



GPs, nurses and pharmacists as prescribers in primary care: an exploration using the social identity approach

Hausärzte/-innen, Diplomierte Pflegefachpersonen und Apotheker/-innen als Arzneimittelverschreiber/-innen: eine Exploration mit dem Ansatz der Sozialen Identität

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Abstract

The social identity approach was used to explore the inter-professional relations between nurse prescribers, pharmacist prescribers and general practitioners (GPs) in primary care in the United Kingdom. We investigated their social identities as prescribers, the influence of social structure in practice settings and the implications for further development of nurse and pharmacist prescribing. Interviews were conducted with 21 GPs, nurse prescribers and pharmacist prescribers in primary care from the south of England. Five themes emerged, including the ambiguous social identity of some nurse and pharmacist prescribers ('a no man's land'), constraining social structures ('the doctor is king'), the content of GPs' social identity ('subtle prescribing'), the content of nurse and pharmacists' social identity ('more than just competent') and context ('engaging with each other's identities'). At some GP practices, there was a willingness to engage with the different social identities and reframe them within the organisational context of a GP surgery. At these sites, where social identities were respected and supported, the social identity approach offered insight into how the resulting teamwork could lead to a shared practice identity focused on multi-disciplinary working. This research provides evidence of how professional and organisational identities can be enhanced and supported. Further, there is the potential for an intervention using the social identity approach to improve patient care.

Abstract

Die soziale Identität wurde als Ansatz verwendet, um die berufsübergreifenden Beziehungen der Arzneimittel verordnenden diplomierten Pflegefachpersonen, Apotheker/-innen und Hausärzte/-innen in der Primärversorgung im Vereinigten Königreich zu erkunden. Wir untersuchten ihre soziale Identität als Arzneimittelverordner/-innen, den Einfluss der Sozialstruktur im Praxisalltag und die Implikationen für die weitere Entwicklung der diplomierten Pflegefachpersonen und Apotheker/-innen in der Arzneimittelverschreibung. Hierzu wurden Interviews mit 21 Hausärzten/-innen, diplomierten Pflegefachpersonen und Apothekern/-innen in Südengland durchgeführt. Fünf Themen kamen hierbei zum Vorschein, einschließlich der mehrdeutigen sozialen Identität einiger diplomierter Pflegefachpersonen und Apotheker/-innen ('ein Niemandsland'), dem Zwang sozialer Strukturen ('Der Arzt ist König'), dem Inhalt der sozialen Identität der Hausärzte/-innen ('subtile Verschreibung'), dem Inhalt der sozialen Identität der Pflegefachpersonen und Apotheker/-innen ('mehr als nur kompetent') und deren Rahmen ('Auseinandersetzung mit der Identität der jeweils anderen'). In einigen Arztpraxen gab es eine Bereitschaft zur Zusammenarbeit mit den verschiedenen sozialen Identitäten und dazu, diese im organisatorischen Kontext einer Arztpraxis zu überdenken. An diesen Stellen, wo soziale Identitäten respektiert und unterstützt wurden, bot der Ansatz der sozialen Identität einen Einblick, wie die resultierende Teamarbeit zur Identität einer Gemeinschaftspraxis konzentriert auf multidisziplinärer Arbeit führen könnte. Diese Forschung liefert Anhaltspunkte dafür, wie berufliche und organisatorische Identität verbessert und unterstützt werden könnte. Darüber hinaus ist das Potenzial vorhanden, dass eine Intervention unter Verwendung des Ansatzes der sozialen Identität zur Verbesserung der Patientenversorgung beitragen kann.

Keywords

Primary care – Non-medical prescribers – prescribing – qualitative research – nurse prescriber – pharmacist prescriber – independent prescribing – social identity approach

Keywords

Primärversorgung – nicht-medizinische Arzneimittelverschreiber – Arzneimittelverschreibung – qualitative Forschung – Pflegefachperson als Verschreiber/-in – Apotheker/-in als Verschreiber/-in – unabhängige Verschreibung – Ansatz der sozialen Identität



INTRODUCTION

Over the past two decades, there has been a widespread growth in non-medical prescribing, broadly defined as the extension of the legal authority to professional groups, other than doctors, to write prescriptions. Most commonly, this includes nurses, but can also include pharmacists and allied health care professionals such as optometrists, physiotherapists, podiatrists, radiographers and chiropractors. Non-medical prescribing has been seen as one answer to rising health care challenges in Western countries, that of increasing health care costs and workload associated with a rising elderly population with increasing chronic disease and co-morbidity (Bhanbro et al., 2011; Weeks et al., 2014). The assumption is that nurse and pharmacist prescribers can engage in the on-going prescribing and monitoring of patients with chronic diseases, thereby enabling doctors to see more complex patients.

Globally, non-medical prescribing has developed unevenly across different countries, resulting in different non-medical prescribing models. There are more dependent prescribing models which allow non-medical prescribers to only prescribe those medicines in a protocol within a specific clinical area. More autonomous models also occur, such as within the United Kingdom (UK) where nurse and pharmacist prescribers can be trained to become independent prescribers and prescribe within any clinical area in which they are competent (Emmertson et al., 2005). Prior to the development of independent prescribing, there was supplementary prescribing, which is a form of delegated or dependent prescribing using a specific clinical management plan (CMP) for each patient. These CMPs were patient-specific, needed the patient's agreement and detailed the specific clinical conditions under which the nurse or pharmacist could prescribe. Later, UK legislation in 2006 allowed for nurses and pharmacists to become independent prescribers where they were able to undertake training to become the practitioner 'responsible for the assessment of patients with diagnosed or undiagnosed conditions and for the decisions about the clinical management required, including prescribing' (Department of Health, 2005). In the UK, the perceived benefits of independent prescribing by nurses and pharmacists were to improve patient care without compromising safety, improve patient access to medicines, increase patient choice in accessing medicines, make better use of the clinical skills of professionals such as pharmacists and nurses and contribute towards more flexible team working in the NHS (Department of Health, 2006). Ultimately it was hoped that non-medical prescribing would decrease the workload of general practitioners.

The advent of independent prescribing by nurses and pharmacists (with the ability to make diagnostic

decisions) has the potential to threaten the traditional dominance of medicine within health care (Weiss, 2011). Prescribing is a clear demonstration of clinical autonomy, core to professional identity and dominance of medicine (Freidson, 1970; Freidson, 1985; Willis, 2006). Indeed prior to the extension of prescribing rights to other professional groups, prescribing was the activity that demarcated the medical profession from other professional groups (Britten, 2001). With the extension of prescribing, the prized medical activity shifted from prescribing to diagnosis, such that, as noted by the editor of the *British Medical Journal*, diagnosis was just about the only activity that still defined doctors (Godlee, 2008). With the development of independent prescribing and the ability to diagnose in 2007, it was not unreasonable to speculate that medical hegemony was at last subsiding. Yet research into the practical operationalization of nurse and pharmacist prescribing has not supported any substantive threat to the medical profession's power. Weiss and Sutton (2009), drawing upon 23 qualitative interviews with supplementary pharmacist prescribers, argued that the factors that helped legitimate their role as prescribers were also those that kept them in a position subordinate to doctors. These factors included blurred definitions of prescribing, pharmacist prescribers self-limiting their prescribing practice to areas of competence and the development of prescribing into a team activity. Cooper et al. (2011) looked at the loss of prescribing as part of the GP's arsenal of skills, and how diagnosis may be used to protect the threat from non-medical prescribing. He also identified a range of 'micro-social strategies' that GPs used to accommodate prescribing by other health care professionals that also acted to maintain medical hegemony. These micro-social strategies included patients' and supplementary prescribers' perception of doctors as being hierarchically superior and doctors' denigration of most routine prescribing.

However, while medical hegemony may still pervade, this does not mean that change has not occurred, particularly in primary care. Abbott (1988) argued that occupations compete by making jurisdictional claims for areas of work. These jurisdictional claims are mediated through interactions and negotiations at a legal, public and workplace level, where contests for jurisdictional claims at the workplace level, in particular, can be extremely fluid, ingrained with potential for challenges to traditional hierarchies (Abbott, 1988). Professionals are increasingly delegating tasks to other disciplinary groups, with previously unskilled workers taking on tasks that, not long ago, were only undertaken by professionals (Charles-Jones et al 2003). The development of independent prescribing by nurses and pharmacists is part of this process involving vertical substitution, with nurse and pharmacist prescribers adopting tasks normally discharged by the medical



profession (Nancarrow & Borthwick, 2005), but also forming new hierarchies within professions. This dynamic landscape suggests that the threat to medical hegemony may be one way of understanding this process. Other theoretical perspectives might also offer valuable insights. One perspective that has been increasingly used in health care is the social identity approach (Haslam, 2014). Kreindler et al. (2012) argue that professionalization research has provided rich description of the strategies used by professional groups to increase their professional status. However, they suggest this literature focuses on groups' instrumental motivations to gain professional status (e.g. increased power and autonomy), but with less exploration of their psychological motivation to maintain a positive social identity. It is from this emphasis on the psychology of inter-group processes that the social identity approach (SIA) emerged in the 1970s. It seeks to explain how people's behaviour is structured not only by their personal sense of self, but also by their membership in social groups (Haslam, 2014). SIA comprises two theories: The social identity theory (SIT) (Tajfel & Turner, 1979) and the self-categorisation theory (SCT) (Turner et al., 1987).

SIA can be a practical tool for synthesising health workplace dynamics and identifying mechanisms for positive change. SIA explores how we see ourselves, and others, in terms of social categories, and how this affects our perceptions, attitudes and behaviour. SIA has five key dimensions (Kreindler et al., 2012): *social identity*, how people categorise themselves into an 'in' or 'out' group; *social structure*, the structural status and power dimensions within a professional setting; *identity content*, which talks of group members internalising 'group norms', which are used to guide behaviour; *strength of identification*, the concept that professionals may be members of many groups, but are generally more affiliated with some than others; and *context*, which describes how organisational structure and working practices can change the way people view each other and alter patterns of group interaction (Kreindler et al., 2012).

Haslam (2014) recently reviewed the social identity approach, discussing how previous research using SIT in social psychology can be used to inform practical applications of SIT in health. Using this approach, the role of team members is not only largely structurally determined, but the changing nature of the roles themselves shape the very structures within which they work. SIA literature suggests that successful mobilisation within the health care team will involve crafting a new identity amongst and with the team, rather than placing a ready-made model in the workplace and expecting all members to understand and accommodate these changes. Leaders of these groups become identity champions (Haslam, 2014). In health, SIA has been used to explore

inter-group conflict and how doctors use medical records to express their speciality identity (Hewett et al., 2009). While the use of the SIA in health is not new, it has yet to be applied to GP, nurse and pharmacist prescribing in primary care. This research aimed to explore the group identities of GPs, nurses and pharmacists as prescribers. In particular, we sought to describe the social identities of GPs as prescribers, nurses as prescribers and pharmacists as prescribers, as well as the extent to which these identities are expressed and accepted. In addition, we sought to use the social identity approach as a way of understanding how nurse and pharmacist prescribing could be developed in the future.

METHODS

This was a qualitative study, which was part of the Communication in Consultations (CIC) study that took place between October 2009 and September 2011. The study received NHS ethical approval and research and development permission from 36 primary care trusts (PCTs) across southern and central England and Wales. In the main CIC consultation study, over 500 consultations between patients and GPs, nurse prescribers (NPs) or pharmacist prescribers (PPs) were audio-recorded. The independent prescribers recruited to the CIC study needed to be working in primary care with NPs and PPs having obtained their qualifications post 2003. GPs, NPs and PPs were recruited with the support of local primary care research networks through newsletters, websites and e-mails. The main CIC study findings have been published elsewhere (Riley et al., 2012; Weiss et al., 2013, 2015). The qualitative study involved interviews with a sub-group of prescribers that took part in the main CIC study. There were 51 prescribers in the CIC study: 20 GPs, 19 nurse prescribers (NPs) and 12 pharmacist prescribers (PPs). From these, 21 prescribers were recruited for the interview study, seven from each of the prescriber groups.

Interviews with prescribers were conducted after the recordings for the main CIC study were completed. At the end of the main CIC study, prescribers were asked if they were interested in being interviewed and, if so, further details of the research were supplied. Written consent was obtained before setting a mutually agreed date for interview. Prescribers were purposively sampled to yield a diverse sample with respect to surgery size, geographical location, level of deprivation of the practice area, prescriber gender and prescriber age.

A topic guide was developed to explore the participant's experience of non-medical prescribing, their awareness and impact of these new roles, how these new roles have impacted upon professional status and clinical



responsibility, any benefits or concerns about the extension of prescribing and any concerns about patient safety. All prescriber interviews were conducted face-to-face and were digitally audio-recorded. Audio files were transcribed and anonymised.

Data were analysed thematically using the principles of the constant comparative technique (Green, 1998). Transcripts were first imported to NVivo and codes ('nodes' in NVivo) were created and relationships between codes were explored in the transcript narratives. Codes and sub-codes were identified by the researchers (JP, RR) within the GP and NP transcripts and explored within and across prescriber groups. These codes were grouped into clusters, which were then re-examined and refined further. Due to recruitment difficulties, the PP interviews were conducted later in the project timeframe. These interviews were analysed by MCW using the original coding frame, after completion of the project. Once this preliminary inductive analysis had been conducted, MCW explored the emerging clusters of codes and related these to the key dimensions of the SIA. These dimensions included social identity, social structure, identity content, strength of identity and context (Kreindler et al., 2012). These were then further refined with the twin aim of maintaining the integrity of issues and themes emerging directly from the data while drawing out insights, which resonated with the SIA.

RESULTS

Interviews were conducted with 21 prescribers: seven GPs, seven nurse prescribers and seven pharmacist prescribers. Three sets of GP and nurse prescribers were from the same practice (GP1 and NP3, GP25 and NP26 and GP36 and NP37). Two GPs (GP16 and GP21) had neither a nurse or pharmacist prescriber in their practice, all other GPs had experience of working with nurse or pharmacist prescribers. Interviews lasted on average 39 (GPs), 42 (NPs) and 51 (PPs) minutes. Pharmacist prescribers tended to be slightly younger (mean age = 42 years) compared with nurse (mean age = 47 years) or GP (mean age = 51 years) prescribers. The characteristics of the participating prescribers are presented in Table 1.

Data are presented under themes aligned with the SIA and include 'A no man's land' (social identity), 'the doctor is king' (social structure), 'subtle prescribing' (identity content), 'more than just competent' (identity content) and 'engaging with each other's identities' (context).

A no man's land

In primary care, nurse and pharmacist prescribing was introduced into an existing hierarchy of inter-professional

Table 1: Characteristics of Participating Prescribers

Code*	Gender	Age	Prescribing Area	Location
GP01	M	62	General Practice	Semi-rural
GP05	M	44	General Practice	Semi-rural
GP16	F	58	General Practice	Urban
GP21	F	50	General Practice	Urban
GP25	M	50	General Practice	Town & Fringe
GP35	M	53	General Practice	Semi-rural
GP36	M	42	General Practice	Rural
NP03	F	37	Minor ailments	Semi-rural
NP10	F	48	Minor ailments	Town & Fringe
NP12	F	55	Warfarin/Minor Ailments	Urban
NP24	F	43	Minor ailments	Semi-rural
NP26	F	55	Diabetes	Town & Fringe
NP30	F	38	Minor ailments + triage	Urban
NP37	F	50	Minor ailments	Rural
PP19	M	52	Hypertension	Urban
PP32	F	36	Medicines Review	Urban
PP45	M	43	Medicines Review	Urban
PP46	F	38	Blood Pressure Clinic	Sub-Urban
PP49	M	38	Hypertension	Sub-Urban
PP51	F	47	COPD	Urban
PP57	F	41	Blood Pressure Clinic	Urban

*GP = General Practitioner, NP = Nurse Prescriber, PP = Pharmacist Prescriber

relations. Although nurses have been able to prescribe since the 1990s, even in 2009, nurses and pharmacists working as prescribers were still considered to be quite 'new' roles. It was evident from the interviews that nurse and pharmacist prescribers saw themselves as different, both from their wider professional group and from other prescribers such as doctors or other nurse or pharmacist prescribers. This ambiguity of space, somewhere between a doctor and a non-prescribing nurse, meant that significant numbers of new prescribers currently found themselves in a 'no man's land'. Prescribing nurses in particular found themselves no longer part of the nursing social and working space, yet neither afforded an invitation into the social or clinical meeting space of the GPs. Many talked of their isolation from regular practice clinical meetings.

NP30: "I don't think the communication is great at all. And the GPs meet every Monday and they have a meeting, whereas I haven't had a meeting with the GPs en masse, I think, for about ... oh, it must be about 8 or 9 months... you just need to get on with it really."



The reception team too were unsure of their place, whether they should be offered the administrative support extended to GPs in the surgery, or whether nurse prescribers should organise their own administration. As noted by one nurse, even those within her own profession did not consider her part of their social group:

NP26: "I don't really have much to do with anything that the nurses do at all. Which dynamically doesn't work brilliantly, because you're not a GP and you're not a nurse".

The ambiguity of the social identity of the nurse prescriber was exemplified in the wearing of a uniform. As noted by Tellis-Nayak and Tellis-Nayak (1984), most non-prescribing nurses wear a uniform whereas doctors wear what they like. As such, clothing is a visual reminder of the power imbalance between doctors and nurses. In some surgeries, nurse prescribers are expected to continue to wear uniforms, while others asked them not to and to align themselves more with the GP prescribing team. This caused complications in team dynamics for nurses and also, to an extent, some confusion for patients.

NP30: "I think the one thing they [other nursing staff] did have a problem with is that we don't wear a uniform, and I think they thought, oh, so you think you're too good to wear a nurse's uniform. And it wasn't my choice at all not to wear a nurse's uniform; it was the GPs who felt they didn't want us to wear a uniform."

NP37: "Coming out of uniform and coming out of a treatment room and being in a consulting room like the GPs, they sort of saw that as a transition."

The uncertainty created by nurses' emerging innovative roles, between GPs and nurses as well as between different groups of nurses, has been described previously (Williams & Sibbald, 1999). The social identity of nurse prescribers was clearly distinct from their wider professional group, situated in between a non-prescribing nurse and a doctor. For pharmacist prescribers, there was a similar ambiguity, albeit for different reasons. All of the pharmacists had been (or were currently) employed by the PCT and went into individual practices with tasks associated with the PCT's agenda of, for example, rationalising drug choices (e.g. switching patients from one drug within a category to a cheaper version) or conducting PCT audits. As such, the practice was not paying for the pharmacist's time but if the pharmacist had time, they could run clinics or engage in other tasks that the practice identified. As described by one pharmacist:

PP49: "I'd like to put my name somewhere regularly along with the doctors, or on the website, so I'm there, linked in and people can see me, that I'm part of the surgery. But because I'm not strictly speaking... I'm not employed by the surgery, other than being extra, additional help occasionally....But, yeah, it kind of leaves me in a bit of no-man's land."

Pharmacists felt that not only weren't they a part of the surgery but that their prescribing was a secondary role and less secure financially:

PP46: "Nurse prescribers, quite a lot of them are employed by the practice, so they have regular funding, whereas for the pharmacist prescribers there are a couple that are employed by the practice, but most of us are employed by the PCT, so actually prescribing is a secondary role to our job, as we're actually employed to be pharmaceutical advisors and we must get all of our advisory roles done first, so that means audits and bits and pieces done, and then they said if there's any spare time and you're doing all your work then you can do your hypertension.. your clinics, but it's actually a secondary role."

For these nurse and pharmacist prescribers, neither group saw themselves as fitting in with existing practice structures. For nurses, this was about not fitting in with their wider professional group who were already employed by the practice. For pharmacists, the lack of fit within the practice was about their PCT role being external, potentially viewed as a policing role by the practice and financially insecure. In practice the prescribing role of the pharmacist was subordinate to this PCT role and a 'free' service to the practice. This was compounded by the fact that there were usually only a few (one, or possibly two) nurse or pharmacist prescribers at each surgery site so there were few other existing practice exemplars to align themselves with. As described in the next section, the extent to which this role fitted in with existing practice structures was influenced by the social structures and power relationships within each of the surgery settings.

The doctor is king

The social structures within and external to the practice in which the nurses and pharmacists worked could impose restrictions or boundaries on their role and what they could prescribe. Prescribing constraints, imposed by the practice's GP partners, conveyed a clear message of who controlled and limited their prescribing and reinforced the medically dominant professional and social hierarchy. This could create some tension around prescribing:

NP3: "That's the way it is here – nurses are nurses and GPs are GPs here. I mean, I am a patient advocate and if I felt very strongly that something wasn't relevant for them clinically...I would put the best case that I could down. But I don't really feel that I would have much to say, I don't really feel they'd listen to me perhaps in that regard, they'd be like, well, we're GPs, we're the partners here, we make the decisions and that's final really. I do feel it's a fait accompli here. But historically this is the way this place has been run for a long, long time."

This nurse prescriber contrasted her current experience with her previous role in a practice, which was forward-thinking and happy for her to take on 'new things'. Yet this lack of recognition or understanding of the nurse prescriber's role could also come from other nurses and pharmacists:

NP10: "I think there is still the doctor is king and certainly I've just had an interesting discussion with a nurse in hospital who didn't think I should be referring... it wasn't a prescribing decision, but nonetheless it's that kind of, 'well, you can't do that, that's a doctor type role'. And I think there will always be that."

NP26: "I've actually had a pharmacist ring me up and tell me that I've signed a doctor's prescription, that's in the last 3 months. So it's educating everybody, isn't it, to understand."

The doctors' and patients' views of the nurse prescribers, frequently drew upon traditional nursing stereotypes of being more caring, task focused and less formal:

NP12: "What do nurses do? They talk to patients, they listen to patients, they're more hands-on, they're probably working more at the same level that the patient is, they're maybe not using such medical language there, more approachable."

These nursing stereotypes could then be used to increase patient throughput to nurse prescribers:

NP3: "I don't think patients are afraid to come and see a nurse, they always say, 'oh, I didn't want to waste the GP's time' is a classic, because they feel that a lot of GPs perhaps make them feel like they're wasting their time with a mundane illness, where they want reassurance."

While a reliance on approachability may help facilitate access and through this, patients' recognition of the

nurse prescriber role, it could also reinforce traditional nursing stereotypes associated with caring and low status (McDonald, Campbell & Lester, 2009, Dingwall & Allen, 2001). This could lead to patients' perceptions of different 'kinds' of prescribers, with nurses at a lower level than prescribing GPs.

Subtle prescribing

According to Tajfel and Turner (1979), one of the ways in which unequal status groups operate when wishing to either increase or decrease the magnitude of status difference is through social creativity, by creating new group ideologies. Weiss (2011) suggested that doctors have tried to emphasise the uniqueness of their own role as diagnostician (as opposed to prescriber). However, this unique role in diagnosis has become more tenuous (Weiss, 2011) as the new independent prescribers are also able to diagnose the patient's condition. For this reason, a more nuanced role for GPs as diagnosticians and prescribers needed to be developed. GPs, as a prescribing group, are then left to try to carve out a particular prescribing identity, distinct from the other prescribers. This identity sees GP prescribers as risk takers and as having a particularly intuitive ability to put their finger on what is wrong with a patient:

GP21: "What GPs are very good at is taking risk, assessing risk, I think. Nurses seem to be trained more to...follow protocols and guidelines, and if something doesn't fit within those then to seek further advice".

GP01: "I think that's the danger of other people doing it [prescribing], is they don't appreciate actually in general practice prescribing for chronic disease especially is very subtle and often takes many months or years to get right for that patient."

GP5: "Because, as we always say, yes, nurses can do 90% of our work, the trouble is you only know which 90% [until] after you've done the work."

This GP later goes on to give an example of the particular expertise a doctor has:

GP5: "I mean, this is a good example and I mention it because I'm still very pleased with myself for spotting this menopausal patients' hot flushes were not menopausal hot flushes. And I don't know how I knew that they weren't but I thought, hang on, what else is going on here? She had a rare kind of tumour, in fact."

Through this emphasis on the subtleties and indeterminacy of prescribing that could not be reduced to a protocol or



other more formulaic forms of learning, GPs as prescribers were seeking to define their group in a way which was positive, distinctive and enduring (Haslam, 2014). This identity, with its focus on abstraction and more challenging intellectual skills, was also clearly viewed as being superior to nurses' and pharmacists' prescribing role. Combined with the social structures within the GP surgery setting that reinforced the hegemony of medicine, this sense of a superior group prescribing ideology could be used as a rationale to restrict and oppress other prescribing groups:

GP21: "We probably weren't prepared to remunerate her [nurse prescriber] as much as she thought she should be, because partly in our eyes she wasn't going to be doing that much extra that she wasn't doing before."

Equally, if GP prescribers felt this identity was being undermined, they would lament the introduction of nurse and pharmacist prescribing as encroaching on their prescribing territory:

GP01: "I'd ask the question why. Why? I mean if you want to be a doctor, be a doctor, if you want to be a nurse, be a nurse, but if you're a nurse you can't do nice bits of doctoring that you feel... I find it odd that other professions want to grab bits of medicine that's out.. with their own training. I don't want to go and start doing nurse duties and I don't want to start doing pharmacist duties particularly. So why blur the edges all the time?"

More than just competent

Competence is the cornerstone of nurse and pharmacist prescribing in the UK. Although core competencies for nurse and pharmacist prescribers were originally devised by the National Prescribing Centre (now part of the National Institute for Health & Care Excellence), prescribing competence is now part of medical training as well (Maxwell & Whalley, 2003; Mucklow, Bollington & Maxwell, 2011). However, while these initiatives describe the generic core competencies to become safe and effective prescribers, the term 'competence' was used by our nurse and pharmacist prescribers to describe the clinical areas in which they felt they had the clinical knowledge and confidence to prescribe. As articulated below, identifying the clinical areas in which a new prescriber is competent and limiting your practice to these areas has become a core professional ideal for new prescribers (Weiss & Sutton, 2009):

NP10: "I'm comfortable in what I do, I'm professional in what I do, I don't go beyond my boundaries".

NP12: "The bottom line for all of us non-medical prescribers, if it's something that's out of your area of knowledge and skills, then you have to not go there and refer on".


NP26: "I think for anybody, it's about prescribing within your competence. I'd never step outside".

These prescribers described what they do as having a high level of knowledge and skills but within circumscribed areas of practice. However, this is not the only accepted meaning of the word competence. On the one hand, it can mean doing something to the level of the bare minimum, although it can also be defined as embracing all that is required in terms of knowledge and understanding, because anything less is not competent (Lum, 1999). Pharmacists' and nurses' definitions appear to encompass the latter meaning although by defining themselves in terms of competence, because of its multiple meanings, they risked making it sound as if their prescribing was at a lower level to doctors'. This is in conjunction with their competence being limited to one or two specific areas of practice. Yet there were other new prescribers, having started with one particular clinical area, expanded beyond this to multiple areas of competence:

PP45: "Most of my colleagues have stuck with their original prescribing competence. I reacted to questions that were being asked – could you do X? So I thought, well, could I do X? And I've then made myself competent in that particular area."

PP51: "I do know where my competencies are and where my weaknesses are, and I don't sort of go beyond my scope of practice. But I have learnt over the years... extending my scope of practice as I felt more confident, and then went and sort of commissioned training or shadowed somebody, just so that I can improve my competencies and take on more of the long-term conditions and manage them in general practice."

Nurse and pharmacist prescribers have defined their social identity in terms of competence but have sought to cast this in terms of having a high level of knowledge and skills in one or more circumscribed areas of practice. While this attribute may constrain what they are able to do and have some negative connotations of doing something at a minimal level, these representations went far beyond this to a highly skilled and valued aspect of nurse and pharmacist prescribers' group identity. Indeed, the transformation of competence into a professional virtue is part of an ideology, which reaffirms their own positive distinctiveness and the group's social worth



(Kreindler et al., 2012). It can also be seen as an example of social creativity where nurse and pharmacist prescribers, as the lower status group, seek to enhance their standing without challenging the higher status group of GP prescribers (Haslam, Reicher & Reynolds, 2012).

Engaging with each other's identities

GP prescribers' identity was focused on their role as subtle prescribers, with an intuitive ability to put their finger on causes of more opaque patient presentations. Nurse and pharmacist prescribers saw their identity as one of a knowledgeable, skilled professional whose expertise was in particular clinical areas of practice. There were situations where an appreciation of each other's identities did appear to be acknowledged by the other professional group:

GP16: "Our nurses are extremely skilled at COPD, asthma, diabetes... they lead on healing skin, and we take their advice. So they are, I think, dealing with a smaller field but pretty knowledgeable and skilled."

It was not only that the skills of each other's professional groups were acknowledged but they supported each other and functioned better as a team:

NP26: "There are times when I know what I need to do, but it's slightly more complex, so I will say to the patient do you mind if I just go and get some advice? Or if I've just passed a colleague and I'll go and get some advice. And I think it's really important to function in this way".

PP19: "The thing that GPs are really good at is they're almost like a blind consultation where they've got no idea what's going to walk through the door..."

PP32: "And for the practice and the doctors, they've got a good skill mix, so everyone's got their slightly different areas of expertise and I think that works really well. So quite often the doctors will still ring me and say – or pop in and say – what do you recommend for this, what are we supposed to be prescribing for this?"

The data reinforced a key insight from Turner's self-categorisation theory: "it is through our self-definitions as group members that social influence occurs and that social belief systems shape what we think, what we care about and what we do" (Haslam, Reicher & Reynolds, 2012; p202). The context, in this case a mutually supportive and respectful working environment, can lead to enhanced levels of interactions between groups. The

creation of a multidisciplinary team is in itself a context change (Kreindler et al., 2012). This is relevant not only between traditional prescribers and new prescribers, but also between the new prescribing groups themselves:

PP32: "In some surgeries generally the nursing team can feel a bit threatened by having pharmacist prescribers, because it's quite a new thing still. It's about identifying our different areas of expertise and actually working together."

As noted by Haslam et al. (2012), the power of groups is unlocked by working with social identities, not across or against them. This was evident in the way some practices were able to describe how the team worked together within the practice:

GP36: "We now view our nurse prescriber in with doctor workload, so if we have a nurse prescriber on leave, we replace her with a locum GP. So there's been really a switch over to functioning as more akin to a GP than to a traditional nurse."

GP35: "It's just like having another partner who can deal with certain conditions, and who also works as a nurse within the practice".

NP3: "It's working together. So a GP might traditionally see a patient with diabetes twice a year... and the nurse could actually see the patient one of those times. ...So hopefully the patient had a very good, broad package of care..."

Hinted at in the third quote above is the potential for different social identities to work together to benefit patient outcomes. In his review, Haslam (2014) suggested that if we wish to reap the benefits of social identity theory, it is not just respectful engagement with social identities that makes a difference but that these groups can become a vehicle for improvement in patients' lives. Productive interaction within groups who each have a distinct social identity can be mobilised at an organisational level to develop a shared working understanding of the organisation, which is itself reconstructed by the social identities within it (Haslam, Eggins & Reynolds, 2003). A sense of this dynamic process, the willingness to engage with different social identities and reframe these within the organisational context of a GP surgery, is conveyed by this pharmacist prescriber:

PP51: "From the day I came here in 2004 to now, I've had nothing but support. They created a consulting room for me, put all the systems in place, the diagnostics, even putting notices in the notice-



board for the first year or two so the patients were aware. And the staff were all made aware of it, we have practice meetings, the practice nurse was consulted.....And since then the reception staff see me as an incredible source of support.....the repeat prescribing person uses me as her mentor; her support. The data quality people, they come to me.... because it goes two ways – they're accepting me, I'm giving it to them.....We have regular clinical meetings as a practice – myself, the GPs and the nurse. And then we also have multidisciplinary meetings every 6–8 weeks with matrons, district nurses, palliative care“.

Respect and recognition for each other's social identities and supporting each other through teamwork appeared to be the route towards forming a shared practice identity oriented towards multi-disciplinary patient care. While this study did not explore the relationship between patient outcomes and organisation of care within the different practice settings, other intervention research using a social identity approach has demonstrated a link between group membership and well-being (Haslam et al., 2008, 2010; Cruwys et al., 2013). This suggests that SIA could be a powerful tool for understanding the link between practice identity, organisation of care and patient outcomes.


DISCUSSION

This research applied the social identity approach to the novel area of non-medical prescribing in primary care. It was a useful tool to inform findings from GP, nurse and pharmacist prescriber interviews regarding their perceptions of professional identity and group working in the primary care setting. In addition to describing the social structures that impacted on these roles, how particular individuals described themselves and their professional group enabled different professional group identities to be hypothesised. Further, the social identity approach offered an explanation for why there were cases where these professional groups were able to come together to form a positive organisational group identity at the practice level. This was through recognition and respect for each other's social identities, where support and teamwork enabled the development of a shared practice identity focused on multi-disciplinary patient care.

Our findings similarly emphasise the dynamic nature of SIA where a change in the context (nurse and pharmacist prescribing) provokes a change in the different prescribers' identities, which in turn enables further context change (greater multi-disciplinary working). This cyclical phenomenon has been observed by Kreindler et al. (2012) who states that “*mobilisation of shared identities can facilitate the adoption of concrete changes,*

while changes in working arrangements can stimulate the re-shaping and re-interpretation of social identities” (Kreindler et al., 2012, p. 365). Our work provides some evidence of this iterative relationship between context and identity.

Indeed, both the ‘subtle prescribing’ and ‘more than just competent’ themes also underscore the interactive, cyclical and dynamic nature of SIA. While both are described here as part of the identity content dimension, they could also be seen as part of the social structure. The social creativity of GPs, nurse and pharmacist prescribers to create new identity content for themselves can be seen to fit with the existing literature on the professionalising strategies that GPs, nurses and pharmacist undertake to enhance their professional status (Nancarrow & Borthwick, 2005), and part of SIA's social structure dimension. However, these findings also suggest that social creativity is being used to form new inter-group relationships. Identity content influences social structure, which then influences and reinforces further changes in identity content through greater inter-group working. Previous research has found that, in those settings where different health care professionals worked well together and had reciprocally respected social identities, there was greater teamwork and role satisfaction. De Moura et al. (2009) used the social identity theory to explore the relationship between organisational identification and job turnover, finding that organisational identification offered a strong motivator towards decreasing turnover intention. Further work has suggested a link between teamwork and better patient care, even in situations of high workload. These researchers found that the relationship between increased workload and better quality patient care was moderated by teamwork, as measured by relational climate (Mohr et al., 2013). Higher workload was associated with lower quality of care when there was lower relational climate, but with better quality of care when there was higher relational climate. Further evidence comes from a study involving 991 Medicare beneficiaries. These authors found that patients of those organisations with higher levels of team commitment, as measured by perceived task delegation, role collaboration, patient orientation and team ownership, had better physical and emotional health at two years following baseline assessment than patients in lower functioning organisations (Roblin et al., 2011). These studies draw attention to the importance of organisational features noted in our research such as role collaboration and teamwork. This suggests that in the organisations that we observed where differing social identities were respected and supported, a positive organisational identity in terms of multi-disciplinary working may also be more likely to provide better patient care than those practices where traditional hierarchies and rigid professional boundaries predominated.



However, Finn et al. (2010) discuss how the very ambiguity of the word ‘teamwork’ enables sufficient space for different groups to co-opt it in the service of their own professional interests. Relating back to Haslam (2014), if the political superordinate identity of teamwork is imposed instead of exposing and engaging identity fault lines, then the potential for a positive organisational identity to emerge will fail. A strategy of social identity suppression ‘*will fail to capitalise on the inherent potential for identity based difference to be a basis for productive higher-order integration and creativity*’ (Haslam, 2014, p. 10). Similarly, others have suggested that, if the government wishes to support the development of new roles, they need to take account of the group identity focusing on the individual as a prototypical member of a social category and their professional identity (Currie et al., 2010).

Indeed, Haslam et al. have used the social identity approach to develop a model to enable employees to identify and mobilise both personal and shared group identity resources to improve organisational outcomes (Haslam, Eggins & Reynolds, 2003). Haslam’s model, Aspire (Actualising Social and Personal Identify Resources) is a four-stage model that involves identifying the social identities of employees (e.g. those self-categorisations that are perceived to be most relevant for them to be able to do their work) and relating these identities to an organisational sub-group’s and the broader organisation’s goals. This is followed by a stage in which this information is used towards an organisation’s planning and goal setting. As noted by Kreindler, social identities can not only be used to resist change but also cope with change and achieve it (Kreindler et al., 2012). While the participants in this study have not gone through an ‘Aspire’ process, in those sites where there was greater acceptance of new roles and better teamwork, the social identities of the different groups concerned did appear to be taken into account and moved towards a broader group or practice identity. Equally, in contrast to the ‘Aspire’ model, our participants started with a context change (the introduction of nurse and pharmacist prescribing) instead of identity mobilisation. It may be that the level of context change in our study was at a sufficiently minimal level to provoke a modest level of identity reconstruction, without causing too much identity threat (although some identity threat was observed). Interventions that are delivered in groups that heighten the group’s social identity have been shown to offer patient benefit (Haslam et al., 2010). Future interventions using social identity models, which

enable different prescriber groups to recognise the social identities of others, could be developed to increase the acceptance of new roles, facilitate better teamwork and ultimately, improve patient care.

Study limitations

The data considered in this paper comprises 21 prescribers in the south of England and so may not be generalizable within or across these prescribing groups. The sample was also taken from prescribers who had volunteered to participate in a communication study and therefore may be biased by being more aware of communication issues within their practice or more innovative in their approach to patient care.

CONCLUSION

The social identity approach provides a useful vehicle for understanding the social identities of GPs as prescribers, nurse prescribers and pharmacist prescribers. It has also examined how social structures, such as uniforms, meeting attendance and use of working space may affect social identity expression. Further, where social identities were respected and supported, the social identity approach offered insight into how the resulting teamwork could lead to a shared practice identity oriented towards multi-disciplinary working to facilitate patient care. Future work should focus on developing and evaluating social identity approach interventions, which enable identity based differences between professional groups to be the basis for productive higher-order integration and creativity. This may also further elaborate the dynamic and cyclical nature of the different dimensions of the social identity approach where context, social structure and identity iteratively influence, inform and reinforce each other. These, in turn, can be used to construct positive, shared practice based identities, which, ultimately, may be associated with improved patient care.

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