical prescribing practice nurse.

Interestingly, the non-medical prescribing professionals who work in the community and primary care settings and are using their qualification as part of their role, All spoke about the cost saving objectives and benefits that the employer experiences. Here, where cost saving and the employers' agendas are the main drivers, the professionals had their qualification utilised much faster and far more easily than others who tried in other areas. Thus demonstrating the influence of the organisation and the key role they play in the supporting and enacting of the non-medical prescribing qualification.

R08: "there are some doctors who will send their nurse on a course because they want them to come back and run all these clinics. If we're honest, probably linked to QOF which is in turn is linked to money so by getting these patients in, getting the money so the practice is getting money, in order to do that they need that person to be a prescriber in the role" Lecturer and non-medical prescribing lead, University and Hospital.

The findings show that where pharmacists are employed by or able to use their non-medical prescribing qualification in the community, generally in general practice settings, the common objective for the role of the prescribers was to “save money” and “cost saving” or to get practices to work within and deliver prescribing budgets.

> *R02: “I'm very much I kind of have, well ultimately I have to save money [laughs] that’s the, that’s the, you know, we have to get budgets online, there’s no getting away from that, that’s what I'm there to do” Primary Care Pharmacist, GP Practice.*

> *R16: “effectively what I’m doing for the surgery is that I’m helping them to achieve cost targets” Community Pharmacist, Chain.*

> *R02: “there’s quite a lot of pressure from the PCT that it has to be seen as cost saving thing as well as a quality thing, so, you know obviously, I will be required to probably some kind of audit work on. On the clinics to prove that it is cost saving” Primary Care Pharmacist, GP Practice.*

Now while this is an end product and essentially patients are being reviewed and seen, this objective, which is sanctioned by the employing organisation, is a far cry from the government and the professional rhetoric for the last 15 years and more, that being around patient access, greater choice and utilising under used skills of professions. In practice however, where these financial aims are driven and enforced by the host organisation, often failed to match the anticipated objectives or intentions of the non-medical prescriber. This deviation was typically accepted by the non-medical prescribers concerned, as they saw the role difference as a short-term measure. Accepting this enabled them primarily to get backing to access the course and secondly, it was a way in which they could put their qualification into use. By having the qualification, prescribers hoped to prove their worth in the long-term as non-medical prescribers and professionally to their employers.

> *R02: "it's seen to be doing something its developing the role of the pharmacist really which you know again is kind of when the PCTs don't exist it's something that I think is quite important I think for pharmacists to be able to do" Primary Care Pharmacist, GP Practice.*

The key thing here is that effectively, the organisation not only governs the intake and use of non-medical prescribers within any particular organisation, but they also define in what way the prescriber will "use" their non-medical prescribing qualification to best fit with that organisation. The professionals who undertake the course spoke about how they have to repay the organisation that paid for their training or the conditions or specific 'deals' that

they have with their practices or organisations. Almost as if they are indebted to them and in doing so, have to work off the debt before earning the freedom or proving themselves enough to the role that they intended.

> *R02: "the deal was obviously to do your course you have to have a, a medical sort of supervisor so as a thank you for my supervisor then obviously, they get 6 months of me doing a clinic as a kind a, that was a condition of being my DMP…I was fortunate that I didn't have to prove myself. I mean I proved myself I guess because I was performance managed in the sense that I had to save a certain amount of money…because I had to be, they'd invested something, they had to get that cost back, which I think I've done" Primary Care Pharmacist, GP Practice.*

Although in another example, in relation to a hospital Trust it was suggested that non-medical prescribing needed to be "a sensible and a good thing", the justification to support non-medical prescribing is observed here as a way for organisations or doctors to push their own interests or agendas. Sensible and good in most instances refer in relation to those deemed so by the employers or organisation, typically driven by cost cutting, keeping to budgets and saving money. Of course, money and budgets are of great importance in terms of sustainability and service delivery, however, there is no mention here of the main

government drivers behind non-medical prescribing, that is, the patient and making better use of the professionals skills.

As we know, the amended policy and laws regulating prescribing practice and permit changes to these procedures and practices at an organisational level. Yet, when it comes to the implementing and the carrying out of these new tasks; the changes that are accepted and practiced are very much down to the setting or the organisation and the way in which it can be utilised in that setting and how they go on to endorse them. In essence, organisational constructs support and surround working activity.

> *R08: "there's just no point in getting the qualification if you can't [use it]. But it just shows how important services being ready for [it is]…and that makes it even more difficult when you're talking about independent pharmacists because the organisation is a business it's a company isn't it… A pharmaceutical company, not a, you know, a selling company. So actually, their whole organisational strategies and support systems etcetera are not set up to think about CPD and prescribing, prescribing policies. What they can do what they can't do, whether you're going to restrict what the pharmacist can prescribe, are they going to leave it just to the pharmacist, are you going to have it up to GPs? The whole thing makes it difficult. Which is why you will find that only the most, you know, tenacious and*

motivated pharmacists will find a way through to enable them to do it. Those that are doing it just for their own professional development obviously think it will be good but don't have those links into practice, It becomes an expensive, you know, use of time because trying to do it afterwards is rather difficult" Lecturer and non-medical prescribing lead, University and Hospital.

The non-medical prescribing qualification goes far beyond a professional attending a course and leaving with a qualification. If an organisation is not equipped to accommodate such a service and the different practices and policies that need to be in place to facilitate this, the move from completing the qualification to implementing it and using it in practice is not guaranteed. In the above quote, pharmacy and independent community pharmacists are given as an example to highlight different issues faced as a group.

The transition to or acceptability of non-medical prescribing in certain settings, for pharmacists in particular, presents its own difficulties. Even though there are distinct problems associated with particular settings or organisational settings, these are not impossible to overcome and in the first instance, the government drivers that pushed for non-medical prescribing intended its use primarily in community settings. The organisation has the final say as to whether or not a particular professional will be allowed to use their qualification in practice or not and in what way and to what extent this will be used. The

whole way in which pharmacy works here would have to change to accommodate these changes in practice. The following examples illustrate this.

> *R03: "…it just didn't lead anywhere. I could have, the only other way would have been if I went for a different job. But, within my current job there wasn't an opportunity and I didn't want to go for a new job, I was happy where I was" Professional Development Manager, Pharmacist, Pharmacy Chain.*

> *R15: "at the moment within the company there isn't any arrangements. I mean possibly there's been arrangements with the PCT…I'd probably have to look at a new job altogether to make, to make use of it" Pharmacy Manager, Community, Supermarket.*

The pharmacist in the above example, when speaking about non-medical prescribing and being able to use it in their current job, states that the setting and the company which he works for is not set up in a way whereby he could work as a prescriber. If he were "to make use of it" he suggests that he would need to look for a new job altogether. This example shows how setting is so important. So much so that it determines if a professional can do a task/perform a job and in doing so determines an individual's professional path and future in a given setting. Although the above examples refer to specific professional groups, it

suggests that the setting, more so than the profession and professional, plays a pivotal part in the implementation and delivery of services.

Observation

07:45 am. The pharmacist signs on to the computer and checks his emails. He checks the store's performance via company 'Targets'. Targets as store manager and targets as pharmacist. The check shows that this store was the "lowest in the area". The pharmacist comments that he has to make money for Mr XXXXXX. The pharmacist describes the 'shop' activity as something that is a professional activity as you have to match products to the person. The pharmacist meets with the rest of the team before store opening and tell them that the figures show that the they are below target and that they need to increase sales this week.

Community Pharmacist and Store Manager, Community, Chain.

When professionals or individuals work for an organisation they become almost organisational actors and as such, the professionals and their roles are very much governed by that organisations' strategies, goals, policies, priorities and practices. This is true whether the pharmacist prescribes or not.

7.3 Organisation Work Planning

R16: "I think the company would like to be able to support us to deliver these services but I think they have a real difficulty logistically doing that" Community Pharmacist, Chain.

R07: "The Trust policy is very clear that we encourage non-medical prescribing. So if an individual manager for no good reason said no, then they'd have to explain to the Trust i.e. me, why they're doing that… the policy is on the intranet it's very clear, it's an encouraging course" Associate Director Medicines Management, Pharmacist, Hospital.

In this example, the role of the organisation directly affects the professional. This is because as an organisation and host, they determine what standardised behaviours of individuals and or groups that will be performed within their organisations. More specifically with regards to what tasks they can and cannot carry out as the organisations structure dictates how far they accommodate and retain certain services. Some pharmacists have had to completely adapt their role in order to utilise their non-medical prescribing qualification. This professional has had to move settings and access services outside of the organisation in which they originally worked in order to set-up and deliver non-medical prescribing. The setting or the context here again, determines what the individual can do.

R01: "it's actually transferring and getting areas that aren't used to having non-medical prescriber's, getting them up and running to accept and to allow you to use that really, you know quite a valuable skill for the service. Actually getting them to allow you to put it into practice in this new area… when I did my course there were two community midwives on it. There were just the three midwives on there and you know, they've been using it ever since they qualified as a non-medical prescriber. Whereas nearly five years down the line, I'm still fighting to use it in mid- [sic], the same professional group" Midwife, Hospital.

This example demonstrates that the professional group here is not the concern, rather the setting and at what stage it is at in accepting non-medical prescribers and allowing them to prescribe.[25] The fact that the midwife qualified at the same time and in the same way, from the same course as her peers is in this case inconsequential with regards to the midwife being able to use her qualification. At this time, the organisation has played an important role in relation to the pace at which the qualification has been acknowledged and the progress in utilising the non-medical prescribing qualification. Five years down the line and this practitioner was still facing obstacles which prevented her from using her non-medical prescribing qualification despite the valuable skill of prescribing and even though the practitioners role as prescriber was essentially to deliver medication to the patients in a more timely and effective manner. The midwife here suggests that she is "still fighting" to

[25] Even though the practitioner in this example used patient group directions (PGDs) to prescribe, prescribing independently of PGDs was an issue.

be able to use her qualification. The idea of her fighting and for so long highlights a number of questions and issues around the influence and the control that this, and no doubt other organisations hold over the professions. Particularly as the professional here is already prescribing with PGDs and secondly, as the prescribing supports the wider aims of the policy on prescribing.

Scott (2008a) states that institutions impose restrictions by outlining moral, legal and cultural boundaries, setting off legitimate from illegitimate activities. In this case, for non-medical prescribing, the data collected shows that the different settings themselves determine the suitability, necessity and acceptability of non-medical prescribing for different areas and practices. How the non-medical prescribing qualification works or fits best and essentially where it will be used, funding or budget allocation, in what area or context, with what aim or objective, that is, if indeed it is used at all. Across the different settings, the pharmacists did face a range of difficulties and barriers. Some of these included the setting up and of running clinics, access to budgets and budget allocation, access to patients, notes, and managing the re-distribution of tasks or workload.

In addition to the impact on the tasks performed, the setting directly impacts on and dictates what regulative, normative and cultural cognitive elements are accepted for any professional group. While individual professions have their own fundamental markers and guides, once the professional occupies a particular setting, these elements transform and

embody those governed by the employing organisation. Thereby illustrating the importance of the organisation and the impact that it has on the individual (See Figure 6).

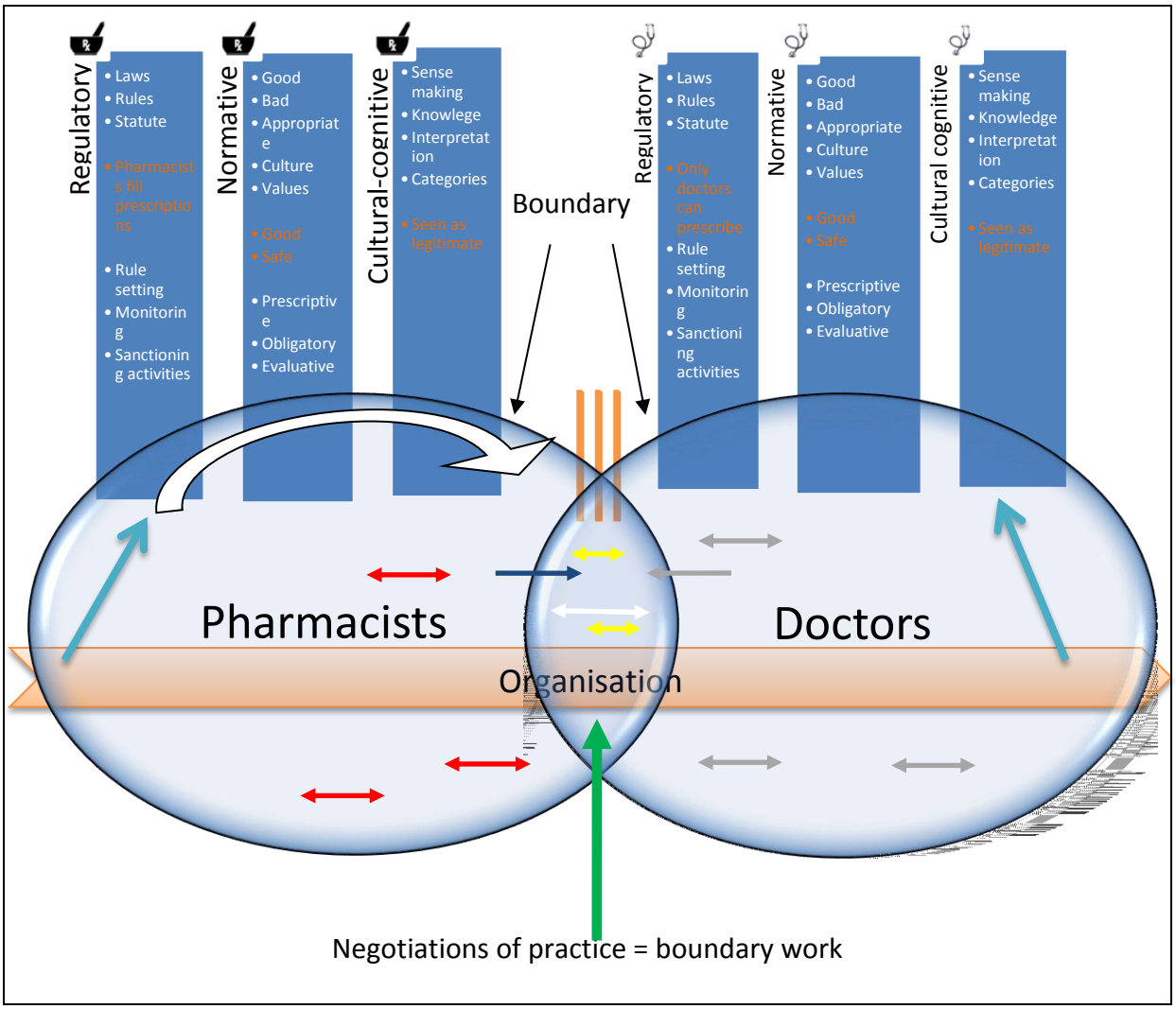


Figure 6: The Organisation and the Redistribution of Work.

Figure 6 reflects the presence and role of the organisation. The introduction of the blue arrows here represents the how role and the influence the organisation impacts on the way professional groups work. In theory, if the organisation chevron was specific to a particular

organisation housing specific professional groups the normative, regulatory and cultural-cognitive pillars in this diagram would all be somewhat different in line with that organisation, the further orange pillars present the professional in the organisation and the way the organisation determines the work of the professional. The pillars here (the orange pillars in the negotiations of practice area) would again be defined and specific for each professional group or individual when looking at overlapping roles or jobs or sharing specific tasks.

The role of the organisation is undoubtedly a significant and an important one. This is particularly true in the health care context where these organisations employ a wide range of professional groups. This is of great consequence for a number of reasons. Not only do these organisations play a key role in determining how these groups operate and the tasks which they perform but consequently, these organisations then impact on the way in which these different professional groups or people acting collectively interact and work together and essentially deliver their service provision. One thing that is plainly evident however is that practices of individuals and professional groups cannot be entirely detached from their service contexts (Scott 2008a). The said service settings play a key part in the tasks performed and the roles undertaken. This idea is presented by Scott (2008a) where he refers to Hughes' work which suggests that institutions interact with the individual and that this interaction creates identities, shapes the life course or careers of these individuals and provide a "licence" to perform otherwise forbidden tasks. With regard to non-medical prescribing:

R08: "the organisation themselves actually authorise that, the student, that person is in a prescribing role and will have access to a prescribing budget and actually that person being a prescriber will make a difference to patients before they come on the course so the organisation determine that" Lecturer and non-medical prescribing lead, University and Hospital.

The organisation plays a key role from the very beginning where practitioners express an interest in doing the course or are put forward by managers and so on. From this expression of interest, organisations approve that professional to go on the course or not. Where this approval is sanctioned, it should then be reasonable to assume that the next stages would be straightforward. Put somewhat crudely, it would be expected that the professional once qualified seek to be added to the societies register. After this and after getting insurance be able to get their prescription pad and or prescribing ID and be able to prescribe in their predetermined role. Nevertheless, in reality, for these professionals, this was not the case for any of them. Of course, where professionals had moved between jobs and or organisations this could and did cause additional issues, nevertheless, such issues are not isolated to these scenarios.

R02: "once you've got the qualification its actually the setting up that's quite difficult because there isn't really any information. Unless you know, my colleague … she's kind of like, "right I'm not actually

sure who I need to speak to get this, you know…the official paperwork sorted out". That's becoming more slick now, because obviously she's [telling me] like, don't do that, do this. Another colleague had already gone through [it] as well about three months ahead of me so she's like go to that person. So I probably gained a couple of months just by not having to, sort of I've learnt from other peoples mistakes" Primary Care Pharmacist, GP Practice.

Where there is a lack of organisation information and direction, practitioners are not only finding it difficult to enact the prescribing role but also the process consumes a lot of their time as they turn to colleagues who have undergone a similar experience. What unites these practitioners is the absence of directive processes that nurture the non-medical prescribing implementation process.

R02: "I have seen the things that have took her time to do so. I'm, there were lessons to be learnt, and I will kind of utilise them, but it, it did take forever. I'm hoping that I have to get my clinic up and running quickly because I'm in a very tight timeframe with the PCT. As in, if I, they've kind of given me this, I suppose, kind of … I have to pay back my practice [laughs] so it's kind of protected time" Primary Care Pharmacist, GP Practice.

Rather than having organisational support and guidance, contractors describe how they are turning to colleagues and peers for verification and validation of what they need to do to enable them to enact the prescribing role. Instead of the organisation guiding their prescribers, prescribers rely on interactions from people they identify as having gone through the obscure route. Learning from the 'mistakes' of others is by no means productive or ideal particularly when the lack of input from the organisation results in timely delays and disparities throughout the implementation of changing roles.

7.4 Finance, Resources and Pharmacy

Money, funding, budgets and pay were featured in various combinations throughout the data. Money, funding and costs were also featured in each of the separate observations at least once whether it was observed conversations about prescribing costs associated to treatments or medicines or moneys connected with services carried out such as Medicines Use Reviews (MURs) for example.

Observation

Pharmacist serves a customer/patient collecting their repeat prescription. The pharmacist takes this opportunity to invite the customer/patient to take part in a Medicine Use Review (MUR). The customer/patient agrees and the pharmacist goes with the customer/patient to the store's consultation room which is situated to the side of the pharmacy. A number of forms are filled in as part of

the MUR. When the MUR is finished the forms are filed and the pharmacist comments that the company will get £3[sic] from the PCT for doing the MUR.

Community Pharmacist and Store Manager, Community, Chain.

Observation

The pharmacist gives a patient their medication. The pharmacist completes a supervised record form. The pharmacist comments that this was a 'medication service'. For which company receives £2[sic] from the government each time this service is carried out.

Community Pharmacist and Store Manager, Community, Chain.

In healthcare, there are tremendous costs and a number of debates around, from those associated with the cost and delivery of medicines and treatments to salaries. There have been funding cuts and recurring government calls for Trusts to save money and subsequent reforms and initiatives to facilitate this. Other money related issues raised include, who pays for what hospital or GP? Whether GPs continue with the same treatment prescribed in hospital for patient or the number of different prescription pads held by a prescriber, different clinics, different funding pots, and different prescription pads.

Funding was an issue with respect to funding non-medical prescribing positions and was a problem for prescribing treatments to patients and delivering services. At a micro level for non-medial prescribers, funding and money features as one of the key sticking point and barrier in implementing the use of the non-medical prescribing qualification and as a barrier to certain activities or prescribing. This is even true of the examples where Trusts seemingly support non-medical prescribing and have Trust policies in place to support and practitioners.

> *R03: "if there's no money, there's no money" Professional Development Manager, Pharmacist, Pharmacy Chain.*

This pharmacist was unable to develop her role after getting the non-medical prescribing qualification. For this pharmacist, the absence of a willing or able funder proved a massive hurdle, one that in this case, she was unable to overcome. The role of the organisation reveals itself here as key because with the absence of funding the role is unable to be carried out. The qualification is immaterial without the funding to back its implementation and use.

> *R14: "I'm lucky in that I have always been considered part of that but although funding is not a particularly large issue there's always the question who's going to pay for it" Advanced Pharmacy Practitioner, Pharmacist, Hospital.*

R17: "Well there's usually something about money involved in it" Community Pharmacist, Chain.

R16: "it always helps if you can offer to help them fill their QOF targets like that" Community Pharmacist, Chain.

R02: "it was paid for by the PCT for me to do it and it, … I think it is seen as erm, a quality way of doing medication reviews. It can save a lot of money" Primary Care Pharmacist, GP Practice.

Here, these pharmacists refer to the funding and the way in which it influences the decision to support their role. R14 in their particular role describe themself as 'lucky' in not having funding as a 'large issue' to them although they acknowledge that there are questions around who pays that are always a consideration. For pharmacist R17 and R02 their statements are directly related to their proposal or carrying out non-medical prescribing within an existing service or practice. For this pharmacist, they suggest that in order to develop or progress, money is usually involved whether that is who pays for a service or what the cost benefits or saving are for the service provider.

The observations also demonstrated how money and funding was taken into account around treatment choices and costs.

Observation

The pharmacist is in her clinic consultation room. She looks over the notes for the patient she is about to call in next. The pharmacist comments that this is a complex asthma patient and that their treatment costs £30,000 a year. This appointment was a Xolair assessment which is carried out annually to see how the patient is responding to the drug as it is very expensive and complete a questionnaire for the treatments funding. The pharmacist has to legitimise the decision to use a particular treatment, in this case due to its cost.

Consultant Respiratory Pharmacist, Hospital.

Funding is an area that impacts throughout medicine and service delivery. In order for additional role and services to be accommodated and developed, funding needs to be made available and accessible. In addition to funding for prescribing role, further constraints concerned with finance exist in terms of medications and items prescribed. This is not out of the ordinary in health care due to the governing budgets and policies however, these still present as barriers to the delivery of different services.

Different issues relating to money which arose in the data were pay and salary. While the reasons professionals had for doing the qualifications varied, generally, people thought it reasonable to have this extension of their role reflected in their pay, although this was not the case for many.

> *R07: "the general rule is that they don't get paid any more money for being a non-medical prescriber" Associate Director Medicines Management, Pharmacist, Hospital.*

> *R06: "I think the pay should be at a standard. If you are a prescriber, your minimum pay should be whatever up to whatever and that's what is a big annoying thing is that you are cheap GPs… I don't think I get paid enough. So I'm, no actually, I think we got 11p per hour rise this year and to me that's a slap in the face" Non-medical prescribing practice nurse.*

> *R07: "if we're talking about non-medical prescribers whatever… issues about pay is a bit of a thorny issue. The way it's supposed to work is you've got a job description that has been agenda for change banded and you're a band 7 or whatever. Now if your job description*

changes, then you are right to ask for a review of that banding… clearly, one of the messages that we're very clear about is that if you're a non-medical prescriber you should make sure that's in your job description. So, some people have put that in their job description and that's gone off for banding and some of them have come back at the same level as they were before. Occasionally they come back at a higher level but that clearly puts a cost pressure on the manager of that particular service and they've got to decide, do I want somebody prescribing or do I not?" Associate Director Medicines Management, Pharmacist, Hospital.

While a number of professionals had gripes and objections in relation to pay, there were practitioners who had the qualification and were happy to deliver the service as a way to develop their role in the future. However, the money to pay the basic wage was not there or there were on-going debates around organisations willingness to pay for the service. The intended non-medical prescribing service that the individual proposes and the importance that the organisation considers non-medical prescribing to have for their organisation (if non-medical prescribing is on their agenda at all) undoubtedly influences the subsequent role of non-medical prescribing for any given organisation. The organisation has the overall decision as to what role non-medical prescribing has within their establishment if any, despite government calls and initiatives.

7.5 Trajectories for Professional Expansion

It has been reported that there is a lack of strategic direction for development of pharmacist NMP posts and that the success of many services are being driven by individual practitioners (Clinical Pharmacist 2011). This is evident in the data collected for this study. Where in some cases non-medical prescribing has been successfully implemented. Most of these cases report that individual practitioners are the ones who have driven the implementation. For some, despite their best efforts and in spite of them 'selling the idea' to organisations or respective organisations seeing its worth, their pushing and driving was essentially ineffective.

7.5.1 Professional Entrepreneurs - The Role of the Individual

While both hospital pharmacists and community pharmacists are able to prescribe independently, the onus is on them to make the most of that opportunity:

> *"There are opportunities available to every pharmacist to develop themselves and the services they provide to the public," Mr Simmons says. "The DoH has listened to what has been said by the profession and has provided the opportunities. Now it's a case of carpe diem!" (The Pharmaceutical Journal 2005).*

Many pharmacists viewed non-medical prescribing as not only something that enables them to utilise the skills amassed through their training and experience, but also as a way in which they can demonstrate their ability.

> *R02: "I think, if I'm being honest, I don't necessarily think you have to be an independent prescriber to necessarily be running clinics because we certainly have practice nurses that are not prescribers see patients… I think what it, to me it gives me an official qualification that I can sort of sell my services" Primary Care Pharmacist, GP Practice.*

Many practitioners have used the non-medical prescribing qualification as a way to exhibit themselves and the services that they have to offer. The role of the individual here is to propel himself or herself in a way which will enable them to show off their capabilities and in doing so, they intend to secure their future roles and profession. Many individuals described non-medical prescribing as an opportunity and one which they chose to invest their time to get funding to complete the course and then to push to get their qualification acknowledged and accepted in their various practice settings.

your role and do more sort of interesting clinical work…if they don't know you" Primary Care Pharmacist, GP Practice.

This is another example of the prominent role of the host organisation and the flexibility in which the pharmacist has had to exhibit in order to develop her role. Knowledge and skills alone in this case were not enough to ensure or determine the role development despite being accredited and capable. This pharmacist has had to prove herself in addition to the non-medical prescribing qualification. She has had to demonstrate her capabilities in order to earn extended freedoms and opportunities to work towards developing her role. Again, the organisation and the budget holders have guided this. This pharmacist states that it is harder to extend your role if 'they' do not know you.

An alternative example illustrates how a hospital's process for enabling non-medical prescribing is explained. In this example, there seems much more facilitation in the implementing of the prescribing role.

R07: "once they're on the register as a prescriber, they're ok to prescribe… really we would have a system of, if they're practicing in what I would consider a sensible way then they're probably not going to have that much input from pharmacy. But if for example they started prescribing drugs that you or I may think was outside their limited competence then I would be going straight to them and

saying look you're a mental health nurse, you've just prescribed azathioprine or something, which is a drug for arthritis, so why do believe you're competent?" Associate Director Medicines Management, Pharmacist, Hospital.

This contrast highlights in difference a clear Trust policy can make in the practical organisational strategy for the implementation for non-medical prescribing. It removes what could be perceived as discriminatory or unfair obstacles. In that respect, there is value in imposing a minimal requirement for organisations to develop and have an implementation strategy that assists individuals who have the non-medical prescribing qualification to implement use of their qualification in practice.

R07: "I also chair the non-medical practice group we've got where all our non-medical prescribers are required to attend that, we meet every 2 months so 6 meetings a year and they're all required to attend 3 meetings a year to retain their right to practice" Associate Director Medicines Management, Pharmacist, Hospital.

R07: "If someone lapses from non-medical prescribing then I interview them before we call them to start prescribing again to make sure that we're happy that they haven't lost competency or they haven't moved to a new area where they don't actually know

anything about" Associate Director Medicines Management, Pharmacist, Hospital.

7.7 Responding to Challenges in Practice

In the first instance, the setting does in fact influence what job or function in their organisation the professional can and does carry out. This is also highlighted in the previous chapter. Specifically where pharmacists speak about their practice preferences and why they chose to pursue careers in their setting of choice.

R02: "…through my [university] course I knew that community was never going to be for me, I'd much prefer more clinical, but yeah, I suppose went and did a PhD and did a bit of research and then I kind of, I think maybe primary care was the happy medium between community and hospital" Primary Care Pharmacist, GP Practice.

7.7.1 Job Relocation: Impacts and Expectations

Of course, another problem is when professionals who have the non-medical prescribing qualification move job or organisation. Often with the intention of using their non-medical prescribing, but find that the different settings or working environment do not always permit or accommodate prescribing in the same way their previous job or organisation did. Conversely, some find that where they were previously much more restricted in their

former roles or organisation, that their new role and or employer allows for far greater use of their non-medical prescribing qualification.

> *R10: "Well it's hard to fit it in here. At XXXXX where I obviously did [my non-medical prescribing qualification] and had the intentions that actually one day I'd use it. We had an acute pain team, which they do have here, [but] unfortunately I've not had the time yet to actually have a lot of interaction with them… it was actually in theory a great idea but it was just not very practical with the staffing that we had really" Theatres and Anaesthetic Pharmacist, Hospital.*

Where there was a need for the non-medical prescriber in their previous organisation, their new job role at the current Trust, there was no practical way in which she could use it and so the overall job role here was somewhat different to the previous role held. A great challenge of non-medical prescribing is the implementation of it in practice and negotiating the different policies and practices of individual organisations.

The data gathered from the participants show that the different organisations had quite different strategies in terms of enabling a non-medical prescriber to use their qualification in practice. This variance was also evident with respect to the management of non-medical prescribers once they had begun to prescribe. Some organisations had very clear strategies and procedures, while others were described as being almost entirely absent.

R07: "The Trust policy is very clear that we encourage non-medical prescribing. So if an individual manager for no good reason said no, then they'd have to explain to the Trust i.e. me why they're doing that…" Associate Director Medicines Management, Pharmacist, Hospital.

R14: "I'd be wrong to say if there was, there is, there isn't an organisational policy so, meaning there is an organisational policy which obviously underpins the practice and the acceptance by the organisation that people, or groups of people other than doctors are able to prescribe. It is not particularly detailed or specific...I think it has developed almost, well it's not developed, every new case then develops a sort of slightly different, or brings with it its own issues" Advanced Pharmacy Practitioner, Hospital

Both of these quotations are based upon the policies employed in hospitals. Both accounts describe their organisational policy quite differently. It becomes clear from the data, that the specific setting is not necessarily an indicator of the success of these policies and practices. Rather, it demonstrates the different stages at which different organisations are at and the different way in which each organisation accommodates and deals with its non-medical prescribers. Given the different accounts, it is easier to look at the similarities and

the differences between organisations, their challenges and the way in which the professionals concerned act in response to them; rather than trying to concentrate on settings as a precursor for certain practices or experiences. It is important however to consider that the two quotes here come from differing perspectives. One is from a director of medicines management. Someone whose role it is to promote and support non-medical prescribing and the other being from a pharmacist experiencing the policy implementation from the other side, trying to negotiate a channel through the policy to be able to implement use of their non-medical prescribing qualification. That is not to say that either is more or less valid, only, the connotations associated with their individual roles. Even though both extracts come from pharmacists, their experience of the system and its procedures are experienced somewhat differently. This highlights the importance of the individual in the organisation and the role the organisation plays in determining an individual's context within that setting. Specifically here, the ways in which institutional pillars underpin professional practice and the boundary within which they work.

As mentioned earlier, for pharmacists, choosing to work in a particular setting is part of their decision to pursue a particular direction in their chosen profession. It is widely understood that pharmacists in different settings often carry out distinct tasks. Tasks centrally related to that setting and essentially the collective of professionals that work in a particular setting. This includes the patients and service users that access the service and the objective of the specified employing organisation. The challenges become more apparent when professionals in their working environment have to alter or switch their role. The data shows that this occurs when the changes typically effects other professionals as it changes

the primary role which that certain individual carried out and in a number of cases from the data, it shows that this change was not so easily dealt with. The data gathered shows that while some organisations have policies and procedures in place, to deal with non-medical prescribers and go towards accommodating given professionals with this qualification, a number were not logistically or otherwise in a position to enable pharmacists and other non-medical prescribers to use their qualification in the environments which they typically work in. One particular pharmacist who found that she was unable to implement the use of her non-medical prescribing qualification or develop her practice, pursued an altogether different role. She tried unsuccessfully to find a way to get funding to be able to use her qualification to no avail. The pharmacist's response here was to eventually change to a different role completely.

7.7.2 Barriers and Boundary Issues

Whatever the setting or preference, the implementation of non-medical prescribing often presents a number of barriers and challenges. Accordingly, boundaries unavoidably shift according to the setting in which they occur. The setting fundamentally defines and to some extent limits the way it's employees work. This includes a number of things including the actual physical working environment, the interactions that the different groups have with each other, the roles they can and do adopt and the tasks they perform. For example, those pharmacists who work in a community setting will invariably have a very different working day and practices to those pharmacists that work in a hospital setting. In the same way, for example, those hospital pharmacists who work on wards perform altogether different tasks that other hospital pharmacists who work in the dispensary.

Non-medical prescribing has been a long time coming. With over 20 years of lobbying, policy changes and law changes have led to non-medical prescribing being adopted amongst a variety of professions in a range of settings. Where prescribing was not a part of existing roles, the implementation of non-medical prescribing was typically taxing. Even though there were predefined areas where it was believed that non-medical prescribing was a useful thing, this did not make implementation any easier.

> *R11: "I think they're specific, specific clinical settings where nurse prescribing role or other, you know other non-doctor prescribing is probably a good and efficient and right thing to do. So in settings where there aren't doctors around" Consultant Neurologist, hospital.*

> *R07: "there's a very limited number of medics out there in the community to look after those patients then clearly there are a lot of advantages [to non-medical prescribing] in terms of access to therapy" Associate Director Medicines Management, Pharmacist, Hospital.*

Professionals working in the hospital setting considered non-medical prescribing as a good and beneficial thing in instances where there were not always doctors available to prescribe. However, for professionals based in the community setting, the merit of such practices did not necessarily translate into practice.

> *R03: "in community pharmacy, it's really difficult to use unless you work as at the PCT in medicines management or if you work in the GP practice, it's really difficult as community pharmacists to use your qualification" Professional Development Manager, Pharmacist, Pharmacy Chain.*

As pointed out earlier, difficulties and barriers are not unusual for pharmacists because of the changes in their role, with additional services for instance and the changes that using the non-medical prescribing qualification brings. Essentially however, in terms of the implementation of the non-medical prescribing, a number of these barriers are erected due to the processes or lack thereof at the heart of the organisation or providers prescribing policy and priorities and budgets and funding.

It is one thing for the professions to evolve and develop but essentially, when professionals operate within an organisation and are governed by that organisation's policies and guidance. This can significantly affect the fundamental role that is carried out by any given professional at any given time. That is, in the diagram above, (see Figure 6) the orange

pillars reflect the impact of the organisation, in a way that is different from the pillars that are in blue which reflect the governance and guidance of the professions. Where the pillars are orange, this indicates the organisation and the way in which it changes the work of the professionals that it employs.

> *R16: "since the advent of the new Scottish Contract, the advent of accuracy checking technicians and things, and you know things like that it's encouraged us to actually use the clinical knowledge that we've got" Community Pharmacist, Chain*

The previous two chapters outlined how pharmacists perceived their roles, what they felt their boundaries to be and then how these roles were being expanded and the reasons for these changes. There are a number of arguments and examples of the difficulties faced for different pharmacists in implementing the non-medical prescribing qualification. This included finding clinics to run/offer and actually setting up to work within a community pharmacy setting, practice, hospital ward or department. For pharmacists who work in different organisational settings this process of implementation has resulted with them facing a number of challenges.

7.7.3 Undertaking the Non-Medical Prescribing Role

Pharmacists had quite different experiences when it came to implementing their non-medical prescribing qualification. Even though pharmacists personally had quite distinct reasons for doing the qualification, their reasoning did not always support the transition from achieving the qualification to using it in practice nor the objectives that the organisation had for individuals and how they would use their qualification. Upon receiving their non-medical prescribing qualification, for some, putting their qualification into practice was a relatively smooth and straightforward process. However, the majority of non-medical prescribers faced challenges and barriers that influenced their move to becoming a practicing non-medical prescriber or using their non-medical prescribing qualification in the way that they had envisaged. As stated in the previous chapter, implementing the non-medical prescribing qualification and seeing the process through from qualification to practice was the biggest difficulty that they individually faced. The reasons for this presented themselves in a range of ways and varied somewhat.

Pharmacists had various expectations and aspirations that were not realised as a direct result of gaining their non-medical prescribing accreditation. This research data has a number of examples of different ways in which the non-medical prescribing role development has not been realised in the way that the non-medical prescriber had initially envisioned. When asked about how a particular pharmacist felt their role had changed, they felt that it had developed but due to other pressures, namely to do cost saving work, that their role as they thought it would have, had not developed as swiftly as they had hoped.

R02: "it's developed perhaps, not sort of as quickly as I would have liked it to and that's mainly because I've got pressures to do cost saving work. And the easiest way to do cost saving work sometimes is to do mass sort of audit work. Much more switching, quite mundane work. So, I would have hoped that we could have moved away a lot more from that. But as I say, current sort of climate doesn't allow anyone really to do that… [I] think it's changed because I know my practices … I have the most job satisfaction from the big practice because they know me and I know them. It it, you know, and my role has developed because their happy for me to sort of do more clinical things…" Primary Care Pharmacist, GP Practice.

Where pharmacists were unable to implement their qualification, this then impacted on their practice and how that individual then envisaged their future role in pharmacy. Their future now seemed different to that which they had perceived when they registered for the non-medical prescribing qualification. To describe it as "demoralising" for a pharmacist not to be able to implement and use their non-medical prescribing qualification is a very passionate and powerful explanation. This pharmacist describes her experience of how she felt, her frustrations with supplementary prescribing and being incapable of using the qualification in the way in which she had intended. This sentiment is also something that was echoed of other pharmacists in the study that were not able to use their non-medical prescribing qualification.

R03: "I don't prescribe. I haven't prescribed since I've qualified. Never written a prescription" Professional Development Manager, Pharmacist, Pharmacy Chain

This pharmacist completed the course with the intention of using her qualification but was not able to. She described the course as a big commitment but one that she felt would help develop her role. She talks of her non-medical prescribing qualification flatly and without enthusiasm almost as if she has wasted her time in doing the qualification.

R03: "I felt that that [it] would save a lot of money and time and it would be really invaluable role… I managed to convince the PCT of that and so they put me on the non-medical prescribing course. Then unfortunately, just as I came off the course there was a lot of changes within the PCT and a lot of funding changes and basically the funding got cut so …when I came out there was no funding for me. All I was asking for was the funding for my time so that would have been a day a week but there was no funding for that" Professional Development Manager, Pharmacist, Pharmacy Chain.

Here is just one illustration of how the implementation of the non-medical prescribing role can fail. In this instance, the role that the organisation plays is a significant one as the absence of funding meant that this pharmacist could not operate in the role as she had intended, despite having already managed to secure funding to go on the course and successfully complete the course. This pharmacist is another example of one who tried for a number of months to implement her non-medical prescribing qualification. In the absence of securing funding to enable her to do this, meant that in her current role and in that setting that she couldn't use the non-medical prescribing qualification. The problem encountered here by this pharmacist is a problem that was stressed in the Pharmaceutical Journal (2005), Hemant Patel who was at the time the Royal Pharmaceutical Society of Great Britain's Vice-President, was quoted as saying that he believes:

> *"Two types of cost need to be accounted for: the payment for the work done by pharmacists and the reimbursement of any costs they incur… the financial basis is not clarified, hospital pharmacists will be able to prescribe and primary care pharmacists will be able to prescribe, but community pharmacists will not, because the finances will not be in place" (The Pharmaceutical Journal 2005).*

Despite the six-year difference in time between this account and the participant's experiences, this is still something that is occurring and needs to be addressed.

R03: "All I was asking for was the funding for my time so that would have been a day a week but there was no funding for that. Tried to go the GPs that looked after the nursing homes but they didn't want to take any money out. Although they agreed that it was a good idea in principle, they didn't want to take any money out their budget to fund us so it just never got off the ground… I tried through the PCT and the, I got on quite well and they knew that I was there but I just, I just, I gave up. I dunno maybe about 6 months to a year or something and just kind of gave up because I wasn't getting anywhere, there were just too many changes in the PCT and they just didn't have the capacity to start anything new" Professional Development Manager, Pharmacist, Pharmacy Chain.

This pharmacist repeatedly went back and forth looking to secure funding. She approached the PCT, the GPs and the nursing home. All the different organisations saw the value in the prescribing which she proposed but none were prepared or in a position to provide the necessary funding. This process left the pharmacist in a position where she felt she had no other option but to "give up" trying to implement it. This goes some way to ratifying the previous quote where the pharmacist described not being able to use the non-medical prescribing qualification as "demoralising" for the pharmacist. In the case of the pharmacist seeking funding, they not only gave up trying to find funding but also essentially gave up on their non-medical prescribing qualification as she pursued a completely different role – one in which non-medical prescribing plays no part.

R17: "another barrier that is GPs' perceptions of pharmacist prescribers so that creates a huge barrier, so it tends to be pharmacists get to do the things that GPs don't want to do, which isn't necessarily the best use of a pharmacist, or a GP for that matter" Community Pharmacist, Chain.

There almost certainly needs to be better provision and support for independent community pharmacists who undertake and achieve the qualification and go on to need funding or access to services in order for them to deliver their non-medical prescribing provision. This is especially necessary where it is clear and understood what the potential of non-medical prescribing is and that its function being a good thing. Fittingly, the pharmacists intended use of non-medical prescribing here supports the government rhetoric about non-medical prescribing; specifically in relation to improved patient care and increasing patient access to medicine, utilising the pharmacists' skills and easing the burden of doctors:

"Patients' needs will be better met by some pharmacists being able to prescribe medicines for them directly…. This will open up new opportunities for suitably qualified pharmacists to add a prescribing role to their existing responsibilities, in order to provide a better, and more efficient, service for patients" (Department of Health, 2000b).

"The development of Independent Prescribing is part of a drive to make better use of nurses' and pharmacists' skills and to make it easier for patients to get access to the medicines that they need. Nurse and Pharmacist Independent Prescribing is an important part of developing their role in delivering frontline care and a patient-centred service" (Department of health, 2006a).

Despite the objective of non-medical prescribing and the corresponding intention of the pharmacist, in this instance non-medical prescribing proved impossible to implement. This barrier to implementation is not exclusive to the community and for independent pharmacists; however, the data show that in this group it is a recurring problem. Pharmacists in other settings have faced similar issues and in some cases the Trust has sought to respond and act on them.

R07: "My perception is certainly, there were some people who clearly were just keen to do the course and went and badgered their manager for them to do the course. And I think their manager just said whatever, just go and do the course and when they qualified. The manager was saying, actually we don't want you to prescribe. Which obviously is nonsensical because you've already spent all that money on training somebody and then you can't find a role. Which is why

now, we don't let anybody go on the course unless we've got some identified areas where we think non-medical prescribing is a sensible and a good thing" Associate Director Medicines Management, Pharmacist, Hospital.

In effect, this is seen to be a waste of both people's time and money when they go on the non-medical prescribing course to get the qualification but cannot find a way to use it. In order to avoid the instances where practitioners achieve the non-medical prescribing qualification but are unable to implement it, this particular Trust has responded by tightening up its' course entry. What is significant here is that the organisation judges what is "a sensible and a good thing". Again, this does not always tally with the thoughts of the practitioner. In order to prevent this under use of the non-medical prescribing qualification on a wider scale, then an adaptation of this sort of policy and practice should be more broadly employed across different organisations and settings. While in principle, it would be a lot easier to apply in a hospital setting, it is something that would avert the impractical and hopeless qualification of professionals.

7.8 Non-Medical Prescribing Need: Existing Practices and New Roles

It is evident that where practitioners had to go out and sell themselves or fight for their opportunity to prescribe, that this came with a number of difficulties and or constraints. For practitioners, implementing and carrying out non-medical prescribing as part of an existing role, the prescribing in practice or service was carried out far more easily than it was for

those who introduced prescribing practice and or having to create a new role. Although various organisations and professions embrace non-medical prescribing the motivations driving its use was wide-ranging.

> *R14: "And I think that way you're more likely to succeed and probably use your prescribing. Well, yes you're probably more likely to use the prescribing more often than if it's a, you are told this is something that you must do" Advanced Pharmacy Practitioner, Pharmacist, Hospital.*

Throughout the data a number of pharmacists and other health care professionals comment on the usefulness of a prescriber already working in a predefined role or area in order to successfully implement their non-medical prescribing qualification. In the absence of such roles or existing practices, barriers were such that the practitioners abandoned altogether trying to implement use of the non-medical prescribing qualification or were forced to use it in a way that was directed to them. The following examples show different experiences of implementation. In one case, the prescriber was unable to overcome funding issues. In the other, the pharmacists role would change so much so, that there would be a gap in the existing service delivery and this was not workable.

> *R03: "… also you have to make sure that, I mean it's different in my role and a lot of roles there's already need you know. That, a lot of*

people because they're in a GP practice or because they're in hospital or whatever it is, they're all PCT there is a need that they're fulfilling already. Whereas with me, I had to go out and kind of sell myself" Professional Development Manager, Pharmacist, Pharmacy Chain

R10: "it became an issue that if I'd written up these drug charts and signed for them who's going to double check them. Because obviously these patients would end up on my wards, so I would be one of the pharmacists… so I couldn't really, can't really see how I'd implement it on a daily basis" Theatres and Anaesthetic Pharmacist, Hospital.

Both these practitioners are pharmacists and to be able to do fully embrace the non-medical prescribing role, they state that it would have mean that there would have to be some sort of compromise with respect to the job role which they typically performed as a pharmacist or the environment or setting in which they worked in. In these examples, the non-medical prescribing role or prescribing was and is not already an integral part of their daily or routine tasks. Subsequently this presented as barriers for the pharmacists as it meant that the degree to which tasks would need to shift that they would have to change job roles. Pharmacist R03, upon failing to implement the changes that she had initially envisaged to her role and practice, since has changed her job role altogether and has gone into a managerial role in order to progress her career in a way that she couldn't do with the obstacles which she faced when trying to develop her prescribing role. This change could be

thought to be significant as in the previous chapter, pharmacists indicated that they had a clinical or managerial preference. Non-medical prescribing was a way in which pharmacists saw that their clinical career path and future could be developed. In the absence of this option for this pharmacist, she redirected her career path completely.

A number of other reasons and drivers were described. Again, the support and or driving force of the organisation or doctors contributed to the success and the outcome of non-medical prescribing.

> *R09: "the consultants are generally keen, because they're very busy, and if the registrars are busy or are off then it's them that has to do the prescribing. so obviously, if I can help with that then it is one less thing that they have to worry about. So I think they are generally quite supportive" Paediatric Oncology Pharmacist, Hospital.*

The use of non-medical prescribing in this scenario is supported, as it is in essence more convenient for the doctors concerned. For the prescriber the use of non-medical prescribing is also a desirable outcome as the pharmacist here describes how being able to prescribe will give her more control over her work.

R09: "I suppose the main driver is that some of the time, if the doctors are busy they don't write the chemotherapy on time. And then that then puts pressure on me to check it and order it quicker, or you know, I kind of set aside a time and if it's not done by then I have to sort of fit it around other things later in the week. … whereas if I can prescribe it, then I obviously have control over when I can do that and can make sure it's done at the appropriate time to save yeah me kind of" Paediatric Oncology Pharmacist, Hospital.

The ability and freedom to work more independently and manage her workload was an anticipated outcome for this pharmacist. Even though the two parties had different motives for backing non-medical prescribing, each side both feel that they will benefit from the convenience and control over their own work, time and tasks that they perform through its implementation. Again, if the rhetoric around non-medical prescribing is reflected upon here, the use of non-medical prescribing in this team is an example of how the qualification is adapted to suit the different demands and requirements held by the organisational structure and the different hospital areas. It is used in differing ways to define roles and activities in an organisation where there is multidisciplinary working and collaborative prescribing and or shared care of patients.

7.9 Summary

Non-medical prescribing moves pharmacists throughout the different settings and indeed health care away from their more traditional roles and practices. Irrespective of setting, pharmacists all state that they all fulfil their key role or “first duty” in the absence of non-medical prescribing.

The data collected through the course of this study strongly suggests that there is a direct relationship between the organisations and the work carried out by its employees. It is evident that there are a number of barriers and issues faced when the non-medical prescribing qualification is being implemented in practice. Interestingly, even though funding and budgets present as barriers and although the process of implementation is frequently described as challenging, the professionals did not often explicitly put this down to the organisation. Professionals did comment on the ease or struggle their peers had when they went through the implementation process in different departments, organisations or Trusts but they did not directly focus on the actual organisation and the role it plays in the successful or otherwise enactment of the qualification. The data does show however that the organisation and its’ policies and interests play a significant part in how the non-medical prescribing qualification is used and implemented, if at all.

The fact that professionals who have convincing and legitimate reasons for wanting to implement the qualification, and on occasions where there are gaps where its use would be beneficial for the patient, it is still a struggle to get the necessary backing and support to

implement it. This seems to be a common occurrence across the setting, even where the implementation of such role support and endorse the government aims and rhetoric.

The data shows that role of the pharmacist is continually evolving in a bid to preserve their professional status in a changing health care system.

> *R13: "obviously working in the area for so long but I'm not a doctor but I am an expert in making sure that patient is on the right medicine for what they, what their diagnosis is" Consultant Respiratory Pharmacist, Hospital.*

This is important for professionals irrespective of whether they are non-medical prescribers or not. Pharmacy is a technically skilled job and one that occupies a considerable function in the health care system. The pharmacists in this research talk about their knowledge and skills and the role they play in their individual setting. Pharmacists, despite describing themselves as defining their profession or having to gain new skills, occupy a necessary section in the health care system. Even though this is the case, there are a number of occasions where there appears to be a lack of confidence in the role of the pharmacy profession or at least in defending the profession in a changing health care system.

R08: "you need people who are going to lead this, who are going to be the determined and motivated ones, who are going to be knocking on the doors saying 'I can help you with this, I can help you with that, will you just allow me to?" Lecturer and non-medical prescribing lead, University and Hospital.

Chapter 8: Discussion

8.1 Introduction

The past decade has witnessed many changes in the NHS and more broadly healthcare for pharmacists. Chapter 2 looked at existing literature and research that outlined the historical changes that pharmacy has undergone and also how this has affected the profession and its boundaries and practices. The existing empirical research and the body of literature also look at the changes in the healthcare system and to what extent this has guided and impacted on the changes in the pharmacy profession. The data gathered in this research goes some way to explaining the role of non-medical prescribing and how it fits within the tasks of different health care professionals.

This discussion chapter reflects on the content of the data presented in the previous chapters. It will also look at the theoretical and general implications of the results. An evaluation of the research findings in light of the literature review, other empirical research and policy changes in the area is also considered. The implications of these outcomes for policy, practice, and research are presented. In doing so, I aim to provide findings that contribute to the subject of pharmacist non-medical prescribing and the works on the professions. This chapter will go on to provide a conclusion to the thesis. Recommendations which are based on the data collected will be presented and finally suggestions for future research in this area will be considered and tendered.

8.2 Discussion of Findings

Pharmacists are a crucial part of health care but are not always recognised as such. England's public health minister Ms Soubry, while speaking at a forum on CCGs states:

> *"Pharmacists are the "heart of public health" and should be saluted"*
>
> *(Waldron 2013).*

Pharmacist roles continue to develop and the tasks that some pharmacists carry out continue to change, the fabric of pharmacy still remains. Pharmacists are referred to as the experts in medicine due to the knowledge that they hold concerning medicines and their core duty continues to be the assuring the safe delivery of medicines. The pharmacy profession has endeavoured to maintain and defend its jurisdiction by continually evolving and providing additional services that purportedly play to the strengths of pharmacists, taking more control over their sphere of work whilst striving to remain *true* to pharmacy (Eaton and Webb 1979).

The data presented corroborates this opinion as the pharmacists included refer to pharmacy as or identify themselves as experts in medicines and having an abundant knowledge base around medicines. Despite their knowledge, a number of pharmacists came across various

barriers and obstacles when working with other profession or even when working with other pharmacists.

Whilst non-medical prescribing deviates from what was considered the typical role of the pharmacist, there still seems to be the demand and the need for these additional tasks performed. The UK government and policy drivers continue to guide what is considered needed and necessary with regards to the introduction and implementation of extended and enhanced services. Non-medical prescribing represents one of the ways in which the government aimed to modernise the National Health Service (Department of Health 2000a, 2000b, 2006b). Where these extended and enhanced services are in place and operational, in particular non-medical prescribing, there have been a number of perceived benefits reported (Department of Health 2008b). The problem is however, where pharmacists struggle to implement the use of their non-medical prescribing in practice and also where it is implemented, the degree to which the qualification and subsequently the non-medical prescriber is utilised by the hosting Trust, organisation and or service.

While it is accepted and abundantly evident that the role of pharmacists has evolved, there are various factors that affect the degree to which these changes are observed and enacted in practice. In addition, the straightforwardness of these changes varies considerably. The changing demands on pharmacy are on-going and evident in the literature review as the government seek to adapt the tasks of pharmacy by extending their roles and research has been carried out to identify and evaluate these changes.

Among the different services which are currently provided by pharmacists, there was a divide as to the suitability of specific services being carried out by a pharmacist. These are referred to in the data as beneath the skill set of a pharmacist and for some beyond the remit of what a pharmacist does. An example of this is administering of flu jabs as being a task that a much more junior nurse could carry out for example.

Removing the focus from evaluating the perceived use and concentrating on how the individual professional responds to adapting practice and how they enact new or adapted roles at a micro level. The enacting of the roles and its implementation is important in understanding to what extent task sharing was supported and accommodated. As a result of this enquiry, this research highlighted the process of implementation important in enabling the professional to enact their non-medical prescribing role. Though there are a small number of empirical research studies which look at the implementation of supplementary non-medical prescribing (George et al. 2007; Stenner , Carey and Courtenay 2010; Cooper et al 2008; Tonna et al 2007). This research differs in that it looks at the not only the professional and their practices but also the profession in which they are a member of and the research also takes into account the setting in which the individual works in. It focuses on the professional's interactions and the different negotiations involved in a bid to enact the non-medical prescribing role. It touches upon the professional identity of the participants and the professional development, which the practitioners have undergone and are continue to experience.

Despite the numbers of pharmacists that have successfully undertaken the course, the number of pharmacists who are prescribing in practice is proportionately lower (see section 3.2). The data shows examples of cases where the use of non-medical prescribing has been implemented and used successfully by pharmacists in both primary and secondary care settings. While this research reveals that there are still a number of good examples of pharmacist non-medical prescribing being employed in practice across the different settings, as does other empirical studies (Latter et al. 2011), the experience of the majority of pharmacists in this study, and other health care professionals are somewhat different. The implementation process is somewhat problematic. This research reflects the disparity as a number of pharmacists illustrate the difficulties they have faced in trying to implement the use of their qualification in practice. In a number of cases it was the implementation of the non-medical prescribing qualification that poses the biggest problem for pharmacists. The barriers presented for a number of pharmacists were such that they abandoned their attempts to implement and use their qualification.

Previous data chapters show that pharmacists often see non-medical prescribing is an activity that gives practitioners the opportunity to formally take ownership of tasks that they had previously not been able to complete. In addition, the qualification also gives the freedoms and in some instances, the opportunity to develop individual job roles and practices. Upon gaining the qualification, whether or not this move translates into practice, is another matter altogether. In principle non-medical prescribing is said to utilise underused skills that practitioners already have, however, it seems reasonable that for

these roles (non-medical prescribers) to be enacted and to get the most from the qualification, there needs to be an existing gap that the practitioner fills. Where the organisation feels someone is already fulfilling these tasks in practice or where the non-medical prescriber is only competent, comfortable or able to do certain aspects of tasks, this may create barriers in themselves.

The redistribution of work and tasks is something that is happening throughout pharmacy and the National Health Service. However, when considering this redistribution, the data suggests that the organisation plays a critical part in establishing what is and is not transformed for the roles of individual contractors. What motivation the organisation, Trust or employer holds is very important with regards to the transition into practice and where that transition will be and will take the pharmacist:

> *"A strategy of health care 'modernisation' has encompassed calls for the redrawing of professional boundaries and identities, linked with demands for greater workforce flexibility. Several tasks and roles previously within the exclusive domain of medicine have been delegated to, or assumed by, allied health professionals, as the workforce is reshaped to meet the challenges posed by changing demographic, social and political contexts The prescribing of medicines by non-medically qualified healthcare professionals reflects these changes" (Boyce and Borthwick 2007).*

The NHS modernisation is an on-going process. More recently, the latest wave of changes has seen the NHS currently in the process of big changes in the way that health care is being delivered with the introduction of clinical commissioning groups (CCGs). Even though PCTs and SHAs are no more, the issue of the organisation is still a prominent one.

There are a number of existing debates which suggest that cross boundary working, inter and intra professional relationships and medical dominance influence the extent to which professions task share and redistribute tasks. For example Britten (2001) sees prescribing as the main 'battleground' bringing general practitioners into conflict with other parties who threaten their autonomy and she suggests that the expansion of pharmacist roles, more so than any other health care profession as their main threat and 'battle' to defend clinical autonomy. This idea is hinted at in the research through the response of a consultant but not enough to be considered an issue or main factor. However, what does come through from this research is that, while these factors do present for some professionals at varying degrees, the main issue or difficulty which professionals cite is around the implementation of their qualification and is much more complex and has a number or factors which affect its use. Various issues came up amongst the pharmacists and other health care professionals. The main ones originated with education, the organisation and funding. Although these in themselves are much more complicated than they first appear.

In a national study evaluating non-medical prescribing (Latter et al. 2011), one of the key findings raised indicated that only about half of Trusts reported a strategy or written plan for the development of non-medical prescribing and that if workforce planning was to be effective, more Trusts need to develop their strategic approach for non-medical prescribing. This has shown itself to be an issue for a number of non-medical prescribers interviewed for this study and continues to cause problems. One professional in this research, a midwife, had been pushing to implement use of her non-medical prescribing qualification, and at the time of interview had been trying to get the trust's permission to use her non-medical prescribing qualification since passing her non-medical prescribing course some five years prior. This was despite people on her course qualifying at the same time and being able to put their qualifications to use in practice almost directly after in their respective Trusts. Another example is a pharmacist who after trying for a number of months eventually gave up trying to implement use of her non-medical prescribing qualification, despite the Trust, the GP practice and the associated nursing home all seeing the worth of the service the pharmacist proposed – 1 day week. Nevertheless, no one was prepared to fund the time for the pharmacist to enable her to deliver this service.

Studies carried out five and six years ago, and studies carried out in the last 12 months have also revealed similar incidents to some of those findings presented in this research. That is despite the time that has elapsed and the supposed modernisation of the National Health Service, developments and the increased opportunities for different health care professionals the same issues continue to occur.

Where pharmacists attempt to change roles within a current job, particularly in community pharmacy, this presents two key issues. First, funding. The funding or absence of funding that is necessary to allow for the pharmacist to deliver the service. The second issue is the fact that in order to enable the pharmacist to deliver the prescribing role, this often requires the creation of a new role which leaves the pharmacists original role needing to be filled. This then presents a void in the current service and then it is left to the host organisation to determine how necessary it is for this change to occur as it has to justify funding the role. For a number of pharmacists in this study, this adjustment was for whatever reason, not sanctioned even where the role was supported in principle. While this concern or issue of funding is real and justified to Trusts, the fact that pharmacists and other health care professions are able to undertake the training yet are prevented from using it clearly presents an issue that needs addressing. There is no standardised implementation template, and in reality, the development of such a tool could pose quite troublesome given the diversity of roles practiced by pharmacists. However, a simple template or algorithm which could be used when accessing the non-medical prescribing course and funding could prove beneficial if it took into account the process from application to do the course. A template that goes right through to qualification implementation and its use in practice to highlight barriers or issues that both practitioners and organisations should be aware of and in theory overcome before practitioners are left with a qualification that has no use in their current work sphere or organisation. This could also serve as a means of negotiation of role change or role development where positive, successful examples exist and are highlighted and communicated.

In order for pharmacists to enact their prescribing role a number or pharmacists described how they had gone out and 'sold' themselves and what they have to offer to Trusts and or organisations, using their non-medical prescribing qualification as a way to showcase themselves. The literature has also suggests that to facilitate this kind of role adaption, pharmacists have to individually seek to promote themselves and highlight their strengths and capabilities, in line with the perceived needs of the host organisation.

The data implied that the pharmacists working in hospitals interact to a greater extent with other health care professionals and as a consequence, how individual pharmacists might enact their prescribing role is somehow clearer. Nevertheless, there were still a number of barriers encountered by non-medical prescribers in implementing and enacting their non-medical prescribing qualification. I would suggest that the professional body and the wider profession have a role to play in supporting the role of the pharmacist. More importantly, enlightening the wider audiences and associates about the scope of pharmacy and promoting the role of the pharmacist. Pharmacy is a profession who are heavily relied on to identify and correct errors made by medical prescribers due to their knowledge and experience or medicines and their interactions. Due to their relationship with medicines and the fact that they are almost a safety net for both medical prescribers and patient, then it would be reasonable for their expertise and additional non-medical prescribing qualification to enable them to justifiably implement their prescribing role more readily.

8.3 Implications for Policy and Practice

The knowledge obtained through conducting this research has illuminated a number of implications for policy and practice. As identified at different points throughout this thesis there are still some uncertainties regarding the best ways implement the non-medical prescribing qualification. The lack of clarity about how the qualification should be implemented in a practical way, meant that professionals encounter a number of obstacles and barriers in their efforts to enact their prescribing qualification and for some professionals, they abandoned trying to implement the qualification altogether. While a number of professionals described how they tried to consult various people within their Trust or organisation for guidance, professionals often had unsuccessful interactions. The data shows that pharmacists and other health care professional report how they found that their respective Trusts in a number of cases weren't able to support the expansion of their role. From both a policy and a practice level, this issue requires attention.

The organisation plays a big role in the implementation of non-medical prescribing as in essence, a specific organisation governs what interest it has in non-medical prescribing and what role it can and will play in their organisation. According to a national evaluation of pharmacist and nurse independent prescribing in England half of the Trusts surveyed did not have a strategy for the development of NMP posts (Latter et al. 2011). This research shows that while non-medical prescribing has been successfully implemented and is being used in different areas of practice, there remain gaps in the use across settings and contexts. This lack of strategy could arguably be perceived to be down to the absence of need in particular

settings, due the strong, routine presence of medical doctors and prescribers or overall ignorance around non-medical prescribing.

Some professionals described how organisations had their own agendas and priorities which didn't always marry with those of the professional, often entrenched around funding. With the breakdown of the PCTs it remains to be seen if this change will make it easier or more difficult for professionals to implement the use of their non-medical prescribing qualification. Nevertheless, in either case, for better or for worse, the organisation must consider the process of implementing the non-medical prescribing role and the wider benefits which the prescriber offers. In terms of policy and practice this is a real issue as first and foremost, the establishment of non-medical prescribing was done so with five key aims in mind (Department of Health 2006b):

- Improve patient care without compromising patient safety
- Make it easier for patients to get the medicines they need
- Increase patient choice in accessing medicines
- Make better use of the skills of healthcare professional
- Contribute to the introduction of more flexible team working across the National Health Service

With the organisation and or practices using their own motivations and in some cases ignoring the points above, they are failing to engage with the policy initiative as is its

intended use and therefore creates an issue in that the way the non-medical prescribing qualification is interpreted and used sometimes differs from the government driver.

With the recent NHS reforms, particularly in the community setting, and the formation of NHS England who are responsible for community pharmacy services, clinical commissioning groups (CCGs) and local professional networks (LPNs) these changes are set to continue and further impact on the roles of pharmacy. While these changes are underway, pharmacy has the opportunity to work closely with these groups and in doing so, could use them as a platform or an opportunity to showcase pharmacy as a profession and what pharmacists can do and in what ways they could benefit different services and practices. Particularly with CCGs for example, as they are being tasked to find big savings year on year in the NHS budget and pharmacists successfully using their non-medical prescribing qualification in a role that helps to meet these targets.

8.4 Limitations

I hope that this work has explored the profession of pharmacy, the negotiations of practice with regard to pharmacists and enacting of the non-medical role and the role of the organisation. The methods used to answer the research questions, while clearly having their strengths also have a number of limitations. The number of interviewees could have been increased to further incorporate a wider range of pharmacists who were prescribing. However, due to the small numbers of qualified and practicing pharmacist non-medical prescribers within the geographical regions which I had approval to recruit from, this was

difficult. Another difficulty was that a number of pharmacists declined to participate given their work loads. In addition, it would have been advantageous to carry out one-to-one interviews with professionals working in multi-disciplinary prescribing teams this would have helped to get a richer breadth of data and would also help in triangulating the data.

Further insights are required to fully understand the implementation processes and the micro processes taking place. Despite interviewing a number of pharmacists, other health care professionals and professionals in a supervisory role, the latter had no immediate point of comparison. There are examples of professionals who offer different insights into processes experienced in implement the non-medical prescribing qualification. Interviews with Trust management and or non-medical prescribing leads from respective Trusts or organisations would have helped to provide additional data which could be used to compare what organisations or Trusts perceive or intend to happen in implementing the non-medical prescribing qualification. I could have helped to clarify what is actually being experienced by the professionals undergoing the implementation process. The absence of this restricts the extent to which any mismatch can be identified in a particular Trust or organisation and their supposed organisational infrastructure and the potential absence of an infrastructure. This approach would have also enabled me to look more specifically at different Trusts, organisations and settings to see if the differences played any part in the implementation of non-medical prescribing or lack thereof.

Due to the time consumed in trying to recruit and carrying out the observations, only three sets of observations were completed. There is an absence of a community pharmacist non-medical prescriber in the observation group. This omission was not intentiaonal. However, due to being unable to identify a community or general practice pharmacist who was a practicing non-medical prescriber and willing to participate in the observations within my assigned geographical areas.

Due to the small number or 'other' health care professionals interviewed, it would have been beneficial to have a minimum of 3 or 4 in each group (nurses, doctors, midwives and reception or support staff) to allow triangulation and to identify any trends or patterns in practices, experience and or attitudes. In addition, the extra data from other health care professionals would aid in building a stronger comparative case.

There is a disjoint between policy around non-medical prescribing in practice where roles, identities, power and negotiations between actors at various levels are on-going. The research highlights another dimension to the complexities the implementation of non-medical prescribing in practice, that is, the stratification of professionals and the potential side-lining of non-medical prescribing professionals by Trusts and organisation managers.

8.5 Recommendations

From the results of this research, it is evident that there are a few recommendations that can be made:

- Focus on the role that pharmacy plays in health care delivery. Pharmacist play an invaluable and distinctive role and as such, as a profession, Instead of continually re-defining what pharmacy is it might be more valuable for the pharmacy profession to re-align and reassert what pharmacy is and pharmacists do.

- The assembly of national and local support networks for prescribing pharmacists, in terms of helping new prescribers. This possibly could be an online facility which enables pharmacists to get into contact with other pharmacist prescribers; those already established and those in the process of implementing their qualification. A service for pharmacists who already have their non-medical prescribing qualification and also those who do not. A place central where pharmacists can go to as a point of reference for examples of good practice, service implementation and utilisation as well as challenges and barriers met and so on.

- The perception of pharmacy and pharmacists needs to be addressed on a large scale. Pharmacists in this research have described themselves as a profession that are struggling to define themselves which indicates that there needs to be some transparency and precision in defining what it is that pharmacists are and what pharmacists do. This is not only necessary for pharmacists but also for other health care professions and members of the public. Though pharmacists suggest that undertaking different training and carrying out new tasks will be helpful for their

careers and future of their profession, they individually work to promote and 'sell' themselves and what they can do and have to offer in a bid to secure a future for themselves in their profession. I would recommend that the General Pharmaceutical Council the regulator and the Royal Pharmaceutical Society have a big role to play in taking the lead in advertising or marketing pharmacy, pharmacists and the wealth of skills and services they have to offer. In this respect, on-going rhetoric and government aims around making better use of pharmacists' skills[26] might be better focused and better employed in practice.

- Encourage communication and more collaborative working between different healthcare professionals in a bid to promote improved working relationships and in subsequently aiding the awareness of the role of pharmacist prescribers and the role it can play in a particular setting, Trust or organisation. It is important that the role of non-medical prescribing is promoted to and within Trusts and organisations. This awareness will work towards encouraging and fostering wider acceptance ad use of pharmacist prescribers an also help the individual pharmacist who is working alone to promote or 'sell' themselves.

- It would be beneficial to have central guidance from the Department of Health which makes it essential for Trusts and health organisations (where appropriate) nationally to have a policy for the introduction, use and development of non-medical

[26] (Department of Health 2006b)

prescribing role in their respective organisations and further policies tailored to specific clinical areas, departments and services.

8.6 Further Research

In order to develop this research and address questions raised there are a number of ways this work could be developed further:

- While there is research assessing the effectiveness, acceptability, efficiency of non-medical prescribing, further research which focuses on the process of accessing funding and support to do the non-medical prescribing course and the subsequent movement from qualification to implementation would be beneficial to identify not only trends, barriers, boundaries but also systems and strategies that are working in practice. This could help to work towards developing a model which could be used to facilitate the implementation on non-medical prescribing in practice.

- It would be interesting to carry out research which looks specifically at Trust and organisational policy and practice for the implementation or adaption of new roles and services. Including allocation of funding, use of budgets and allocation in different areas. Looking at and comparing different financially incentivised services and practices and see if there are any differences in the implementation and delivery of them compared to other services such as non-medical prescribing. Looking at this

area might help develop a functional and effective program that better accommodates certain changes in practice that impact on or influence organisational actions.

- For Trusts that have non-medical prescribing development policies, it would be interesting to evaluate these policies in conjunction with the Trusts non-medical prescribers, both those prescribing and those who are not using their prescribing qualification. Specifically looking at that Trust polices, access to and content of; and assess the ease in which non-medical prescribers are able to utilise the policies and how helpful this policy was in enabling them to implement their non-medical prescribing role.

- It would be interesting to look at a selection of Trusts and organisations to examine the way non-medical prescribing is used in practice in these specific organisations. Looking specifically at the Trust or organisations aims and objectives for non-medical prescribers and how the Trust measures and or assess these outcomes. It would then be useful to see to what extent these Trust or organisational aims correspond with the aims and aspirations of the non-medical prescribers and the Department of Health aims.

- It may be useful to conduct further research which looks more widely at professionals. Looking at different professions and using the negotiations diagram

and substitute the pharmacy and doctor spheres with a medley of different professions and also different professional groups within a single profession to examine behaviour and assess if there are patterns in which one group is more adaptable or one is a 'dominant' profession and if any flexibility detrimentally affects that profession. Also, substitution and interaction will also be useful in considering to what extent different groups' professional boundaries are fixed or more fluid. This is interesting to look at when considering argument around professional boundaries and also beneficial in terms of the arguments around medical dominance, threats to medical dominance and to what extent this still exists and impacts on the role of non-medical prescribing and the division of labour.

- In terms of a establishing a definitive interpretation of the pharmacy profession, it would be valuable to carry out a large scale, national research study which extended over a cross section of pharmacists in a variety of settings to explore what it is they do and their perceptions of what the pharmacy profession is. Looking at how the different tasks and services have impacted on pharmacy and the jobs that are carried out. Attitudes towards non-medical prescribing and what it means to pharmacists and pharmacy.

8.7 Conclusion

The aim of this study was to examine boundary work, non-medical prescribing and the role in the wider organisational context. The research centred on exploring the perceived

boundaries of individuals roles and boundaries of the profession as they saw them. How boundaries are being extended and why professions and individuals were seeking to extend the boundaries was also examined. The relationships presented, looking at the progressive erosion and reformation of boundaries and the impact it has on both professions and professionals. To answer this I looked at pharmacist roles, non-medical prescribing and the role of the organisation. This research explores how professionals enact the non-medical prescribing qualification in terms of contextual factors such as organisational and Trust considerations.

The research collected data that allowed me to explore the expansion of pharmacists roles and practices and NMP. The literature demonstrates how the credibility of pharmacy and confidence in the profession are constantly changing. Pharmacy is given additional freedoms in one area and then they experience the removal of freedoms in others. Pharmacy is a somewhat adaptable profession. While there are solid boundaries there is a much more convincing defence of their jurisdiction of the pharmacy profession needed. Pharmacists and pharmacy need to assert their position and expertise and share this and publicise it widely. Not only as professionals and experts in medicines but also with regards to the role of pharmacy in wider health care and the significant role that they play. Pharmacists are an integral part of medicine and actually, one of the problems with pharmacy is that Instead of re-professionalising and redefining what pharmacy is, it could be that pharmacy needs to re-assert what pharmacy is and what pharmacists do, emphasising their skills and defending and developing their jurisdiction without compromising or depreciating their role.

Amongst the professionals taking part in this research study, issues around implementation and enacting of the non-medical prescribing qualification were widely reported. The spectrum of issues was broad. The role of the organisation needs to be examined in order for pharmacists to develop individually and deliver their role. In turn the health service and medicines and delivering that service will be greatly improved.

The pharmacy profession has historically been and continues to be in a state of flux with instability evident both in terms of the individuals role and progress and the overall standing of pharmacy:

> *"It seems every year pharmacy is "at a crossroads", has "reached a watershed", and it's "make-or-break". I just hope the current pharmacy degree teaches how to deal with that" (Xrayser 2013).*

A number of participants comment on the fact that pharmacists really should have been and it would have been logical that pharmacists would be the first profession to be non-medical prescriber. The professionals in this study are willing (and do) to embrace the changes. For a number of pharmacists these activities are ones that they have described as their aspirations, there is conflict for some pharmacists around non-medical practice among the pharmacy profession. Pharmacists state that they do not want to 'de-skill' junior doctors or other medical staff and consider this a real concern in enacting a non-medical prescribing

role. Willing to compromise their aspirations and even the future development of their profession.

Pharmacist prescribing has been described as being the holy grail for the profession of pharmacy many years ago (Barnett 2008) and it is still and activity that many pharmacists hope to be able to do. The government has changed the laws and practices in such a way that it for a number or pharmacists prescribing is now a reality. There is still a long way to go in challenging confusion and misinformed perceptions of pharmacy and the scope of their practices. In addressing non-medical prescribing, access to the qualification and implementation and practice of the role for pharmacists, pharmacy as a profession would benefit from a wide campaign whereby the diverse abilities and practices of pharmacists are highlighted to not only organisations and practitioners but also to pharmacists themselves.

> *R15: "…it's just I think pharmacy is struggling for an identity at the moment really as to what it is. It's certainly no longer about making medicines…It was, it is still predominantly supply of medicines but I think the financial model is moving away from that and in doing so sort of making it difficult…to get an identity really" Pharmacy Manager, Community, Supermarket.*

This education and drive would go some way towards challenging some of the barriers and misconceptions faced by pharmacists who endeavour to expand their roles in line with government aims and social need.

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Appendix

Appendix 1

Participant Characteristics

1. Are you: Male ☐ Female ☐

2. In which age bracket are you? 18-25 years old ☐ 26-30 years old ☐
   31-40 years old ☐ 41-50 years old ☐ 51+ years old ☐

3. What is your professional qualification ……

4. What is the length of time you have been qualified ……

5. What is your Job title ……

6. How long have you been in your current job? ……

7. Do you hold a Non-Medical Prescribing Qualification? Yes ☐ No ☐
   If yes, how long have you held this? ……

8. How often do you prescribe? Never ☐ Almost never ☐ Several times a month ☐ Once a week ☐ Several times a week ☐ Every day ☐

9. Do you have a competency which you prescribe within? Yes ☐ No ☐
   If yes, Please state what this is ……

10. What setting do you work in? (tick all that apply)
    Hospital ☐ Community ☐ Academic ☐ Lab based ☐
    Other ☐ Please State ……

Appendix 2

Semi-Structured Interview Schedule

1. Please can you tell me your job title (qualifications) and can you tell me how long you've done this job.

2. Can you describe a typical day at work? If someone had to stand in for you, what jobs/tasks would they have to do?

   Who are the main groups or individuals you interact with on a day-to-day basis?

   In what ways or forms do you interact with these groups, e.g. in decision-making about medicines use, flagged up safety issues?

   How do you justify your professional input when working with these groups, do you make reference to your expert knowledge, familiarity with the organisation, understanding of the patient?

3. Please can you describe your prescribing role?

   Process? Diagnosis?

4. Why and how did you decide whether to be a non-medical prescriber or not?

   When you first started prescribing what did it seem like, for example, what made it difficult or easy?

When you first started prescribing as a NMP did you find it easy or difficulty working with other clinical groups and patients? Verbal/written? Decision making?

How did you try to tackle this problems?

How has the role changed over time?

5. Has your job changed in any way since the introduction of pharmacist non-medical prescribing? How? For better or worse?

   Semi/open prescriptions

6. What does it mean to be a non-medical prescriber as a pharmacist? SP? IP?

7. Which other health professional groups do you interact with? What are the differences between these groups?

8. How do you work with these groups?

   How do you share/split tasks? What is your role? Locations? Logistics?

9. How is this interaction?

   Good? Bad? Please can you give examples; how is it good? How is it bad?

   To what extent and in what ways is your prescribing role seen as appropriate and legitimate by those you work with, why and in what ways?

In what ways do people ever challenge or question your prescribing role? On what grounds?

Who are the main groups you see as supporting or endorsing your prescribing role? – How do they do this?

How do you justify your prescribing role to other groups – expert knowledge, knowledge of organisation, and so on?

How do organisational or managerial processes support your prescribing role?

How do organisational or managerial processes hinder your prescribing role?

What are the risks of non-medical prescribing? How could these be tackled?

What are the benefits of non-medical prescribing? How are these brought to fruition or undermined?

Does your work place setting impact on the way that you work, the tasks that you perform?

10. Does your workplace setting impact on the way that you work with others?

11. Is the level of knowledge that someone has an indicator of their ability to do a job/perform a task?

12. Would you recommend to other pharmacists that they become prescribers?

Appendix 3

Participant Characteristics Table

This table show the participant characteristics of my interview sample. The highlighted participants (marked with *) were interviewed and observed.

Sex	Age	Qualification	Years since qualification	Job title/description	Length of time in current post	Do you have NMP qualification?	Length of time qualified as NMP	What is your prescribing Competency?	Do you use your NMP?	Setting (Hosp/Comm)
Female	5	MRPharmS	22 years	Non-medical Prescribing lead (Pharmacist)	5 years	No	N/A	N/A	N/A	Community
Female	5	MRPharmS	Over 20 years	Medicines safety lead (Pharmacist)	9 years	No	N/A	N/A	N/A	Community
Female	5	BSc RGN RM	32 years	Midwife	10 years	Yes	4 years	Midwifery and sexual health	Almost never	Hospital
Female	3	Pharmacist	15 years	Primary care pharmacist and research pharmacist	6 years	Yes	3 months	Dyspepsia	Never	PCT GP practices
Female	3	MRPharms	12 Years	Professional development manager (Pharmacist)	2 years	Yes	4 years	None - general	Never	Community
Male*	5	MRPharms	36 years	Pharmacist and store manager	7 Years	No	N/A	(Minor ailments)	N/A	Community
Female	3	MRPharms	9 Years	Locum community pharmacist	4 years	No	N/A	(Minor ailments)	N/A	Community
Female	5	RGN specialist practitioner	over 20 years	Practice nurse, Specialist practitioner		Yes	7 years	General	Every day	GP Practice

Sex	Age	Qualification	Years since qualification	Job title/description	Length of time in current post	Do you have NMP qualification?	Length of time qualified as NMP	What is your prescribing Competency?	Do you use your NMP?	Setting (Hosp/Comm)
Male	4	MRPharms	25 years	Associate director medicines management (Pharmacist)	21 years	No	N/A	N/A	N/A	Hospital
Female	4	RGN DPSN(DN)	27 years	Lecturer, non medical prescribing lead	11 years	Yes	11 years	NPC Competence nurse ???	Never	Academic
Female*	3	Pharmacist	10 Years	Paediatric Oncology Pharmacist	3 years	Yes	1 year	Paed oncology	Never	Hospital
Female	3	mpharmacy	6 years	Theatres and anaesthetic pharmacist	1 year	Yes	2 years	Acute post op pain	Never	Hospital
Male	5	BSc, MBBS, DCH, FRCP,FRCPCH	30 years	Clinical associate professor and honorary consultant paediatric neurologist	10 years	N/A	N/A	N/A	N/A	Hospital/academic
Female	4	MRPharms, PhD	27 years	Lecturer in paediatric clinical pharmacy (Pharmacist)	13 1/2 years	No	N/A	N/A	N/A	Hospital/academic
Female*	3	MRPharmS	19	Consultant respiratory pharmacist	10 years	Yes	6 years	Respiratory medicine	Several times a week	Hospital
Male	3	BSc NMP- SP	17 years	Associate professor in clinical pharmacy/ advanced pharmacy practitioner	2 years	Yes	7 years	NPC	Never	Hospital/academic
Male	3	Bpharm	12 years	Pharmacy manager (Pharmacist)	7 Years	No	N/A	N/A	N/A	Community

Sex	Age	Qualification	Years since qualification	Job title/description	Length of time in current post	Do you have NMP qualification?	Length of time qualified as NMP	What is your prescribing Competency?	Do you use your NMP?	Setting (Hosp/Comm)
Female	3	BSc Pharmacy, MRPharmS	13 years	Pharmacist	12	Yes	6.5 years	Atrial Fibrillation, Smoking Cessation	Several times a week	Community
Female	5	BSc Hons Pharmacy	26 years	Pharmacist Development and Deployment Manager	6 months	Yes	4 years	Travel health, Contraception, ED	Once a week	Community
Female	5	RGN, RM	26 years	Project lead - productive maternity	14 months	No	N/A	N/A	N/A	Hospital
Female	5	BSc		Medical Receptionist	11 months	N/A	N/A	N/A	N/A	Community
Female	3	RGN		COPD Specialist Nurse	10 months	No	N/A	N/A	N/A	GP Practice, Hospital and Community
Male	4	B Med Sci (Hons), BM, BS, DCCH, MRCGP	23 years	General Practitioner		N/A	N/A	N/A	N/A	Community
Female	5	Pharmacist	20+ years	Head of medicines safety (Pharmacist)	5 years	No	N/A	N/A	N/A	Community

Appendix 4

Question Development Table

Objectives	Issues	Question
To explore how pharmacists acquire and maintain their jurisdictional legitimacy to prescribe.	• Definition of jurisdiction? By whom? • Role of the state →Policy aims/reforms: accept/reject? • A pharmacists role? (and other Health Care Professional roles) Baseline - What they did before (already prescribe medicines) - Job role • Necessary Training, curriculum – qualification, Continuing Professional/Personal Development • Knowledge and knowledge claims, skill, expertise and practice – carrying out the task • Setting? Support / collaboration/relationships • Supplementary Prescribing/ Independent Prescribing	• Please can you tell me your job title (qualifications) and can you tell me how long you've done this job. • Please can you describe your prescribing role? • How do you justify your prescribing role to other groups – expert knowledge, knowledge of organisation, and so on. • Is the level of knowledge that someone has an indicator of their ability to do a job/perform a task?
To understand how pharmacists interact and negotiate their prescribing roles with others.	• Already prescribe? What is the difference? • Intra and inter professional relationships, divisions/competition? - Collaboration? • Competency? • Setting? Physical and finance	• Can you describe a typical day at work? If someone had to stand in for you, what jobs/tasks would they have to do? • Which other health professional groups do you interact with? What are the differences between these groups? - How do you work with these groups? How do you

	• Funding? Budget? Targets? • Communication and negotiation – access to patient records? Access to clinics? Change in job role? • Accountability? • Trust?	share/split tasks? - What is your role? Locations? Logistics • In what ways or forms do you interact with these groups, e.g. in decision-making about medicines use, flagged up safety issues? • When you first started prescribing as a NMP did you find it easy or difficulty working with other clinical groups and patients? Verbal/written? Decision making? - How did you try to tackle these problems? - How has the role changed over time? • Does your workplace setting impact on the way that you work with others? • Is the level of knowledge that someone has an indicator of their ability to do a job/perform a task?

To identify the key boundary issues/tensions for pharmacists whilst undertaking their prescribing role.	• Intra and inter professional relationships - Size (physical/organisation)/type of organisation - Independent contractors? Who pays? Financial drivers or restraints? • Time – job pressures • Support? Collaboration? Partnerships? • Access to patient records/history? • Extension of traditional role • Acceptance by patients? Patient agenda • Accountability – responsibility (responsible pharmacist)	• When you first started prescribing what did it seem like, for example, what made it difficult or easy? • When you first started prescribing as a NMP did you find it easy or difficulty working with other clinical groups and patients? Verbal/written? Decision making? • Who are the main groups or individuals you interact with on a day-to-day basis? - How is this interaction? - Good? Bad? Please can you give examples; how is it good? How is it bad • To what extent and in what ways is your prescribing role seen as appropriate and legitimate by those you work with, why and in what ways? • In what ways do people ever challenge or question your prescribing role? On what grounds? • Who are the main groups you see as supporting or endorsing your prescribing role? – How do they do this?
To explore the wider socio-cultural and organisational factors that shape prescribing and boundary work.	• What is the size and type of the organisation? ££££ • Chain? Independent? Hospital? Community? • Market dictates role as does access to patient records/history? • Hierarchy - frameworks • Social gradient – need for the service? NMP? Geography? Prevalence? Practice?	• To what extent and in what ways is your prescribing role seen as appropriate and legitimate by those you work with, why and in what ways? In what ways do people ever challenge or question your prescribing role? On what grounds? • How do organisational or managerial processes support your prescribing role? • How do organisational or managerial processes hinder your prescribing role? • What are the risks of non-medical prescribing? How could these be tackled?

To examine if the expansion of pharmacist non-medical prescribing enhance or diminish the professional status of the pharmacist.	• Already prescribe? What is the difference in accountability – patient records/history? Pharmacist status? Referral-partnership IP/SP? • Does NMP 'rules' undermine what pharmacists do? - Competency? Prescribing limitations? • Deskilling? Better use of underutilised skills?	• Has your job changed in any way since the introduction of pharmacist non-medical prescribing? - How? For better or worse? - Semi/open prescriptions • What does it mean to be a non-medical prescriber as a pharmacist? SP • What are the benefits of non-medical prescribing? How are these brought to fruition or undermined?
To explore **how** professionals respond and adapt to changes in work roles and boundaries.	• Policy change? Role change - Erosion and reformation of boundaries. • The relationship between boundary work and the professions? • Background? • Environmental/spacial?	• Why and how did you decide whether to be a non-medical prescriber or not? • When you first started prescribing as a NMP did you find it easy or difficulty working with other clinical groups and patients? Verbal/written? Decision making? - How did you try to tackle this problems? - How has the role changed over time?
To determine whether the organisational setting determines how professionals adapt to or adopt this change.	• What is the size and type of the organisation? - Independent? Multiple? Hospital? • What determines an individual's job/working practice in this setting? - Area manager/ targets/ budgets/ incentives/ motivations?	• How do organisational or managerial processes support your prescribing role? • How do organisational or managerial processes hinder your prescribing role? • Does your work place setting impact on the way that you work, the tasks that you perform? • Does your workplace setting impact on the way that you work with others?