

PHARMACISTS' PERCEPTIONS OF
THE NATURE OF PHARMACY
PRACTICE

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ABSTRACT

The pharmacy profession is formed of different sectors. The two main ones are community and hospital pharmacists. Sociologists have examined if community pharmacists are a profession or not as a result of their marginalised role in healthcare and links with commerce. Few sociological studies have included hospital pharmacists. This study engaged with the theories from the sociology of the professions such as the neo-Weberian social closure perspective, professions as an interrelated system and Foucault's concept of knowledge and power to explore the nature of pharmacy practice in healthcare in England, United Kingdom. Its purpose was to reveal new insights into pharmacists' perceptions of the nature of pharmacy practice linking this to their status in society.

This qualitative collective case study consisted of four cases studies. Each case study included five pharmacists from community pharmacy, acute hospital, mental health or community health services, respectively. A total of twenty pharmacists were included. Only pharmacists registered for 5 years or more, who had worked in the relevant healthcare setting for at least 2 years and provided written consent were entered. Data were obtained from one in-depth individual semi-structured interview using a guide covering how they viewed their practice, contributions made to healthcare, their future and how others viewed pharmacists. Each pharmacist was asked to complete a diary for 5 days to include any positive contributions or frustrations experienced. The data for each case were analysed using inductive thematic analysis followed by a cross-case analysis. Five themes were identified; (i) the hidden healthcare profession, (ii) important relationships, (iii) pharmaceutical surveillance, (iv) re-professionalisation strategies and (v) two different professions.

The core function defining the pharmacy profession is pharmaceutical surveillance, shifting the sociological understanding of pharmacists' practice away from dispensing. There is an internal split between community pharmacists and pharmacists in other healthcare settings due to differences in practice, re-professionalisation strategies and relationships with doctors including lacking ideological professional solidarity. Pharmacists are not recognised as healthcare professionals by the public but as 'typical community pharmacists' with an image as shopkeepers. Pharmacists interpret professionalism as a controlling rather than an enabling ideology. The status of pharmacists in society today remains unclear.

DECLARATION

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed:

Dated:

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CONTENT:	
ABSTRACT	3
DECLARATION	5
ACKNOWLEDGEMENTS	7
ABBREVIATIONS	15
CHAPTER ONE: Introduction	17
1.1 The pharmacy profession: Setting the scene.....	18
1.2 Societal purpose and responsibilities of the pharmacy profession.....	19
1.3 The socio-political and economic context.....	21
1.4 The international context of pharmacy.....	23
1.5 The research question.....	25
1.6 Organisation of the thesis.....	26
CHAPTER TWO: The sociology of the professions and pharmacy	29
2.1 Introduction.....	29
2.2 Approach for reviewing the literature.....	30
2.3 Theories from the sociology of the professions.....	31
2.3.1 Functionalism and trait approach.....	32
2.3.2 The 'power approach'.....	35
2.3.2.1 Power and knowledge.....	40
2.3.3 Professions as an inter-related system.....	40
2.3.4 Professional status.....	43
2.3.5 Professionalism as a discourse.....	44
2.3.6 Defining professions.....	47
2.3.7 Professional regulation.....	49
2.3.8 Professionalisation as dynamic processes.....	52
2.3.9 Working theories on sociology of the professions.....	55
2.4 Sociological examination of the pharmacy profession.....	57
2.4.1 The nature of pharmacy practice and professional status.....	58
2.4.2 Medical hegemony and jurisdictional uncertainties.....	61
2.4.3 Internal divisions.....	64
2.4.4 Dispensing and information-giving	65
2.4.5 Surveillance, discipline and 'pastoral power'.....	67

2.5	Research question and study aims.....	68
2.6	Summary.....	72
CHAPTER THREE: The case of the pharmacy profession in England....		75
3.1	Introduction.....	75
3.2	Historical development of the pharmacy profession.....	75
3.2.1	“Chemists and druggists” versus apothecaries.....	75
3.2.2	The Pharmaceutical Society.....	78
3.2.3	The introduction of the welfare state and the NHS.....	81
3.2.4	Hospital pharmacy.....	81
3.2.5	Education and training.....	83
3.2.6	What’s in a title?.....	85
3.2.7	Gender.....	85
3.2.8	Code of ethics and independent regulator.....	86
3.3	Sources of status for the pharmacy profession today.....	88
3.3.1	Intra-professional divisions.....	88
3.3.2	The nature of pharmacy practice.....	89
3.3.2.1	Education as a re-professionalisation strategy.....	94
3.3.2.2	Community pharmacy and commercialism.....	94
3.3.2.3	Prescribing.....	96
3.3.2.4	Pharmacists’ mind-set.....	99
3.3.3	Professional relationships.....	100
3.3.3.1	Patients and customers.....	100
3.3.3.2	Doctors and other healthcare professionals.....	102
3.3.3.3	Pharmacy technicians.....	104
3.3.4	Professional power.....	106
3.3.4.1	Political autonomy.....	106
3.3.4.2	Economic autonomy.....	108
3.3.4.3	Clinical autonomy.....	110
3.4	Summary.....	114
CHAPTER FOUR Methodology and methods.....		117
4.1	Introduction.....	117
4.2	Rationale for a qualitative research design.....	118

4.3	Researcher role and position.....	120
4.3.1	Researcher paradigm.....	120
4.3.2	Sociological theories and paradigmatic divides.....	128
4.3.3	Methodologies considered.....	129
4.4	Collective case study design.....	134
4.5	Rationale for using collective case study methodology.....	137
4.6	Limitations of case study research.....	143
4.7	Participants.....	144
4.7.1	The research sample.....	144
4.7.2	Entry criteria.....	145
4.7.3	Recruitment of participants.....	146
4.8	Research ethics and governance.....	147
4.9	Data collection methods.....	151
4.9.1	Semi-structured interview guide.....	153
4.9.2	The interview.....	154
4.9.3	Transcribing.....	156
4.9.4	Diary.....	157
4.10	Data analysis method.....	158
4.10.1	With-in case analysis.....	159
4.10.2	Cross-case analysis.....	162
4.10.3	Moving from data to theme.....	163
4.11	Rigour and quality.....	172
4.12	Summary.....	175
CHAPTER FIVE	Findings.....	177
5.1	Introduction.....	177
5.2	Theme one: The hidden healthcare profession.....	178
5.2.1	Sub-theme: Lacking visibility.....	178
5.2.2	Sub-theme: The unrecognised healthcare professional.....	181
5.2.3	Sub-theme: Delivering healthcare in a shop.....	184
5.3	Theme two: Important relationships.....	187
5.3.1	Sub-theme: Working with doctors.....	188
5.3.2	Sub-theme: Helping patients.....	194
5.4	Theme three: Pharmaceutical surveillance.....	196

5.4.1	Sub-theme: Surveillance of healthcare professionals.....	197
5.4.2	Sub-theme: The medicines police.....	204
5.4.3	Sub-theme: Influencing patients' behaviour.....	206
5.5	Theme four: Re-professionalisation strategies.....	208
5.5.1	Sub-theme: Professionalism.....	208
5.5.2	Sub-theme: Delegation, education and supporting.....	213
5.5.3	Sub-theme: Competing with nurses for new jurisdictions.....	220
5.6	Theme five: Two different professions.....	222
5.6.1	Sub-theme one: Community pharmacists as dispensers.....	223
5.6.2	Sub-theme: Reduced mobility between healthcare settings...	226
5.6.3	Sub-theme: No collaboration across healthcare settings.....	229
5.6.4	Sub-theme: Clinical versus dispensing pharmacists.....	231
5.7	Summary.....	233
CHAPTER SIX	Discussion.....	237
6.1	Introduction.....	237
6.2	The core function that defines pharmacy.....	240
6.2.1	Medicines and medicines-use as social objects	240
6.2.2	Pharmaceutical surveillance.....	242
6.2.3	Cognitive pharmaceutical services	246
6.2.4	Encroachment, delegation or a new jurisdiction.....	250
6.2.5	Pharmacy interventions.....	252
6.3	Images of pharmacists.....	253
6.3.1	Shopkeepers and sticking labels on boxes.....	254
6.3.2	The 'medicines police'.....	256
6.3.3	Pharmacy practice – myths versus reality.....	256
6.3.4	Acting as healthcare professionals.....	259
6.4	Pharmacists identity – who are they?.....	260
6.4.1	Medicines experts.....	261
6.4.2	A weak collective professional identity.....	263
6.5	Professionalism and pharmacists.....	264
6.5.1	Professionalism in pharmacy practice.....	264
6.5.2	Registered healthcare professionals.....	265
6.5.3	Professionalism and commercialism.....	267

6.6	Inter-professional relationships.....	269
6.6.1	Dependency on doctors.....	270
6.6.2	Nurses – friend or foe?.....	276
6.6.3	Pharmacy technicians - a help or hindrance?.....	278
6.7	Intra-professional tensions.....	279
6.7.1	Internal divisions or a split?.....	279
6.7.2	Limited socialisation.....	280
6.7.3	Diversification – strength or weakness?.....	282
6.7.4	Unified or multiple voices.....	284
6.8	Summary.....	286
 CHAPTER SEVEN Reflexivity and reflection.....		289
7.1	Introduction.....	289
7.2	Reflexivity and reflection.....	289
7.2.1	Qualitative research approach.....	290
7.2.2	Engaging with the sociology of the professions.....	291
7.2.3	Research question.....	292
7.2.4	Interviewing fellow professionals.....	293
7.2.5	Analysing and making sense of the data.....	294
7.2.6	Writing style.....	296
7.2.7	Doing research whilst working.....	297
7.2.8	Sense checking the findings.....	298
7.3	Research strengths and limitations.....	298
7.4	Further developments of pharmacy in England.....	302
7.5	Summary.....	303
 CHAPTER EIGHT Conclusion.....		305
8.1	Introduction.....	305
8.2	Sociological perspectives of the pharmacy profession.....	306
8.2.1	The core function of pharmaceutical surveillance.....	307
8.2.2	Subordination increases autonomy.....	309
8.2.3	Internal split.....	310
8.2.4	Healthcare professionals or shopkeepers.....	313
8.3.5	Professionalism as an enabling ideology.....	314

8.3	Policy implications for the pharmacy profession.....	316
8.4	Implications for the sociology of the professions.....	317
8.5	Recommendations for future research.....	319
8.6	Dissemination of the findings.....	321
8.7	Concluding remarks.....	321
REFERENCES.....		323
 APPENDICIES		
Appendix 1	Literature search.....	355
Appendix 2	Background information: Four healthcare settings.....	359
Appendix 3	Study information sheet.....	363
Appendix 4	Consent form.....	368
Appendix 5	Interview outline.....	370
Appendix 6	Semi-structured interview guide.....	371
Appendix 7	Five Working Day Reflective Diary.....	374
Appendix 8	Ethics and governance approval.....	382
Appendix 9	Basic information about study participants.....	388
 Lists of tables:		
Table 1	Summary of the collective case study including the four separate case studies.....	136
Table 2	Summary of data collection.....	151
Table 3	Themes and sub-themes.....	177
 Lists of figures:		
Figure 1	Dynamic model of professionalisation.....	55
Figure 2	Ontology, epistemology and methods (Adapted from Hay (2002).....	121
Figure 3	Researcher paradigm continuum.....	128
Figure 4	Case study boundaries (Based on Miles and Huberman, 1994, p. 25.).....	138

ABBREVIATIONS

AfC	Agenda for Change
AHP	Allied Healthcare Professionals
AIMp	Association of Independent Multiple Pharmacies
APTUK	Association of Pharmacy Technicians United Kingdom
BDA	British Dental Association
BMA	British Medical Association
CCA	Company Chemists' Association
CCG	Clinical Commissioning Groups
CHSP	Community Health Services Pharmacists
CMHP	College of Mental Health Pharmacy
CPPE	Centre for Pharmacy Postgraduate Education
CoP	Community of Practice
CP	Community Pharmacist
CWR	Collaborative Working Relationships
DH	Department of Health (England)
DMP	Designated Medical Prescriber
EHC	Emergency Hormonal Contraception
IPA	Interpretative Phenomenological Analysis
IPF	International Pharmaceutical Federation
GMC	General Medical Council
GP	General Medical Practitioner
GPhC	General Pharmaceutical Council
GSL	General Sale list
HEFCE	Higher Education Funding Council for England
HP	Hospital Pharmacist
MEP	Medicines, Ethics and Practice. The professional guide for pharmacists
MDT	Multidisciplinary team
MHP	Mental Health Pharmacist
MUR	Medicines Use Review
NHS	National Health Service
NICE	The National Institute for Health and Care Excellence
NMS	New Medicines Service
NPA	National Pharmacy Association

NPSA	National Patient Safety Agency
NVQ	National Vocational Qualification
OTC	Over-the-counter medicines
PCCPN	Primary and Community Care Pharmacy Network
PCT	Primary Care Trust
PDA	Pharmacists' Defence Association
POM	Prescription-only medicine
PSA	Professional Standards Authority
PSNC	Pharmaceutical Services Negotiating Committee
RCN	Royal College of Nursing
RPS	Royal Pharmaceutical Society
RPSGB	Royal Pharmaceutical Society of Great Britain
SCR	Summary Care Records
UKCPA	United Kingdom Clinical Pharmacy Association
UK	United Kingdom
USA	United States of America
WHO	World Health Organisation

CHAPTER ONE: Introduction

This study aimed to address the research question: *How do pharmacists working in different healthcare settings perceive their status in society today?* in relation to the pharmacy profession in England, United Kingdom (UK).

In line with other healthcare professionals, the pharmacy profession has strived to gain similar status to that enjoyed by the medical profession (Freidson,1970). There have been discussions in the sociology literature since the 1960s to the present day about pharmacists' status, although examination of the pharmacy profession has been largely neglected by sociologists (Mesler, 1991; Dingwall and Wilson,1995; Bissell and Traulsen, 2005; Broom et al, 2015). The majority of studies have centred on community pharmacists' status mainly with reference to various traits or attributes applied as a way of determining if pharmacy is a profession or an occupation (Denzin and Mettlin, 1968; McDonald et al., 2010; Harding and Taylor, 2015). In contrast, Dingwall and Wilson (1995) maintain that it is more important to examine the "every day work of pharmacists" (p.117) including exploring this in the context of "the distinctive work settings of retail and hospital pharmacy" (p.112).

These sociology studies show that pharmacists have a marginalised social role within healthcare (Denzin and Mettlin, 1968; Harding and Taylor, 1997; Edmunds and Calnan, 2001; McDonald et al, 2010). Limited sociology research has been carried out on the pharmacy profession and little is known about how pharmacists themselves perceive their pharmacy practice in healthcare (Dingwall and Wilson, 1995). Most studies have focused on community pharmacists and hardly any have included hospital pharmacists (Dingwall and Wilson, 1995; McDonald et al, 2010; Petrakaki, Barber and Waring, 2012; Broom et al, 2015). To bridge this gap this study engaged with the theories of the sociology of the professions to explore the pharmacy profession in England to increase the explanatory capacity of this study. This study drew on existing sociology literature examining the pharmacy profession, whereas literature pertaining to the sociological examination of other professions was only included where this helped to shed further light on the pharmacy profession. The purpose was to reveal new insights into pharmacists' perceptions of the nature of pharmacy practice linking this to their status in society today.

The literature or national policy documents often contain references to the generic 'pharmacy profession' or 'pharmacy', which may denote pharmacists, pharmacy technicians and other pharmacy ancillary staff. In this study these terms only refer to pharmacists. If pharmacy technicians are included this is made explicit.

1.1 The pharmacy profession: Setting the scene

In the UK, the undergraduate degree for pharmacists is currently a 4-year Master of Pharmacy degree followed by a pre-registration year of training in practice after which candidates sit a registration examination set by the General Pharmaceutical Council (GPhC), which is the statutory body for pharmacists and pharmacy technicians.

The pharmacy workforce in England consists of pharmacists and pharmacy technicians who must also be registered with the GPhC together with unregistered support staff such as dispensers and pharmacy assistants.

In 2011 a total of 46,310 (37,887 in England) practising pharmacists were registered with the GPhC (Hassell, 2012). There are two main sectors in pharmacy: community and hospital. According to a GPhC registrant survey undertaken in 2013, 72% of registered pharmacists work in community pharmacy and 23% in hospital pharmacy (GPhC, 2014). The remainder work in other healthcare settings, academia and the pharmaceutical industry. This GPhC survey showed that the majority of registered pharmacists were employed with a small proportion (8%) being business owners (GPhC, 2014). In 2012 a total of 21,361 (17,772 in England) pharmacy technicians were registered with the GPhC (Seston and Hassell, 2012). Pharmacy technicians constitute just under a third of all registrants on the GPhC register.

Community pharmacy is often referred to as 'retail' pharmacy or the 'chemist shop' situated on the high street, in supermarkets or health centres. In England these are privately owned businesses, ranging from single shops or small local chains run by a single pharmacist owner or partnerships, or by small or large multiples such as supermarkets, which are owned or corporately managed. A multiple chain is defined as six or more stores (Sukkar, 2016a). In 2016 there were more than 14,000 community pharmacies in Great Britain with 61.6 % of these being large multiples (owning 100 or more pharmacies) and small multiples (owning between

6 to 99 pharmacies); the remainder 38.4% being independents (owning between 1 to 5 pharmacies) (Sukkar, 2016a).

Community pharmacy in England is contracted by the National Health Service (NHS) and funded from the public purse to provide pharmaceutical services. In England these services consist of essential, advanced and locally advanced services. The essential services include, for example dispensing NHS prescriptions, repeat dispensing services and disposal of unwanted medicines (PSNC, 2017a). There are four advanced services that community pharmacies can provide and receive remuneration for: the Medicines Use Reviews (MURs) service, which is aimed at helping patients to get the best out of their medicines, the New Medicines Service (NMS) where pharmacists help support patients using their new medicines most effectively, appliance use reviews and stoma appliance customisation (PSNC, 2017b). Locally advanced services can include supplying emergency hormonal contraception, 'stop smoking' schemes, supervised administration of methadone and minor ailment schemes. Pharmacies can also sign up to become a 'Healthy Living Pharmacy', delivering public health messages and services (PSNC, 2017c).

Hospital pharmacists are also involved in dispensing medicines from the hospital dispensary. They see patients on the wards to check their medicines. They have access to patients' medical notes and laboratory tests. They are co-located with doctors and nurses and work in multi-disciplinary teams attending consultant-led ward rounds (Child, Cooke and Hey, 2011).

There have been national developments aimed at establishing pharmacists in a clinical role as healthcare professionals to extend their jurisdiction, which include the establishment of the consultant pharmacist role in 2005 and being given prescribing rights in 2003 (See *Section 1.3, The socio-political and economic context, Chapter 3, Sections 3.3.2.1 Education as a re-professionalisation strategy and 3.3.2.3, Prescribing*).

1.2 Societal purpose and responsibilities of the pharmacy profession

Since the 1960s, the requirement for pharmacists to compound medicines disappeared due to this being taken over by the pharmaceutical industry. This left community pharmacists mainly dispensing medicines, whereas the introduction of the clinical pharmacy concept in hospitals was considered to develop the

profession (Cotter, Barber, McKee, 1994). Politically there is a realisation that the act of dispensing cannot sustain the future of pharmacists. There has been increasing pressure for pharmacists to act as healthcare professionals and to serve the community better than they currently do (See *Section 1.3, The socio-political and economic context*). Over the years there has been a call for pharmacists to assert their societal purpose or 'social mandate' by articulating their overall contribution to society and responsibilities in addressing the needs of patients (Brodie, 1981; Hepler and Strand, 1990; Wiedenmayer et al, 2006).

Parsons (1939), taking a functionalist approach, argues that professions are there to serve society and maintain social order. The implication is that a profession has a societal purpose and responsibilities. Hughes (1958) refers to this societal purpose as a profession's 'social mandate', which is its assertion about its contribution to society. A profession's social licence is what society or the State has agreed or licenced the profession to do that is distinct from other professions. The distinction between the social mandate and social licence is important as the social mandate is about the ideals of the profession, whereas its licence relates to what society thinks the profession is doing, which can also act as a constraint in a profession trying to move towards its social mandate (Dingwall and Allen, 2001).

Today, medicines therapy is the most frequently used intervention in any healthcare setting (RPS, 2013). Medicines-related errors are costly in terms of hospitalisations, doctor visits, clinical tests and remedial therapy (Wiedenmayer et al, 2006). Problematic poly-pharmacy is increasingly becoming an issue especially in the elderly and patients with chronic disease. Problematic polypharmacy refers to a patient being prescribed multiple medicines inappropriately or where the intended benefit of the medication is not realised (RPS, 2013; Duerden, Avery and Payne, 2013). The traditional process of doctors prescribing medicines and pharmacists dispensing them is no longer sufficient to ensure patients receive safe, effective medicines and that they will adhere to their therapy (Wiedenmayer et al, 2006). Consumerism is increasing with medicines being viewed as commodities (Hibbert, Bissell and Ward, 2002). Medicines can be purchased in other places other than a pharmacy, such as supermarkets, petrol stations or ordered over the internet. Medicines procurement and handling is progressively being taken over by non-pharmacists (Wiedenmayer et al, 2006; Green and

Hughes, 2011). The public may ask if there is still a need for pharmacists and what value they bring to healthcare.

Hepler and Strand (1990) maintain that the pharmacy profession has a responsibility to make it its mission to address the needs of society and individual patients. Hepler and Strand (1990); Strand et al, (2004) and Berenguer et al, (2004) explain that this involves pharmacists delivering patient-focused healthcare with the aim of improving health and reducing medicines-related adverse events as part of their social mandate. The implication is that pharmacists have not fully articulated their social mandate or contribution to healthcare. Unless there is a shared understanding between society and pharmacists as to what their social mandate is, then it remains uncertain what pharmacists do in practice or are needed to do to meet the needs of patients.

This functionalist approach that Parsons (1939) represents examines the social role of professions and not what professions know or do.

Hughes (1958) and Abbott (1988) criticise the functionalist approach as it ignores “who was doing what to whom and how” (p1), instead stating the importance of examining what work professions do with Abbott (1988) maintaining that a profession exists in an interdependent system with other professions where they are in continual dispute over jurisdictional boundaries.

Even if pharmacists clearly articulate their social mandate they will have to carry this out in practice. This means it is the act or nature of their practice that determines how pharmacists are viewed by society and their status within it (Abbott, 1988).

1.3 The socio-political and economic context

The professional development and status of pharmacists is not static and will change with time due to pressures and incentives at local and national level, which includes various internal and external interests at sociological, political, technological and economical levels.

At the centre of a profession is the possession of expert or esoteric knowledge that “is distinctly theirs and not part of the normal competence of adults in general” (Freidson, 1994, p.157). Over the last 30 years government policies in England have recognised that pharmacists have distinct expertise that can be utilised

beyond dispensing. They have supported pharmacists to pursue strategies of extending their practice to deliver more patient-centred services within the NHS. The main focus has been community pharmacy, but with applicability to pharmacists working in hospitals and other sectors. This is because having community pharmacists with 5-years of training mainly undertaking dispensing is not sustainable in today's healthcare environment (Department of Health (DH), 2000, 2003, 2005, 2008). To ensure the pharmacy workforce is being fully utilised community pharmacists need to move away from focusing on dispensing medicines, although important, to take on a range of clinical services (DH, 2008; NHS England, 2013).

The White Paper, *Pharmacy in England – Building on strengths – delivering the future* (DH, 2008) was considered significant as it gave a comprehensive outline of the future of pharmacy in England.

This White Paper aimed to identify more clinical roles in the future for pharmacists within different healthcare settings in addition to providing the safe and effective dispensing of prescriptions. Community pharmacists were to deliver patient care, in particular promoting health and well-being. The White Paper stated that the strength of community pharmacy is that it can offer healthcare on every high street whereas hospital pharmacists already have demonstrated their role as part of clinical teams delivering “safe, high quality care to patients” (DH, 2008, p.5) adding “high quality and value-for-money services” (DH, 2008, p.6). Two years after its publication a new government took office, and its implementation appears to be limited.

Despite several policy documents the rate of change has been slow and has not been helped by the financial incentives for community pharmacy not being aligned to support this shift. The Royal Pharmaceutical Society (RPS) report, *Now or Never. Shaping pharmacy for the future* (Smith, Picton and Dayan, 2013), followed by NHS England's, *Call to action for community pharmacy* (NHS England, 2013), added to the urgency of community pharmacists moving away from the act of dispensing towards utilising their expertise to expand their practice to deliver more clinical services. The message was that pharmacy's future could be in jeopardy if action was not taken by the profession itself (Smith, Picton and Dayan, 2013, 2014). According to the *Now or Never: Shaping pharmacy for the future* report

(Smith, Picton and Dayan, 2013) one of the barriers for the pharmacy profession is that other healthcare professionals as well as the public and patients lack understanding of what pharmacists do and can do in healthcare. This report noted that within the pharmacy profession there are several national leadership bodies recommending that these should aim to “unite around a clear narrative of the role, purpose and potential of pharmacy” (p.10), to ensure that pharmacists have strongly focused professional leadership nationally and locally by “reshaping pharmacy as a care-giving profession of equal status and profile to medicine and nursing” (p.10).

The Nuffield Trust report of 2014, *Now more than ever: Why pharmacy needs to act* (Smith, Picton and Dayan, 2014), found that, “the conclusion of the 1986 Nuffield Foundation Review of Pharmacy (The Nuffield Foundation, 1986) reached much the same conclusion as *Now or Never*” (p.11), implying that there has been limited change to pharmacy over the last 30 years. The concern is community pharmacists are heading for a crisis threatening their identity, status and autonomy.

1.4 The international context of pharmacy

The pharmacy profession in England forms part of a larger global pharmacy community. Due to the European Economic Union pharmacists can qualify in one member state and work in another (Hassell, 2012). The majority of the international pharmacy workforce practise in community pharmacies with few in hospitals and other health facilities (Mossialos et al, 2015). Pharmacists’ university education varies from country to country but is typically 5 to 6 years with additional post-graduate study (Anderson, 2002; Mossialos et al, 2015). In the majority of countries pharmacists must register with a regulatory body before practising pharmacy (Mossialos et al, 2015). Pharmacy practice varies between different countries and within some countries (e.g., Canada) as do healthcare systems (Mossialos et al, 2015). In the majority of countries community pharmacies are remunerated based on dispensing fees, there being few financial incentives to provide non-dispensing patient-focused services (IPF, 2015). In some countries it is only possible to buy over-the-counter (OTC) medicines in community pharmacies although internationally there is an increasing trend for OTC medicines to also be sold in other locations (Wiedenmayer et al, 2006; IPF, 2015). The ownership of community pharmacies differs between countries; in some this is

limited to pharmacists but overall there is an international political move for deregulation to allow these to also be owned by chains and non-pharmacists (Morgall and Almarsdóttir, 1999; Carlsson, Renberg and Sporrang, 2012; Vogler, Habimana and Arts, 2014; Mossialos et al, 2015).

In line with the developments in England (See Section 1.3 *Socio-political and economic context*) internationally there is a political drive for community pharmacists to extend their practice towards patient services by utilising their expertise beyond dispensing as a professional survival strategy (Wiedenmayer et al, 2006; IPF, 2015; Mossialos et al, 2015):

“Pharmacists should move from behind the counter and start serving the public by providing care instead of pills only. There is no future in the mere act of dispensing. That activity can and will be taken over by the internet, machines, and/or hardly trained technicians. The fact that pharmacists have an academic training and act as health care professionals puts a burden upon them to better serve the community than they currently do”. (van Mil, Schulz and Tromp; 2004, p. 309)

The above statement demonstrates the importance of the ‘act’ of pharmacy practice in demonstrating to the public the contributions pharmacists make to healthcare. Wiedenmayer et al (2006) explain that although pharmacy is the third largest healthcare profession (this includes pharmacy technicians) it is an underutilised resource in a world with increasing healthcare needs. They call for pharmacy services to be integrated into the broader healthcare systems.

The International Pharmaceutical Federation (IPF) (2015) report recognises that society is often unclear about what it is that pharmacists do, saying there is a need for pharmacists to communicate this clearly to patients, the public and policy makers. This report also asks for a “social contract” (p.4) for the pharmacy profession whereby it is given responsibility for aspects of patient care and in return receives recognition by society for its contribution to healthcare. This implicitly suggests that internationally the pharmacy profession is seeking to regain or increase its status in society, this being linked to the act or nature of pharmacy practice in healthcare (i.e., the professional work pharmacists do).

1.5 The research question

Sociological examination of the pharmacy profession has been neglected and undertaken sporadically by sociologists focusing mainly on community pharmacists. Although in England community pharmacists constitute the largest group of pharmacists, this omits almost a quarter of the pharmacy profession who work in hospitals.

Pharmacists have not determined or articulated clearly what unique contributions they bring to healthcare or exactly what the nature of pharmacy practice is besides dispensing. If the pharmacy profession is unable to articulate this then other healthcare professionals, decision makers (e.g., the State, commissioners), the public and patients and therefore society will not know what pharmacists do and the contributions they make. It is not enough to verbalise the contributions made by healthcare professionals, they also need to 'act' as healthcare professionals delivering healthcare (Mandy, 2008; van Mil, Schulz and Tromp, 2004).

It is the nature of pharmacy practice that provides an explanation when examining the status of the pharmacy profession (Dingwall and Wilson, 1995). Little is known about how pharmacists perceive the nature of pharmacy practice relating to community pharmacists but also to hospital pharmacists.

The purpose of this study was to understand and provide insight into pharmacists' own perceptions of the nature of pharmacy practice and the implications this has for the pharmacy profession linking this to its status in society today.

The research question that guided this study was: *How do pharmacists working in different healthcare settings perceive their status in society today?*

To answer the research question a qualitative collective case study that consisted of four cases studies was used. Each case study included five pharmacists from community pharmacy, acute hospital, mental health or community health services, respectively. A total of twenty pharmacists were included. Data were obtained from one in-depth individual semi-structured interview using an interview guide covering how they viewed their practice, contributions made, how others viewed pharmacy

and the future. Each pharmacist was asked to complete a diary for five days to include any positive contributions or frustrations experienced. The data for each case were analysed using inductive thematic analysis and a cross-case analysis undertaken (See *Chapter 4, Methodology and methods*).

1.6 Organisation of the thesis

Although this thesis is linear in structure the actual research journey itself was non-linear, fluid and iterative in nature.

Chapter 2, *The sociology of the professions and pharmacy*, outlines the approach to reviewing the literature. It includes a discussion of the theories related to the sociology of the professions, which provided the working sociology theories for this study. This is followed by a discussion of the existing sociology literature examining pharmacy and how this led to the research question and aims of this study.

Chapter 3, *The case of the pharmacy profession*, covers a broader contextual discussion of the pharmacy profession in England to increase the understanding of how it is viewed today and how it got there by outlining its historical development.

Chapter 4, *Methodology and methods*, discusses the rationale for using collective case study methodology and the design of the study. It explores further the researcher's research paradigm, describing the methods and processes used to sample, collect and analyse the research data.

Chapter 5, *Findings*, presents the study findings from the data analysis, including presenting the main themes and sub-themes.

Chapter 6, *Discussion*, discusses the study findings and interprets these in light of the sociology of the professions theories, including exploring the implications for the nature of pharmacy practice. It introduces additional theories in view of the findings made.

Chapter 7, *Reflexivity and reflection*, provides an insight into how the role and position as a researcher and practising pharmacist influenced the research processes. The strengths and limitations of the study are discussed.

Chapter 8, *Conclusion*, summarises the key findings and how this study contributes to knowledge about the pharmacy profession and the sociology of the professions including suggestions for future research. Plans for dissemination of the findings are stated.

CHAPTER TWO: The sociology of the professions and pharmacy

2.1 Introduction

The previous chapter outlined the basis for this study. It was determined that the pharmacy profession has been largely overlooked by sociologists. Studies that have been undertaken have focused on community pharmacists, the largest group within pharmacy, disregarding hospital pharmacists in England (Mesler, 1991; Dingwall and Wilson, 1995; Bissell and Traulsen, 2005; GPhC, 2014).

Pharmacists in England are under increasing pressure to contribute to healthcare by serving the public better than they currently do. Politically the act of dispensing can no longer sustain the future of pharmacists (DH, 2008; Smith, Picton and Dayan, 2013, 2014). Pharmacists have not articulated their contribution to healthcare in addressing the needs of patients by asserting what their social mandate is in society (i.e. the aspiration of the profession) having already obtained a social licence to dispense medicines (Hughes, 1958; Hepler and Strand, 1990; Smith, Picton and Dayan, 2013, 2014). The result is a lack of a shared understanding between society and pharmacy as to what its social mandate is, due to uncertainty about what pharmacists do in practice or are needed to do to meet the needs of their patients (Hepler and Strand, 1990).

It was reasoned that it is the act or nature of pharmacy practice that provides an explanation for the status of the pharmacy profession in society today (Dingwall and Wilson, 1995; Abbott, 1981; Mandy, 2008; McDonald et al, 2010).

The purpose of this study was to understand and provide insight into pharmacists' own perceptions of the nature of pharmacy practice and the implications this has for them when examining their status in society today.

This chapter outlines the approach to the literature review, followed by a discussion of the relevant theories of the sociology of the professions that forms the basis of the theoretical framework for this study.

The theories from the sociology of the professions and the review of the sociology literature pertaining to the pharmacy profession justify the research question and aims for this study.

2.2 Approach for reviewing the literature

The reasons for reviewing the literature were many and varied, including placing the study in the socio-political context in England (See *Chapter 1, Section 1.3 The socio-political and economic context* and *Chapter 3, The case of the pharmacy profession in England*). It identified what was already known about pharmacists' status and their practice as well as any gaps in the sociology literature (See *Section 2.4 Sociological examination of the pharmacy profession*) and provided a rationale and a need for this study. It also supported the formulation and reformulation of the research question, positioned the study within the existing literature, provided a basis for contributing to knowledge and informed the chosen and emergent nature of the qualitative research approach (Hart, 1998; Merriam, 2009). The literature review was continuous, iterative and interactive as different aspects were explored. Different questions had to be asked of the literature at different times during the study, which Merriam (2009) describes as having a dialogue with the literature.

The literature searches were explorative and emergent rather than truly systematic. Greenhalgh and Peacock (2005) explain that relying on systematic protocol-driven literature search strategies for complex topics is less effective and may not reveal important information and that informal browsing, pursuing references in referenced papers and accessing the 'grey' literature may yield important sources that would otherwise be missed (Greenhalgh et al, 2005). 'Grey' literature refers to studies or articles with limited distribution or where this material may not be available through easily accessible sources (Alberani, Pietrangeli and Mazza, 1990).

Hart (1998) explains that "all reviews, irrespective of the topic, are written from a particular perspective or standpoint of the reviewer" (p. 25). The literature reviews included looking towards other professions for research on similar topics and to discover relevant theories, including delineating various sociology theories and from these developing a conceptual framework for the study. The selection method of articles, books and documents (e.g., NHS national policies) was likely to reflect the researcher's search and practice orientation including inadvertently misinterpreting the intention of the original authors.

Following the initial literature searches it became apparent that there were limited publications in the sociology literature about pharmacists' status and their practice. The literature searches mainly focused on pharmacists within the United Kingdom (UK) but also included sociology literature from other countries where considered relevant (Appendix 1). This was broadened out to include the sociology literature pertaining to other professions but only where this was thought to inform this study about the pharmacy profession. This study centred on practising pharmacists in England. The literature searches were restricted to English language publications for practical reasons. Appendix 1 includes examples of databases which were accessed and the search terms used.

The identified literature was assimilated into sections that present themes and trends including relevant theories as a way of depicting the larger picture related to the sociology theories of the professions and the pharmacy profession as discussed in this chapter and the more contextual information on the pharmacy profession in England covered in *Chapter 3, The case of the pharmacy profession in England*.

2.3 Theories from the sociology of the professions

Some scholars question the relevance of studying professions in modern society (Gorman and Sandefur, 2011) whereas others maintain they remain the "least researched and under-theorised areas of social life" (Traulsen and Bissell, 2004, p.107) due to the complexities surrounding professions (Macdonald, 1995; Adams, 2015; Suddaby and Muzio, 2016; Saks, 2016).

This section offers an overview of some of the key theories from the sociology of the professions. The functionalist and trait approach is discussed, followed by the 'power approach', which centres on professions influencing the State to sanction professional monopolies from a neo-Weberian social closure perspective (Witz, 1992; Macdonald, 1995; Saks, 2016). The Foucauldian perspective is discussed as it provides a theoretical platform for examining professional groups in terms of knowledge and power (Ryan, Bissell and Traulsen, 2004).

Abbott's (1988), *The System of Professions. An essay on the division of expert labor* takes a different approach by emphasising the work professionals do in practice and how they compete for jurisdictions with other professions.

Professionalism as a discourse is discussed, referring to Evetts' (2013) interpretation.

There are different levels at which professions can be studied. The macro-level refers to larger scale social processes and structures such as examining professions in socio-political and economic contexts, which is where the functionalist and neo-Weberian social closure perspectives are mainly applied (Saks, 2016). The micro- and meso-level refers to examining individuals or groups of practitioners in their social setting such as their workplaces or organisations (Evetts, 2011).

In the sociology literature the professional organisation that represents a profession at a national level is referred to as an institution, society, association or body. In this thesis the term 'professional association' is used. A professional association represents a profession through acting as a political lobby group in furthering or defending the memberships' 'corporate' interests, by negotiating or bargaining with the State and other key stakeholders and in promoting the public's perception of the profession. This professional association is the most significant body that is seen internally and externally in representing a profession's interests (Macdonald, 1995).

There are other professional institutions such as learned societies, other associations such as trade unions or other interest groups. These are referred to in this thesis as 'interest groups'.

The concept of 'professionalisation' and how this is applied in this study is explained, with 're-professionalisation' referring to strategies to maintain or enhance professional status (See *Section 2.3.8 Professionalisation as dynamic processes*).

2.3.1 Functionalism and trait approach

Functionalism grew out of theoretical efforts to explain and examine the role of professions in relation to their function and relevance to society without considering what they do in practice or their competence (Bissell and Traulsen, 2005). Talcott Parsons (1902 – 1979) (1939) speculates that professions gain status and authority through their technical competence in their specialist field of practice. He sees professions as having a stabilising role in society by being

devoted to delivering community-orientated services rather than pursuing their own self-interests for economic gain due to the objectivity of their technical competence and their professional associations not sanctioning the pursuit of self-interests.

The trait approach was developed by sociologists in search of attributes that define the common core of professions by differentiating them from occupations (Greenwood, 1957; Denzin and Mettlin, 1968). This led to a large number of attributes being described that needed to be fulfilled to transform an occupation into a profession (Abbott, 1988; Macdonald, 1995; Harding and Taylor, 2002; Bissell and Traulsen, 2005). These include, for example altruism rather than individual self-interest, not being in pursuit of personal profit, expertise based on theoretical and practical knowledge, being a self-regulating profession, the confidential professional-client relationship, shared ethical values or a code of ethics, autonomy and control over its own work (Greenwood, 1957; Harding and Taylor, 2002; Bissell and Traulsen, 2005).

Functionalism and the trait approach succumbed to empirical and theoretical critique (Johnson, 1972; Abbott, 1988; Macdonald, 1995; Freidson, 2001). Critics of the stabilising role of professions on society failed to explain for example competition and conflicts within and between professions (Bucher and Strauss, 1961; Abbott, 1988). They neglect factors such as the prior existence of powerful and entrenched professional groups (e.g., medicine) and the extent by which the State may impose its own grants or limitations on a profession and the content of its practice (Evetts, 2006; Macdonald, 1995; Saks, 2016).

The trait approach does not provide an abstract theory of professions with the attributes being empirically questionable as there is no consensus as to what the common core attributes of a profession are and there being no systematic interrelations between these or a theoretical rationale supporting them (Johnson, 1972). These attributes were often applied as a checklist or as a step-by-step process, referred to as a 'professionalisation process', whereby an occupation that reached this common core of attributes would reach the end stage of becoming a profession. (Johnson, 1972; Abbott, 1988; Witz, 1992; Macdonald, 1995) (See *Section 2.3.8 Professionalisation as dynamic processes*).

These attributes are assumed to have universal applicability despite being based on examination of few professionals (e.g., medicine) taking no account of space and time, thereby having limited relevance (Johnson, 1972; Macdonald, 1995; Abbott 1988). Dingwall and Wilson (1995) point out different attributes can equally be applied to occupations that are not normally associated with being professions depending on the attributes selected (See *Section 2.3.6 Defining professions*).

Despite these criticisms the trait approach is used by professions themselves to justify that they are professionals assuming clients or the public comply with the view professionals have of themselves. The trait approach can be applied in favour of a profession without focusing on its work due to the underlying functionalist assumption that this work benefits society (Harding and Taylor, 2002).

It remains a powerful prospect and enabler for pharmacy to be considered a profession (Evetts, 2003; Evetts, 2006; Williams, 2007). This is reflected in the *Royal Pharmaceutical Society (RPS) Medicines, Ethics and Practice: The professional guide for pharmacists* (RPS MEP, 2016) stating that:

“It is important to recognise that pharmacy is not just an occupation; it is a profession and pharmacists are professionals who exercise professionalism and professional judgement on a day-to-day basis”.
(p. 6)

The RPS MEP (2016) refers to, for example, altruism, pharmacy having standards and codes of conduct, being a regulated profession and being recognised by the public as a profession. The RPS uses the trait approach as professional rhetoric with the aim of moulding the practice of individual pharmacists but also as a way of legitimising pharmacists’ professional status to the public.

An issue that is often discussed is community pharmacists’ lack of altruism due to commercialism being their overriding focus (See *Chapter 3, Section 3.3.2.2 Community pharmacy and commercialism*). Altruism refers to a selfless concern for others. This is based on self-sacrifice, potentially placing a professional in a situation that may be detrimental to themselves. Bishop and Rees (2007) argue that altruism is not an appropriate foundation for professional behaviour but rather it should be one of pro-social behaviour focusing on “actions that benefit others” (p.391) but without this being at the expense of the individual professional. Altruism or pro-social behaviour can be at an individual professional-client level but also at a macro-level by, for example, pharmacy speaking up for patients who

may not have the same voice in the media. The pharmacy profession does not have a strong voice in the media and therefore in the public arena (Smith, Picton and Dayan, 2013) (See *Chapter 1, Section 1.3 The socio-political and economic context*). If the pharmacy profession is unable to speak up on behalf of patients, then the opposite may also be applicable in that the public will not speak up on behalf of pharmacy if it is under threat (Morgall and Almarsdóttir, 1999) (See *Sections 2.3.3 Professions as an inter-related system and 2.4.3 Internal divisions*).

2.3.2 The ‘power approach’

The ‘power approach’ refers to how professions persuade society to grant them a privileged position in society as they exist to serve their own self-interests and not those of broader society through trying to control the environment and social conditions that surround them (Brante, 1988; Witz, 1992; Macdonald, 1995; Suddaby and Muzio, 2015). For Parsons (1939) from a functionalist perspective, power is considered a driving force used by professions to maintain a harmonious functioning social order.

Hughes (1958) distinguishes between a profession’s ‘social licence’ and ‘social mandate’, pointing out the importance of a profession gaining a social licence achieved through bargaining explicitly and implicitly with society, via the State. (See *Chapter 1, Section 1.2 Societal purpose and responsibilities of the pharmacy profession*). A social licence can be interpreted as an area of activity that society has agreed or licensed a profession for that is distinct from other professions (Dingwall and Wilson, 1995; Dingwall and Allen, 2001). This licence is often associated with professional regulation although Hughes (1958) explains it is broader and more implicit than actual legal permission by also including society’s expectations of what a profession should be doing. Dingwall and Allen (2001) explain that a profession’s social licence draws attention to its “material base and the structural constraints of its work settings” (p. 64), indicating that although a profession’s social licence legitimises its work it can also act as a constraint if a profession aims to expand its work and boundaries.

The scope of a profession’s social mandate is often wider than what the public or society is prepared to grant it (Hughes, 1958). A social mandate can be considered an area for further negotiation between society and the profession in how it asserts its contribution to society and how it wants to develop and expand

its practice and areas of responsibilities further in serving society (Hepler and Strand, 1990).

In the context of this study, a profession's social mandate is viewed as its collective aspirations in terms of social and professional purpose including areas of activities a profession should take responsibility for. If a profession can articulate its social mandate, it generates an opportunity to debate the relationship or link between its social licence (i.e., current licensed activities) and social mandate (i.e., aspirations) as a basis for expanding its practice and boundaries including gaining professional recognition and acceptance by society for its work. According to Hughes (1958) a profession should establish and maintain a position for itself within society to protect its licence and assert its mandate.

Professions use their licence and mandate to control work granted by society by having gained the support within the socio-political and economic context (Hughes, 1958; Freidson, 1970; Macdonald, 1995). Hughes is critical of examining professions at the macro-level instead advocating exploring what they actually do in practice in their everyday life to maintain and negotiate their position linking his theories closer to Abbott's (1988) work than to the neo-Weberian social closure perspective (Hughes, 1958; Larson, 2013). Hughes' works hints at potential conflict situations that professions experience in establishing, maintaining, defending or wishing to expand their professional work and boundaries.

According to Macdonald (1995) and Bissell and Traulsen (2005) theorists such as Karl Marx (1818-1883) and Max Weber (1864-1920) developed theoretical approaches to analysing the social world that should be considered in relation to the sociology of the professions. Macdonald (1995) explains that Karl Marx developed social theories based on capitalism and communism as two opposing theories being critical of capitalism. He was particularly interested in the economic relationships underpinning the political and social structures in society (Bissell and Traulsen, 2005). According to Marxism professions are viewed as unjustified elites that limit the opportunities for others, thereby reinforcing the social class system and its inequalities (Bissell, Traulsen and Haugbølle, 2002). Emerging from these theories is a perspective where professions are compared to or considered in the same way as manual workers on an assembly line in a factory leading to the proletarianisation of professions having a de-professionalising effect on them (i.e., loss of status) (Macdonald, 1995; Bissell and Traulsen, 2005) (See *Section 2.3.8*

Professionalisation as dynamic processes). For example, as professions are increasingly employed by bureaucratic organisations it is postulated that their autonomy and control over their working practices are curtailed by being subjected to rationalisation (Bissell and Traulsen, 2005; Larson, 2013). This rationalisation is based on for example (i) their work being divided into separate technical tasks, some of which can be undertaken by less qualified and less costly employees, or being replaced by automation (e.g., utilising new technology), (ii) systemisation of knowledge into bureaucratic procedures and guidelines reducing or removing professional judgement, (iii) their market shelters no longer being protected by the State or (iv) a profession losing its control over training and credentialing of its members (Macdonald, 1995; Freidson, 2001; Taylor, Nettleton and Harding, 2004; Bissell and Traulsen, 2005; Larson, 2013).

Abbott (1988) rejects the Marxist proletarianisation approach due to its limitation in viewing professions as a social class instead of examining them in their capacity as social groups. Macdonald (1995), Freidson (2001) and Larson (2013) argue that there are some useful elements of proletarianisation that can be applied to professions but criticises its limited view of professions and their motivations by, for example not considering factors such as their pursuit of status and exaggerated claims that professions as social institutions could easily be abolished (Freidson, 2001; Bissell, Traulsen and Haugbølle, 2002).

Functionalists view professions as self-employed whereas in contemporary society the majority of professions are in salaried employment (Macdonald, 1995; Larson, 2013). According to Larson (2013) the question is no longer about being self-employed or employed but is rather about “*for whom* they work and in *what conditions*” (p.233). She argues that status for professions is linked to different kinds of privileges such as abilities for professions within bureaucratic organisations to for example specialise to become experts, having career patterns and promotion opportunities (Freidson, 2001; Larson, 2013).

According to Taylor, Nettleton and Harding (2004) Weber views society as individuals who are pursuing activities to further their own self-interests. It is in the pursuit of self-interest that collective groups or social groups are formed that engage in furthering the self-interest of their members (Murphy, 1986; Macdonald, 1995). Witz (1992) explains that Weber’s closure theory has been developed

further by other scholars such as Parkin and Murphy, which is referred to here as the neo-Weberian social closure perspective (Murphy, 1984, 1986; Macdonald, 1995; Saks, 2016). Murphy (1984, 1986) equates closure with monopolisation. Closure theory is based on free markets whereas in terms of professions Freidson (2001) prefers the term 'shelter' to denote the often incomplete nature of closure. Closure in this study follows Witz's (1992) explanation that the aim of closure is to "stake claims to resources and opportunities distributed via the mechanisms of the labour market" (p.44).

This neo-Weberian social closure perspective seems to address the question related to how a profession develops and sustains its claim to a privileged position in society. Witz (1992) explains that a profession does this by mobilising power to enhance or defend its share of resources and opportunities by attempting to exclude others from their profession (i.e., applying power in a downward direction towards a sub-ordinate profession) or through usurpation (i.e., applying power in an upward direction towards a dominant profession) in direct response to being excluded from accessing the privileges of a more dominant profession (Murphy, 1986; Macdonald, 1995). These two strategies are referred to as 'exclusionary' and 'usurpatory' closures, respectively (Murphy, 1986; Witz, 1992; Macdonald, 1995).

Exclusionary closure strategies include a dominant profession focusing on internal intra-professional control by for example defining its membership and educational and credentialing requirements as a way of excluding 'ineligibles' or 'outsiders' (i.e., sub-ordinate professions) (Macdonald, 1995). Usurpatory closure strategies involve the excluded sub-ordinate profession aiming at 'biting' into the advantages of the dominant group that is above it (Murphy, 1986; Macdonald, 1995). Another strategy used by a dominant profession is 'demarcation'. In this study this is viewed as an extension of the notion of exclusion, but rather than the dominant profession mobilising power to keep the subordinate profession out it uses this to demarcate boundaries and to maintain control over the subordinate profession's jurisdiction. This inter-professional control and domination over the affairs of subordinate groups may include deciding what tasks to delegate to these groups or by being involved in defining their competencies to undertake certain work (Witz, 1992) (See *Section 2.4.2 Medical hegemony and jurisdictional uncertainties*).

A criticism of the social closure perspective is that it does not cover the structural relationships between the different closure strategies and that all of the closure strategies involve elements of exclusion (Murphy, 1984, 1986).

In the literature professions mobilise legal legitimation (i.e., professional regulation) (Witz, 1992; Macdonald, 1995; Saks, 2012, 2016) and credentialing (i.e., increase education requirements) (Freidson, 1994, 2001) as tactics for closure. Neo-Weberians are interested in how some professional groups can regulate market conditions in their favour despite competition from other groups by limiting access to opportunities to ineligible professions through the “creation of state-sanctioned occupational monopolies” (Saks, 2016, p.6) emphasising the relationship between professional groups and society. Society is represented by the State being an important stakeholder by for example underwriting the legal boundaries of professions that lead to higher income, status and power compared to other professions in the market place (Saks, 2016).

Freidson (1988) maintains that there are two interrelated dimensions to power of a profession, which are its autonomy (referring to the ability to control its own work) and its ability to dominate or control the work of others. Freidson (1994) notes that there are variations between professions such as those between doctors and pharmacists where both have higher education and an exclusive licence resulting in monopolisation of certain tasks. He concludes that the critical differences between the two professions are that pharmacists are dependent on the orders of doctors (i.e., to dispense their prescriptions). However, more importantly doctors have been more successful in being politically ‘corporately organised’ as their professional associations are powerful in their negotiation with the State in achieving favourable jurisdictions. Implicit in this is that doctors have some control over the division of labour within healthcare. Therefore, there are power differences or asymmetry between different professions that impact on their status. This led Saks (2012, 2016) to conclude that neo-Weberian professionalisation processes are linked to political competition including the ability to influence stakeholders such as the State while not directly being shaped by the knowledge and skills a profession possesses (See *Sections 2.3.5 Professionalism as a discourse and 2.3.8 Professionalisation as dynamic processes*).

2.3.2.1 Power and knowledge

Michel Foucault, a French philosopher or social theorist, has appealed to sociologists because of his concerns with knowledge and power (Macdonald, 1995). O'Neil (1986) explains that Foucault's work can be seen as extension of the neo-Weberian concepts related to closure and power. Bissell and Traulsen (2005) explain that Foucault's work provides a "tool box" (p.150) of concepts and techniques that can be used to explain, illuminate or place an issue in context providing a different perspective. Foucault was interested in how knowledge was used to create power differentials, with power being "one person's will over another's action" (Ryan, Bissell and Traulsen, 2004, p.44) using the example of Bentham's Panopticon as an illustration of this. This prison design aimed to control many prisoners with only a few prison guards by subjecting prisoners to the belief that they were observed at all times with the aim of individual prisoners correcting their own behaviour to that of normalising behaviour through self-discipline (Foucault, 1977). This disciplinary power is manifested through the 'gaze' of professions who define, survey and discipline their subjects (e.g., patients) (Foucault, 1977, 2009). Foucault was preoccupied with the notion of state control of the population, using the term 'governmentality' to describe the political power that operates via the State to bring about desirable behaviour. The State's power relations are described as diffuse and sometimes contradictory. The State operates its powers in different ways to ensure individuals behave in a normalised way through policing, surveillance and regulatory activities carried out by other agents of the State or other institutions. The aim is to engage individuals to invoke self-policing to ensure correct normalised behaviour, aiding surveillance (Nettleton, 1992; Ryan, Bissell and Traulsen, 2004). This helps to illustrate for example that in the neo-Weberian social closure perspective the State is not a neutral stakeholder but also has an interest in professional regulation as this is a way of controlling and influencing professionals and their practice through self-discipline.

2.3.3 Professions as an inter-related system

The neo-Weberian social closure perspective has as its prime motivation for professionalisation monopolisation and status pursuits mainly at the macro-level (Macdonald, 1995; Larson, 2013). Suddaby and Muzio (2015) argue that in reality professions' monopolistic pursuits only constitute a small proportion of a

professional association's focus and resources. The social closure perspective is about strategies on how a professional group negotiates professional boundaries and establishes control of a particular area of jurisdiction in the social division of labour. They mainly achieve this by directing strategies of persuasion towards external stakeholders such as the State and public (Larson, 2013; Saks, 2016). The social closure perspective of professions overlooks important elements, which limits the understanding of professions.

Although professions do exhibit some of the power and conflict perspective related to social closure, Abbott (1988) refocuses the attention upon the importance of examining what professions do and how they maintain control over their jurisdiction in the work place. Abbott argues that the most effective approach to examining professions is to understand professions as emerging from processes of negotiation and conflict with neighbouring professions by engaging in continuous jurisdictional disputes within a dynamic inter-related system of professions:

“the foundations of inter-professional competition is laid in the very acts of professional work itself”. (Abbott, 1988, p. 35)

Abbott (1988) describes jurisdiction as “the link between a profession and its work” (p.20), which confers status and power. In this study jurisdiction is understood as the control a profession has over a specific area of work, the right to perform the work through its social licence, defining best practice standards and at the same time the exclusion of others. Professions have to undertake active work to maintain, defend or increase their jurisdiction by making additional jurisdictional claims. Jurisdictional claims are made in the workplace but are only recognised once there are concrete social claims and legitimate responses from the public and State to these (i.e., society) (Abbott, 1988; Macdonald, 1995).

Professions engage in various strategies to establish boundaries between their and other professions' jurisdictions. The neo-Weberian social closure perspective covers various strategies professions deploy to close their jurisdictions to other professions (Witz, 1992; Macdonald, 1995; Larson, 2013). According to Abbott (1988) professions engage in work to establish their claim to exclusive competence over a particular area of work, emphasising the active work professions have to do to construct and maintain boundaries. Fournier (2000) refers to this as professions having to undertake constant “boundary work” (p. 69)

to preserve or expand these. Professions will respond to threats to their existing jurisdiction by reasserting the legitimacy of their existing boundaries, involving for example at the macro-level their professional association in defending their existing epistemic and jurisdictional boundaries (Abbott, 1988; Freidson, 1994).

Making new jurisdictional claims involve expanding into new areas of work through either encroachment or delegation (Abbott, 1988; Nancarrow and Borthwick, 2005). Encroachment refers to a profession extending its work that is part of another profession's territory (e.g., community pharmacists taking on tasks normally considered to be part of doctors' work) (Nancarrow and Borthwick, 2005). However, a dominant profession may set the terms of reference for any boundary challenges or 'territorial battles' through demarcation strategies aimed at controlling the jurisdictional boundaries of sub-ordinate professions (Abbott, 1988; Macdonald, 1995; Reebye et al, 2002).

Abbott (1988) explains that inter-professional competition and conflict over jurisdiction can result in what he describes as "jurisdictional settlements" (p.69). This refers to shared jurisdiction over activities and knowledge control between professions with the most common jurisdictional settlement being referred to as subordination where the dominant profession controls the division of labour for a subordinate profession through delegation. Freidson (1988) asserts that the medical profession exercises its influence and power over other healthcare professionals. It is claimed that pharmacists, regardless of being community or hospital pharmacists, are subordinate to the medical profession due to their practice being controlled or limited by the more dominant medical profession (Turner, 1995; Bissell and Traulsen, 2005).

Freidson (2001) criticises Abbott for not having developed a systematic rationale for distinguishing between different kinds of professional work as he concedes this has consequences for the status of a profession. Macdonald (1995) objects to viewing professions as being part of a system as this implies they are competing and interacting with each other in a systematic way whereas in reality professions interact in a non-systematic fashion. He also criticises Abbott for failing to consider the motivations and intentions of professions and stakeholders. Despite criticisms Abbott's (1988) theory allows analysis of the work professionals do whereas the social closure perspective, which focuses on professions' organisational structures at the macro-level, largely ignores what it is professions do in their everyday practice.

2.3.4 Professional status

Status is relevant for professions (Abbott, 1981, 1988; Bissell and Traulsen, 2005). Larson (2013) in her new introduction to *The rise of professionalism: Monopolies of Competence and Sheltered Markets* written in the 1970s and first published in 1977, reflects on her original work. Larson now makes the point that although social closure is initially important for a profession in achieving market control it is status that is a more lasting and general strategy for professions, even where they have achieved as much closure as they can expect, confirming the centrality of status to professions. Larson (2013) explains in her original work that status is “Relative prestige and privilege” (p.236) compared to other professions. Abbott (1981, 1988) argues that it is the drive for status that influences the inter-professional conflicts between professions. He refers to a profession’s work as “acts of professional practice” (p.40) to emphasise “the active work that professions have to put in all the time to maintain their claims to a special niche in society” (Macdonald, 1995, p. 164). Abbott (1988) links status to a profession’s act of practice or as described by Mandy (2008) as the “nature and act of practice” (p. 203). Abbott (1981) defines status as:

“..a quality entailing deference and precedence in interaction, a quality of professional and public honor. While status differences imply hierarchical order, one need not assume an exact ranking, but only a loose order of individuals that structures social relations. Status systems are generated by bases or dimensions of honor – power, wealth and knowledge”. (Abbott, 1981, p.820)

Abbott (1981) refers to status differences such as ‘hierarchical order’, ‘ranking’ and ‘social relations’ implying, as Larson (2013) does, that status is relative to other professions but also intra-professionally. This definition includes several underlying factors to account for status such as power, income and knowledge.

Abbott (1981) includes ‘honor’ (honour) in his definition. Honour can be interpreted as the ongoing social evaluation that takes place within a profession, both intra- and inter-professionally and by the public (Crompton, 1987). This social evaluation of a profession’s status takes place based on what is understood and observed by stakeholders and society in terms of a profession’s acts of practice relating status to the nature of practice (Abbott, 1988).

Intra-professional status is internal differentiation or ranking within a profession. According to Abbott (1981, 1988) intra-professional status is attributed to non-routine work. Abbott (1988) argues that intra-professional status relates to the level of professional 'purity', which refers to the ability to reduce the amount of routine and non-professional issues from one's practice by being able to focus on more professional issues by for example specialising or working in an academic environment. The lowest status professionals are those who deal with problems from which human complexities cannot be removed (Abbott, 1988). Abbott (1988) acknowledges that professionals are accorded status by the public who are unconcerned with professional 'purity' differentiating less between internal hierarchies within a profession.

According to Abbott (1981) status is not static (i.e., it changes over time) due to being linked to a particular period in history, nation and culture (Freidson, 1994) but also to inter-professional jurisdictional disputes or conflicts (Abbott, 1981; Freidson, 1994; Bissell and Traulsen, 2005).

In this study status is understood to be a dynamic and changing concept because it is determined in relation to other professions and within a profession itself, and is based on the social evaluation of others such as the profession itself, other stakeholders (e.g., other professions, public and clients) and ultimately society. In this study status refers to social prestige and privileges relative to other professions and as argued above is linked to the nature of a profession's practice (Abbott, 1988; Larson, 2013).

2.3.5 Professionalism as a discourse

Professionalism is widely discussed particularly in the medical literature (Arnold and Stern, 2006; Elvey et al, 2015). There is no universal consensus of what this concept encompasses, making it difficult to assess or measure (Epstein and Hundert, 2002). Hammer (2000) links professionalism to an implicit or explicit agreement within a profession to practice within a "set of appropriate attitudes and behaviours" (p.455). This suggests professionalism is tied into a collective acceptance by a profession to conform to some form of formal or informal collegial control to deliver professional work to certain standards which goes above and beyond those set down by any legal framework (Johnson, 1972; Evetts, 2013). These standards are often linked to a profession's ethical guidance.

The search for a definition and measures of professionalism has led to describing a number of attributes that professions are considered to possess to set them apart from occupations. These attributes are similar to those listed in the traits approach (Greenwood, 1957; Johnson, 1972; Hammer, 2000) (See *Section 2.3.1 Functionalism and trait approach*). Brown and Ferrill (2009) associate professionalism with fiduciary relationships where professionals utilise their expertise to the benefit of clients who in turn place their trust in professionals. Clients have to trust professionals to provide correct advice, not to take advantage of their position, maintain confidentiality, to be competent and to display certain acceptable attitudes, values and behaviours (Evetts, 2006). Therefore, the meaning of professionalism is closely linked to the culture prevalent in society as it refers to values, attitudes and behaviours which are for example influenced by clients' expectations and demands, making it a dynamic process in a continual state of flux (Hammer, 2000; van Mook et al, 2009). Professionalism has been described as a contract between the profession and society (Cruess and Cruess, 2000). The implication is that professionalism is also influenced by expectations the State has of for example healthcare professionals as it funds public healthcare services and as a way of protecting the public (Evetts, 2006).

Evetts (2013) argues that professionalism as an ideology is a desirable concept for professions themselves in terms of their professional "identities, career decisions and senses of self" (p. 783) helping to "maintain their distinct professional values or moral obligations" (p.785) that underpins professional standards making professionals accountable for their actions. For Freidson (1994, 2001) professionalism provides a profession with power to determine who is qualified to perform the tasks and the ability to control and evaluate its work (i.e., set the standards for their practice), which he considers essential to maintain their professionalism. Freidson (1994) maintains that "professionalism is both desirable and necessary for a decent society" (p. 9) which benefits clients, the public and society as well as the profession itself. Freidson's argument is based on the assumption that the profession itself is instrumental in determining what professionalism means for that profession.

Evetts (2013) uses the concept of professionalism as an alternative to functionalism and the neo-Weberian social closure perspective to theorise about professions by drawing on what she considers to be increasing bureaucratisation,

rationalisation and centralised control of professions (Saks, 2016). Evetts (2006, 2013) maintains that professionalism as a discourse is an effective tool for aiding professional change and to control work through a process whereby professionals themselves accept and incorporate professionalism into their work, which is achieved through influencing their behaviours and performance. Evetts (2013) explains that professionalism is a balance between being constructed and operationalised from 'within the profession' and from 'above' or rather imposed externally to the profession either by the State, their employing organisation or other external agencies.

Fournier (1999) links professionalism to the Foucauldian concept of managers within organisations using organisational professionalism as a disciplinary power or mechanisms for professionals themselves to 'normalise' their professional work through choosing to act in appropriate ways as a form of self-discipline (Black, 2002; Evetts, 2006). Fournier (1999) argues that this allows an organisation to ensure professional practice takes place "within a network of accountability and governs professional conduct at a distance" (p. 280).

Increasingly, professionals are employed by bureaucratic organisations that seek to use this disciplinary power as a form of self-discipline to ensure their employees are working within their organisationally defined standards for professionalism, except that these standards may not necessarily be based on the ethos of professionalism for a particular profession and may remove some of their professional autonomy (Evetts, 2003; Suddaby and Muzio, 2015).

The implication of Evetts' professionalism discourse is that professionals work within a wider system which impacts on their own professionalism. This means that professionals undertake their professional work within not only "one but several competing forms of professionalism" (Hafferty and Castellani, 2010, p.288). Evetts' (2006, 2013) professionalism discourse centres on how and who influences and controls the behaviour and conduct or performance of professionals particularly to facilitate professional change but misses out on some of the organisational structures related to professions (Macdonald, 1995) and ignores that professions work within a larger system of professions where they interact and relate to other professions (Abbott, 1988).

Fournier (1999) concludes that “the meaning of professionalism...is not fixed but is highly contestable” (p. 301-302) making professionalism an effective but imperfect disciplinary mechanism.

2.3.6 Defining professions

The terms ‘profession’ and ‘professional’ are used by society in a colloquial sense such as a ‘professional footballer’ with the distinct meaning often being the opposite of being an amateur (Harding and Taylor, 2002). This broad understanding by society may change the general understanding of what it is to be a professional. The concept ‘profession’ is notorious for its varied definitions and usage. The dominant thinking about this concept is based on the trait approach (Harding and Taylor, 2002; Bissell and Traulsen, 2005) (See *Section 2.3.1 Functionalism and trait approach*). Freidson (1994) added to the debate around the value of defining ‘professions’ by pointing out that it is a “socially valued label” (p.19) that cannot be defined as a generic term as it changes over time due to being linked to a particular period in history, nation and culture. The general consensus in the literature is that it is desirable to be a ‘profession’ as this is associated with status (i.e., social prestige and privileges) allowing a high degree of autonomy in the workplace (Macdonald, 1995; Gabe, Bury and Elston, 2004; Timmons, 2011). This is based on the assumption that there is a real difference between an occupation and a profession, that there is a desire for an occupation to become a profession and more importantly if this distinction matters in practice. Hughes (1958) argues that differences between professions and occupations are differences of degree rather than of kind.

Although Abbott (1988) states that, “abstract knowledge is the foundation of an effective definition of a profession” (p.102) he also says discussing a definition shifts this debate away from focusing on what professions do in their work. Dingwall (1976) and Abbott (1988) maintain that sociologists should abandon searching for a firm definition of ‘profession’ instead suggesting using this concept in line with how this is used by a profession itself. Pharmacists refer to themselves as a profession (See *Section 2.3.1 Functionalism and trait approach*).

For Saks (2012) a definition of a profession is still relevant arguing that a neo-Weberian definition offers an alternative by not directly including a profession’s specialised knowledge and skills. Instead Saks’ definition focuses on professions

as “exclusionary social closure in the marketplace sanctioned by the State” (p.4) mainly via “formal legal regulation with registers creating bodies of insiders and excluding outsiders” (p.4) and where their specialised knowledge and skills are not central to the definition. This is based on the assumption that a profession is registered with a regulatory body as an indirect measure of it having achieved social closure (See *Section 2.3.7 Professional regulation*). Central to Saks’ (2012) definition is power mobilised by professions aiming for monopoly through their relationship with the State. Although it is acknowledged that professions do enjoy some economic and social closure it does not provide the full definition of the concept ‘profession’.

Freidson (2001) argues that a profession cannot exist without pursuing some social closure strategies by explaining that it is imperative for a profession to establish, maintain and enhance its jurisdictional boundaries (Abbott, 1988). Freidson points out that social closure strategies are not purely about economic or political power of a profession as implied by Saks (2012) but rather about control “over the *practice* of a defined body of intellectualized knowledge and skill, a discipline” (Freidson, 2001, p.198). Freidson argues that these jurisdictional boundaries allow a profession to concentrate on a body of knowledge and skills that form the basis for a profession’s nature of practice that it can develop, advance, refine and expand.

It is a prerequisite for being a profession that it can determine and find strategies to differentiate itself from other professions. Freidson (2001) argues that to be considered a profession there should be a strong sense of professional community meaning that a profession should be ‘corporately organised’ at the macro-level through an autonomous professional association that is independent of the State. This professional association will represent the profession in its dealings with the State and other key external stakeholders such as other professions and the public (Johnson, 1972; Abbott, 1988). The professional association is also a way of gaining what Johnson (1972) refers to as “collegiate control” (p.45) explaining that professionalism forms part of the profession’s control over the individual practitioner’s behaviour, performance and working standards (See *Section 2.3.5 Professionalism as a discourse*).

There is a lack of agreement in the literature of a definition of what constitutes a profession. It is clear that the term 'profession' cannot be defined by the trait approach, claims to specialised knowledge and skills or autonomy alone; nor can it be defined from the neo-Weberian perspective in terms of social closure focusing on economic and monopolistic activities (Abbott, 1988; Freidson, 1994, 2001; Macdonald, 1995).

In this study a profession is considered to be a cohesive community where members have a shared collective professional identity resulting in a common experience of sharing ways of perceiving, reasoning and solving problems which Freidson (2001) refers to as a professions' epistemological base affecting their knowledge and practice resulting in the "acts of professional practice" (Abbott, 1988, p. 40). This shared collective identity is produced and re-produced through professional socialisation which takes place initially during a shared educational background, professional training and vocational experience resulting in similar basic knowledge and skills and that this socialisation continues throughout their professional career (Macdonald, 1995). It is assumed that a profession evolves through developing new knowledge bases from addressing common problems they face in the course of their work (Abbott, 1988; Freidson, 2001). A profession will continuously pursue various efforts or strategies to enhance, maintain or defend itself in terms of its professional jurisdiction in achieving status (See *Section 2.3.8 Professionalisation as dynamic processes*).

2.3.7 Professional regulation

Whether from the functionalist, trait approach, neo-Weberian social closure or system of the professions perspectives the assumption is that professional regulation is desirable for a profession. This is because this brings legitimacy to a profession's activity within society by limiting access to the profession to practitioners who have completed the required education, training and credentials and who are able to comply with certain practice standards set by the profession itself (Adams, 2017). In the literature discussions on professional regulation are often based on a profession being self-regulating (i.e., self-governing). The assumption is that their professional association is politically well connected to convince the State and other stakeholders that the profession deserves market privileges that are assumed to follow professional regulation including the

professional association being able to implement and manage this self-regulation (Freidson, 2001; Saks, 2012; Adams, 2015). In these situations a professional association takes on dual roles of regulating its own members by acting both as an agent of the State and the profession. It therefore has to serve the profession, the profession's clients and public as well as being indirectly accountable to the State.

Ogus (2000) explains that self-regulation by a profession can be understood as a "deliberate delegation of the State's law-making powers to an agency, the membership of which wholly or mainly comprises representatives of the firms or individuals whose activities are being regulated" (p. 590). This means that a self-regulating profession, through its professional association, sets the standards for governing the work of its members, establishes means whereby it can provide assurance to the public that its members comply with those standards and that actions are taken against those members who do not comply with the required standards and behaviours. This is based on the assumption that a profession is best placed to recognise poor standards, that it will not abuse its privileges by accepting the rewards (i.e., income and monopoly of services) of professional regulation for example by not delivering correspondingly high standards of services to its clients.

Self-regulation is an implicit contract between a profession, state and public, where a profession has to provide adequate assurance about the performance and conduct of its members to the State and implicitly to the public and its clients (Dingwall and Fenn, 1987; Freidson, 2001; Adams, 2017). The State, as a separate agent, is not a neutral stakeholder or a passive by-stander. The State also has an interest in the statutory regulation of professions for different reasons such as it is in the public's interest and it may suit the political agenda (Johnson, 1972; Freidson, 2001; Gorman, 2014; Adams, 2017) (See *Section 2.3.5 Professionalism as a discourse*). Gorman (2014) argues that self-regulation refers to a profession being granted freedom from external regulation whereas Dingwall and Fenn (1987) disagree maintaining that self-regulation is open to renegotiation with the State if it is perceived not to act in the interest of the public. The outcome may be that the State revokes this self-regulation.

For functionalists professional regulation is constructed to grant professions a privileged place in the market and society. In return for these privileges a

profession will act in the best interest of its clients, the public and society as a whole. The result is that professions contribute to the social order, harmony and function of society (Adams, 2017). Similarly, the trait approach often lists self-regulation as one of the attributes or traits required for an occupation to legitimatise its claim to being a profession (Harding and Taylor, 2002). Functionalism and the trait approach are based on the assumption or belief that professions act altruistically by serving the interests of others over their own.

In contrast, from the social closure perspective, professional regulation is not about the public's interests but rather about a profession's self-interest through gaining legal closure aimed at monopolisation of the market (Witz, 1992; Macdonald, 1995; Saks, 2012; Larson, 2013). Professions use the regulatory legislation to restrict access to their professional practice with accompanying rewards in their professionalisation efforts to achieve upward social mobility (Witz, 1992; Larson, 2013). The assumption is that a profession is able to regulate and control the market condition in their favour by restricting the opportunities of other professions leading to increased status (Witz, 1992; Saks, 2012). From the social closure perspective, a profession claiming to serve the interests of its clients and public appears to be no more than a tactic in serving the profession's own self-interest through professionalisation processes and inter-professional conflicts by claiming to be the rightful experts with authority in their areas of practice by aiming to win over key stakeholders such as employers, clients, the public and the State (Abbott, 1988; Freidson, 2001; Adams, 2017).

Different scholars are increasingly arguing that professional regulation is evolving or changing by moving away from professional self-regulation towards establishing regulatory bodies which are less influenced by professions themselves (Evetts, 2013; Saks, 2016; Adams, 2017). It is argued that self-regulation was based on trust which has over time been undermined or eroded with an increasing trend of the public questioning the ability of professions to regulate themselves (Dingwall and Fenn, 1987; Evetts, 2013; Adams, 2017). This shift away from professional self-regulation does not appear to have reduced the desire for a profession to be regulated (Adams, 2017). This has led to disagreement in the literature with some scholars concluding that self-regulation was never an important attribute of a profession and is now a relic of the past (Dixon-Woods, Yeung and Bosk, 2011) whereas others have amended a 'trait' of a profession to being regulated by the

State (as opposed to being self-regulated) and concludes that being a regulated profession continues to be an important attribute for a profession (Harding and Taylor, 2015; RPS MEP, 2016). Adams (2015) points out that professional registration is often discussed in the context of state-profession relations but not in the context of what it means for professionals themselves to be registered with a regulatory body.

2.3.8 Professionalisation as dynamic processes

Professionalisation processes from functionalist and trait approach perspectives are the step-by-step processes or paths an occupation follows to become a profession, it being implied that these processes are similar for all occupations (Macdonald, 1995; Bissell and Traulsen, 2005). In an effort to break with functionalists' use of professionalisation, scholars introduced new terms such as 'professional project', 'professional development' and 'post-professionalisation' whilst still reverting back to using the term 'professionalisation' (Abbott, 1988; Macdonald, 1995; Randall and Kindiak, 2008; Larson, 2013; Saks, 2016).

Freidson (1994), Macdonald (1995), Saks (2012) and Larson (2013) view professionalisation from a social closure perspective as processes an occupation undertakes to achieve market closure. They described this as the 'professional project' which is the strategy followed by a profession to persuade the State and public of the value of its work with the successful outcome being that of achieving a monopoly in delivery of services. For Larson (2013) professionalisation is about a "collective assertion of special social status and as a collective process of upward social mobility" (p. xvii). It follows that professionalisation is a collective process whereby an occupation translates its special knowledge and skills or expertise as a resource into social and economic rewards. Implicit in this is that an occupation will move towards a monopoly of its expertise or service within the professional market thereby achieving status. However, Saks (2012) considers professionalisation as mainly socio-political processes, arguing that these processes have less to do with knowledge and skills and more to do with a profession's ability and power to influence the State and other key stakeholders at the macro-level (Macdonald, 1995, p. 32).

The term 'project' refers to planning activities that are required to be undertaken over a specific period of time to achieve a pre-determined aim. This implies that a 'professional project' has an end goal where a profession will have achieved its purpose of market closure and status and will no longer need to pursue efforts to enhance or defend its position (i.e. it has reached a 'steady-state'). Larson (2013) talks of professional groups having to go through different stages to reach this end-stage. Freidson (2001) concurs with this perspective stating that it is meaningless to discuss professionalisation processes unless there is a defined end-state towards which a profession is moving.

Abbott (1988) criticises these explanations of professionalisation processes because they assume that they are unidirectional in reaching an end-state with the main focus being the profession's relationship with the State rather than with other professions. These do not fully articulate the dynamic changes and social processes that continuously affect a profession over time. Therefore, recognition by the State is thus not the final point of the professionalisation processes, although it is an important stage. Abbott (1988) argues that even when a profession has achieved the required status it will need to maintain and defend this. Abbott (1988) maintains that professionalisation is a continuous process and any attempts to downgrade professional status, once achieved, will need to be fought off, as will challenges from competing groups. Abbott considers professionalisation as dynamic, complex and never-ending social processes. This is in line with Suddaby and Muzio's (2015) argument that the best way to study professions is to move away from viewing them as static social structures but instead viewing them as ongoing dynamic and continuous processes of professionalisation. It is through these processes that professions are involved in conflict and competition having to negotiate with various external stakeholders such as the State, other professions, customers/clients and the public as well as internally within the profession (Abbott, 1988; Suddaby and Muzio, 2015)

The discussion of professionalisation often reverts back to having to define a static end-point such as defining the concept 'profession' by returning to the continuous debate as to what the differences are between an occupation and profession (Dingwall and Wilson, 1995; Evetts, 2013). The commonality between the different understandings of professionalisation processes is that this concept can be understood as relating to processes whereby professions obtain or retain status

(Abbott, 1988; Adams, 2004). At the collective level, a profession can be viewed as going through processes by which it achieves status through 'professionalisation', loses its status through 'de-professionalisation' and also regains status through 're-professionalisation'.

Johnson (1972) and Haug (1972) argue that professions lose status and therefore power through de-professionalisation processes and proletarianisation resulting from bureaucratisation in the name of rationalisation, efficiency and productivity exerting deskilling pressures. They refer to a profession's work being systemised and laid down into simple procedures so that it is possible for external forces to control the work process gradually removing a profession's autonomy and control over its practice replacing it with less skilled and qualified occupations. Abbott (1988) explains that some scholars have ignored that these bureaucracies work within profession themselves. This has for example facilitated opportunities for professions within these bureaucratic organisations to develop their knowledge and skills as well as working within a "*multiprofessional* environment" (p.151) compared to the functionalist assumption that professions are single self-employed practitioners (Suddaby and Muzio, 2015).

The introduction of new technology that replaces previous practices can have a deskilling effect but can also provide new opportunities thereby potentially having both de- and re-professionalisation effects (Abbott, 1988; Bissel and Trauslen, 2005). There are, therefore, dialectical effects on professional work that are simultaneously destroying and creating a profession's jurisdictions. It is therefore possible for a profession to undergo re-professionalisation and de-professionalisation processes simultaneously. If professionalisation is a dynamic, continuous, never-ending process, consisting of re- and de-professionalisation processes happening simultaneously, then it can be argued that there cannot be a static end-point or 'steady-state'. Instead a profession will need to continuously undertake efforts to maintain, defend or improve its status in society relative to others. The goal for a profession is not static but is also moving and is relative to other professions. Abbott's (1981) definition of status makes it clear that this status is relative to other professions and is not static. Therefore this makes the goal of (re)- professionalisation processes a changing one that will always be relative to the status of other professions (Abbott, 1981; Adams, 2004). The concept of professionalisation in this study refers to dynamic, continuous, complex, and never

ending social processes that affect a profession's efforts to gain, maintain, enhance or defend its status in society. In this context, and as a way of exemplifying these dynamic social processes, the terms 're-' and 'de-professionalisation' are used to illustrate that there are several external and internal factors that can facilitate (re-professionalise) or hinder (de-professionalise) these efforts. Re-professionalisation is therefore the social process whereby a profession further develops itself with the aim of for example maintaining and claiming new jurisdictions whereas de-professionalisation is where a profession for example loses jurisdiction or where its autonomy is reduced (Abbott, 1988). De-professionalisation is linked to a profession losing its status. It is taken to mean that the profession either does not or cannot take action to enhance, maintain or defend its status. Figure 1 below demonstrates these dynamic and continuous processes of professionalisation.



Figure 1. Dynamic model of professionalisation

2.3.9 Working theories on the sociology of the professions

The neo-Weberian social closure theory and the functionalist view of professions, although two very different sociological approaches to professions, have in common that they mainly focus on professions at the macro-level by viewing them as social entities or movements with no reference to what it is professionals

actually do in practice. This is unlike Abbott's (1988) theory that has at its starting point what work professionals do in practice.

Abbott (1988) does not dispute that the organisational structures of professions should be examined. His argument is that this approach has ignored professional work and the context in which this work is carried out by only concentrating on how a profession is organised such as its professional association, professional regulation and code of ethics and generally ignoring other professions.

Abbott (1988) redresses this imbalance through his system of professions. He makes the case for shifting the emphasis when studying professions by beginning with the examination of professional life with the main focus being the work professions do or the nature of their practice and inter-professional competition. He states that the latter is a "fundamental fact of professional life" (p.2). Abbott views professions as being part of an interdependent system where jurisdictional boundaries are continuously in dispute, reinforcing this as a dynamic system.

Abbott (1988) implies that by starting from a position of exploring what professions do and inter-professional conflicts that this will aid the explanations as to why some of the organisational structures of professions are as they are including why they have succeed or failed. The emphasis of this study will be Abbott's (1988) theory, which has as its starting point the work professionals do (Macdonald, 1995; Mandy, 2008). The neo-Weberian social closure perspectives will also be drawn on. The functionalist and trait approach perspectives have also been used because professions themselves still refer to elements of this approach as a way of justifying their social position and status in society (Macdonald, 1995). Other theories including those discussed in this section will be referred to and others will be introduced where it is felt this will help to emphasise, explore, demonstrate or illustrate a particular argument or point.

There appears to be no one particular sociology theory that sufficiently explains 'profession'. This demonstrates that there is more than one view on professions. Adams (2015) and Saks (2016) argue that although there are theoretical differences there are advantages of combining these divergent theoretical influences to generate new insights. This may be one of the reasons for there being a tendency in the literature to combine various theoretical approaches in examining professions such as functionalist, trait approach, system of professions and neo-Weberian social closure perspectives spanning different paradigms

offering different views of social reality (Burrell and Morgan, 1979; Abbott, 1988; Witz, 1992; Macdonald, 1995; Larson, 2013; Saks, 2016). Burrell and Morgan (1979) argue that it is not possible to synthesise different paradigmatic sociology theories whereas Saks (2016) disagrees instead accepting that utilising various sociology theories aids the understanding of professions stating that there is “a strong case for a complementary eclectic approach” (p.14). This study aims to keep a flexible and open-minded approach to the sociology of professions theories, but not a totally eclectic approach, as a way of enhancing the understanding of the pharmacy profession whilst acknowledging that this is undertaken from the researcher’s paradigmatic position. (See *Chapter 4, Sections 4.3.1 Researcher paradigm and 4.3.2 Sociological theories and paradigmatic divides*).

2.4 Sociological examination of the pharmacy profession

A literature search was undertaken that centred on peer-reviewed published papers examining the pharmacy profession or some elements of it with reference to theories from the sociology of the professions covering Europe, the United Kingdom, North America (United States of America (USA) and Canada), Australia and New Zealand. A total of 632 peer-review papers were found which were narrowed down to a total of 17 relevant papers. Appendix 1 outlines the approach for this literature search.

The sociology literature on the pharmacy profession links its status to the nature of pharmacy practice in healthcare (Edmunds and Calnan, 2001; McDonald et al, 2010). Becher (1999) argues that an important factor that influences the nature of pharmacy practice is the pursuit of individual pharmacist’s reputations and standing as well as the pharmacy profession’s collective status in society. The nature of pharmacy practice refers to common activities and established practices undertaken by pharmacists within the healthcare setting where they work (e.g., community pharmacy or hospital) and where they develop their pharmacy practice further (Eaton and Webb, 1979; Mesler, 1991; Dingwall and Wilson, 1995; Edmunds and Calnan, 2001; Hibbert, Bissell and Ward, 2002; McDonald et al, 2010; Jamie, 2014; Broom et al, 2015; Waring et al, 2016). Pharmacy practice within a particular healthcare setting is undertaken by social convention allowing

pharmacists to practise (i.e., conduct pharmacy practice) (Abbott, 1988). (See *Chapter 3, The case of the pharmacy profession*).

Three of the peer-reviewed papers are discussion papers examining the status of community pharmacists (Denzin and Mettlin, 1968; Birenbaum, 1982; Harding and Taylor, 1997). The remaining papers are qualitative studies with research data generated from either semi-structured interviews or focus groups or a combination of the two. Interviews and focus groups include a combination of pharmacists, doctors, patients and other stakeholders inside and outside the pharmacy profession with some only including interviews with pharmacists. Four studies utilise dual strategies of observations and interviews (Mesler, 1991; Dingwall and Wilson, 1995; Hibbert, Bissell and Ward, 2002; Waring et al, 2016; Waring and Latif, 2017). Waring et al (2016) and Waring and Latif (2017) report different aspects from essentially the same study. Dingwall and Wilson (1995) follow an ethnography approach through open participant observations and interviews with pharmacists within two community pharmacies in the USA whereas Mesler (1991) collected data through covert participant observations within hospital pharmacies and wards in two hospitals in the USA, which was followed with interviews with pharmacists, doctors and nurses. Hibbert, Bissell and Ward (2002) followed strategies of non-participant observations in community pharmacies as well as focus groups and individual semi-structured interviews with patients and pharmacists as did the study undertaken by Waring et al (2016). In addition Waring and Latif (2017) also reported on interviews with General Practitioners (GPs). The relevant papers cover a time span from 1968 up until today, with the older studies from 1960s, 1970s, 1980s and 1990s still being referred to in the peer-reviewed papers published recently. This shows that scholars still consider these relevant possibly implying there has been little progress within the pharmacy profession or due to sociologists having marginalised the pharmacy profession thereby neglecting this as a topic for sociological analysis and evaluation or a combination of the two (Dingwall and Wilson, 1995; McDonald et al, 2010; Jamie, 2014).

2.4.1 The nature of pharmacy practice and professional status

Pharmacists' professional status was contested in sociology accounts by referencing the trait approach. This led to pharmacists being described as

underdeveloped and seen in the sociology literature as marginal, semi-professional or an incomplete profession lacking autonomy and 'mystique' (Denzin and Mettlin, 1968; Harding and Taylor, 1997). The influential paper by Denzin and Mettlin (1968) entitled: *Incomplete professionalization: the case of pharmacy*, is still referred to in the literature today, and argues that pharmacy's attempts to become a profession has failed due to its failure to recruit individuals with altruistic values, failure to accumulate a systematic body of knowledge, failure to establish cohesive professional associations and failure to engage in activities to ensure control over its 'social object', the drug, and being guided by commercial interests in the retail sector. Harding and Taylor (1997) argue that pharmacy retains some of the core traits, which categorises it as a profession. They maintain that pharmacists possess specialised knowledge obtained through lengthy training, being service-orientated while acting in patients' and the public's best interests rather than pursuing self-interests. They argue that pharmacy has a monopoly of practice by having exclusive rights to sell certain categories of medicines while being a regulated profession, which helps to determine the scope of training and eligibility of membership of the profession and having a code of practice. Dingwall and Wilson (1995) disagree with utilising the trait approach in analysing the status of pharmacy as an all-encompassing list of traits is difficult to achieve, instead suggesting examining the "every day work of pharmacists" (p.117) (See *Section 2.3.1 Functionalism and trait approach*).

Denzin and Mettlin (1968) suggest that hospital pharmacists are "more professional" (p. 377) than community pharmacists because the latter are also concerned with non-professional issues due to working in "retail outlets" (p. 377) selling non-professional items. Holloway, Jewson and Mason (1986) and Dingwall and Wilson (1995) maintain that commercialism and professionalism are not imperatives although more recent findings by Edmunds and Calnan (2001), McDonald et al (2010) and Waring and Latif (2017) suggest otherwise as they conclude General Practitioners (GPs) consider community pharmacists' link with 'trade' a barrier for closer working. The implication is that community pharmacists' link to 'trade' is still an issue to them in extending the nature of their practice particularly as they are dependent on doctors for this (See *Section 2.4.2 Medical hegemony and jurisdictional uncertainties*). McDonald et al (2010) found that community pharmacists extending their practice into undertaking Medicines Use Reviews (MURs) sometimes undertook these based on commercial needs rather

than patients' needs concluding that community pharmacists' "professional status is hampered by the pursuit of commercial, as opposed to patient interest" (McDonald et al, 2010, p. 457), which is similar to the findings made in 1968 by Denzin and Mettlin.

The sociology literature makes reference to pharmacists having lost the extemporaneous compounding of medicines to the pharmaceutical industry (Harding and Taylor, 1997) with Giam, McLachlan and Krass (2011) postulating that it was this aspect of pharmacy practice that provided pharmacists with professional status. This loss of practice left pharmacists with the act of dispensing which is increasingly viewed as a technical function akin to a "factory system of production" (Birenbaum, 1982, p. 872) due to increasing technological developments, social and economic changes including increasing consumer demand threatening pharmacists' status as healthcare professionals if they are not able to expand and develop the nature of their practice further (Harding and Taylor, 1997; Hibbert, Bissell and Ward, 2002; McDonald et al, 2010; Waring et al, 2016).

Birenbaum (1982), Holloway, Jewson and Mason (1986) and Harding and Taylor (1997) argue that the introduction of new technology will have de-professionalisation effects on pharmacists (i.e., loss of status). Petrakaki, Barber and Waring (2012) take a different position. They reason that although introducing new technology can have a de-skilling effect on community pharmacy by eroding the value of its traditional practice it can also present new opportunities. New technology can free pharmacists from the more mundane aspects of their practice and if this is part of a wider healthcare system it may improve their interaction with other healthcare professionals within the healthcare community giving them further visibility in healthcare. It can free up pharmacists' time to "engage in more conceptual activities and develop new capabilities leading to re-skilling" (p. 430) therefore having a re-professionalisation effect. The authors do not address what these new extensions of community pharmacists' practice may be to secure this re-professionalisation. The study by Petrakaki, Barber and Waring (2012) concludes that a profession can experience re- and de-professionalisation processes simultaneously, demonstrating that these are dynamic, continuous and never-ending processes whereby a profession maintains, enhances or loses professional status (See *Section 2.3.8 Professionalisation as dynamic processes*).

The majority of sociology studies have examined community pharmacists with a view to extending the nature of pharmacy practice as a re-professionalisation strategy to retain or enhance their professional status in healthcare (Edmunds and Calnan, 2001; McDonald et al, 2010; Waring et al, 2016). Harding and Taylor (1997) argue that community pharmacists, by extending their practice to cover a broad range of services, are diversifying away from their core function of dispensing which could have a de-professionalisation effect because they will move into areas where they will not be able to make jurisdictional claims. The authors' argument is that community pharmacists' extension of their practice should be based on the core function that defines the pharmacy profession (See *Section 2.4.4 Dispensing and information-giving*).

Clinical pharmacy originated in hospitals and was considered an extension to pharmacy practice giving hospital pharmacists increased clinical involvement on the inpatient wards which was seen as enhancing their professional status (Eaton and Webb, 1979; Mesler, 1991). Later sociological works by Edmunds and Calnan (2001), McDonald et al (2010) and Petrakaki, Barber and Waring (2012) also linked community pharmacists' status to their pharmacy practice by them extending their current practice and jurisdiction. McDonald et al (2010) summed this up as pharmacists being able to "reflect and adapt to changing circumstances...which offer the potential to enhance professional status" (p. 451).

2.4.2 Medical hegemony and jurisdictional uncertainties

Denzin and Mettlin (1968) assume that professionalisation is linear and a step-by-step process whereby pharmacists can become a profession in line with the functionalist and trait approach perspective.

Birenbaum (1982), Edmunds and Calnan (2001), McDonald et al (2010), Petrakaki, Barber and Waring (2012) and Waring et al (2016) all refer to professionalisation or re-professionalisation as processes, efforts or strategies aimed at pharmacists as a way of expanding their practice beyond the act of dispensing medicines with a view to gaining or re-gaining their status, and de-professionalisation whereby they lose status (See *Section 2.3.8 Professionalisation as dynamic processes*).

Holloway, Jewson and Mason (1986) refer to Larkin's "occupational imperialism" model (as referred to in Witz, 1992), which Witz (1992) adopted in her conceptual model of occupational closure as demarcation strategies (See *Section 2.3.2 The 'power approach'*). These are strategies whereby a dominant group such as doctors with greater access to power resources enables them to demarcate professional boundaries of other subordinate groups such as pharmacists. This allows doctors inter-professional control of pharmacists by for example demarcating their professional boundaries within a "distinct sphere of competence" (Witz, 1992, p.47) in the division of labour (See *Section 2.3.2 The 'power approach'*). Holloway, Jewson and Mason (1986) explain that in sociological terms these demarcation strategies help to explain how a subordinate group such as pharmacists pursue collective social mobility without challenging the dominance of doctors within the division of labour in healthcare. Eaton and Webb (1979) explain that the implication is that doctors decide which functions they wish to delegate (i.e., but still retain some responsibility for these) or relinquish (i.e., no longer consider these functions as medical) to pharmacists or other subordinate groups. Eaton and Webb (1979) and Holloway, Jewson and Mason (1986) found that hospital and community pharmacists are forced to accept that doctors retain responsibility for patient care in "exchange for the right to practise certain 'medical' activities on the periphery of clinical medicine" (Eaton and Webb, 1979, p.85). Similar findings were echoed by Mesler (1991), Edmunds and Calnan (2001) and Waring and Latif (2017).

Edmunds and Calnan (2001) and McDonald et al (2010) found that community pharmacists who wished to extend their pharmacy practice were met unfavourably by GPs who displayed traditional attitudes of professional dominance, where these initiatives were hampered by internal divisions within the pharmacy profession and due to the commercial element of community pharmacy. McDonald et al (2010) found that GPs did not value the Medicines Use Review (MURs) reports they received from community pharmacists, speculating that this resistance is probably due to GPs not being in control of MURs, therefore not engaging with this process. It can be argued that this raises issues of status and inter-professional rivalry as GPs may view pharmacists as encroaching on an area of practice traditionally occupied by them (Eaton and Webb, 1979; Harding and Taylor, 1997) or alternatively as a service that is not worth providing in the first place.

The study by Edmunds and Calnan (2001) of GPs and community pharmacists made similar findings to Eaton and Webb (1979) and Holloway, Jewson and Mason (1986) in that GPs followed demarcation strategies by being in control of what new tasks to delegate to community pharmacists whereas they found community pharmacists were not seeking to encroach or usurp doctors but instead wanted to support GPs in a “bid for survival” (p. 943) by freeing up GPs’ time. They found that when GPs considered community pharmacists threatened their jurisdiction they responded by reinforcing and controlling the traditional hierarchies and division of labour between doctors and pharmacists through demarcation strategies.

In hospitals pharmacists occupy the same physical space as doctors, nurses and patients on the inpatient wards, unlike community pharmacists (Jamie, 2014). Eaton and Webb (1979) found that on hospital wards pharmacists were not viewed as encroaching on doctors’ work but instead their presence and work on the wards was accommodated by doctors “within a framework of delegation” (p. 86) whereby doctors maintain hegemony. Mesler (1991) from his study of hospital pharmacists found that their expanded clinical pharmacy role had been accepted on wards noting this took place through a “slow process of encroachment and delegation ” (Mesler, 1991, p.325), whereby pharmacists tried to influence physicians’ and nurses’ activities as a way of making “a difference to the way patients were treated and gain acceptance as new members on the medical team” (p. 326) but without creating professional boundaries conflicts with doctors or nurses and with doctors retaining the overall responsibility for patient care.

The study by Broom et al (2015) of hospital pharmacists noted that within the workplace there is an overlap of duties between different professions leading to continued renegotiating of boundaries to solve practical problems in the workplace. They found that hospital pharmacists may encroach on doctors’ territory when working on the wards although they often retreat back to their own boundaries and jurisdiction thereby not acting as a threat to doctors’ autonomy by leaving or deferring decisions to doctors. The authors conclude that this encroaching and retreating of pharmacists’ boundaries results in jurisdictional uncertainties as pharmacists attempt to influence doctors’ prescribing choices. They argue that these jurisdictional uncertainties are due to pharmacists being unable to prescribe. An alternative reason, which was not offered by the authors,

was that patients are under the care of a consultant who takes responsibility for their treatment thereby maintaining doctors' hegemony (Eaton and Webb, 1979, Mesler, 1991).

The implication of these studies is that pharmacists are reliant on doctors if they wish to expand their pharmacy practice beyond the act of dispensing in their re-professionalisation efforts, which applies to both community and hospital pharmacy. Doctors retain medical hegemony regardless of the healthcare setting in which pharmacists work with pharmacists themselves reinforcing the existing hierarchy (Eaton and Webb, 1979; Broom et al, 2015). Edmunds and Calnan (2001) conclude that pharmacists are not prepared to challenge doctors' existing jurisdiction wanting to avoid conflict "at the expense of their own professional development" (p.951) with Broom et al (2015) stating that the outcome is that pharmacists experience jurisdictional uncertainties in the workplace. Edmunds and Calnan (2001) maintain that pharmacists themselves contribute to their low status because they do not challenge the status quo nor do they challenge doctors' jurisdiction often at the expense of their own jurisdictional claims, thereby avoiding conflict and inadvertently committing themselves to remain in a subordinate role to doctors.

2.4.3 Internal divisions

Denzin and Mettlin (1968) noted that "pharmacy is a moving, shifting conglomeration of persons sharing the common label of *pharmacy*" (p. 377) indicating that there are internal divisions within the pharmacy profession due to having different sectors or segments. Edmunds and Calnan (2001) noted that within community pharmacy in England there are divisions between community pharmacists who are independent and those being employed by large multiples resulting in a lack of unity which weakens pharmacists' re-professionalisation efforts (See *Chapter 1, Section 1.1 The pharmacy profession: Setting the scene*). In addition McDonald et al (2010) also found tensions between community pharmacists working at the 'coal-face' versus the 'head office' and between owners versus employees. Birenbaum (1982) noted that, "community and hospital pharmacists have few common professional interests" (p. 872.). Holloway, Jewson and Mason (1986) also noted that there are internal divisions within pharmacy speculating it is only the fact that pharmacists are registered with the same

regulatory body that provides them with some protection “against usurpatory strategies of other groups” (p. 331), implying that there is a lack of cohesion within the profession.

Morgall and Almarsdóttir (1999) undertook case study research involving semi-structured interviews of community pharmacists in Iceland to explore how they lost their monopoly (i.e., that only pharmacists could own a community pharmacy). They found that deregulation of community pharmacy was allowed to take place due to several unfavourable factors such as a lack of unity within the pharmacy profession and the external political situation aligning at the same time creating the political conditions conducive for this change to take effect. They concluded that an important factor was internal conflict within the pharmacists’ population allowing politicians to take advantage of the absence of their resistance for change by seizing the opportunity to cut the healthcare budget through deregulation of community pharmacy to increase competition. The outcome of this deregulation was that non-pharmacists could now own community pharmacies. The authors found that external inter-professional conflict was not central to this deregulation and that there was no public engagement or interest. This example does not fit the social closure perspective where the expectation would have been for community pharmacists to have resisted the de-monopolising attempts by the State as part of their exclusionary closure strategies (See *Section 2.3.2 The ‘power approach’*). The authors conclude that these intra-professional conflicts appear to play a larger role, possibly an even more significant role than the State, in this de-monopolisation. The implication is that a profession will need to be cohesive in its dealing with the State in its negotiations to gain or maintain the monopoly over an area of practice (See *Chapter 1, Section 1.3 The socio-political and economic context*).

2.4.4 Dispensing and information-giving

Birenbaum (1982) defines a profession as one that has recognition by the State through professional regulation. Holloway, Jewson and Mason (1986) argue that this is only one aspect as a profession can lose autonomy and function without this necessarily affecting its legal licence (i.e., professional regulation). Denzin and Mettlin (1968) argue that community pharmacists view the medicine as a product to be sold or supplied rather than a social object they direct their services towards,

thereby not contributing to healthcare besides supplying a product. They point out that the pharmacy profession has failed to “gain control over the social object which justified the existence of its professional qualities in the first place” (Denzin and Mettlin, 1968, p.378).

Dingwall and Wilson (1995) criticise Denzin and Mettlin for not relying on original data in their paper and that they wrongly treat the social object as a material object instead of considering the medicine “as a basis for social action” (p.125) arguing that according to Hughes (1958) all professions are “constituted around a social object” (p. 125). Dingwall and Wilson (1995) argue that sociologists have mainly been drawn to the product-function of dispensing when examining the pharmacy profession providing a sociologically limited view of pharmacy.

Instead Dingwall and Wilson (1995) set out to explore the nature of pharmacy practice beyond the act of dispensing to identify the core function that defines the pharmacy profession. The authors argue that it is within the nature of pharmacy practice that there is a core function that defines the pharmacy profession that is generic or common to all pharmacists regardless of which healthcare setting they work in. This core function for a profession is understood as an activity that distinguishes and defines one profession from other professions (Dingwall and Wilson, 1995). This core function is based on a profession’s knowledge, skills, abilities and expertise and working methods or techniques that are unique to that profession that are useful and necessary in carrying out its practice (Abbott, 1988; Freidson, 2001).

Dingwall and Wilson (1995) found that ‘information-giving’ was the core function that defines the pharmacy profession based on pharmacists’ specialist knowledge of medicines. This made them conclude that it is the “symbolic transformation of the drugs from natural into social objects” (p.111) that provides pharmacy with its distinct role.

Harding and Taylor (1997) largely concur with Dingwall and Wilson’s findings arguing this symbolic transformation provides pharmacists with a “mandate to provide or offer information/advice” (p.554) suggesting that pharmacists have a recognised authority to “inscribe prescribed or purchased drugs with a particular meaning for the user” (p. 554). They argue it is this recognised responsibility of pharmacists to symbolically transform a drug into a medicine that ensures they are

viewed as 'medicines experts' thereby cementing their professional status in society.

Despite Harding and Taylor (1997) expanding further on Dingwall and Wilson's (1995) ideas they still revert back to stating that the core function of pharmacy is the dispensing thereby departing from what Dingwall and Wilson (1995) were trying to achieve in looking beyond the act of dispensing that is normally associated with pharmacy in an attempt to break with previous sociological work.

Hibbert, Bissell and Ward (2002), in their study of consumers purchasing over-the-counter (OTC) medicines in community pharmacies, conclude that although they do not dispute the transformation capabilities of pharmacists they remind readers that pharmacists are not the only profession who are able to 'transform' the medicine. They question the symbolic transformation process as this makes this a diffuse and unclear area of jurisdiction as this transformational work is not limited to the pharmacy profession but that patients may seek this 'transformational work' from other sources (e.g., GPs and internet). Eaton and Webb (1979) emphasise the advisory role pharmacists have for doctors and patients, where these two parties may decide to either act on this advice or ignore it. The authors argue that ultimately pharmacists defer the responsibility for decisions to doctors.

There does not appear to be other sociological work on the pharmacy profession that has re-visited, expanded on or challenged the findings by Dingwall and Wilson (1995) where they suggest that the core function that defines the pharmacy profession is 'information-giving', which pharmacists use to transform the medicine as a material object into a social one, with recent sociological work (e.g., McDonald, 2010; Jamie, 2014; Waring et al, 2016) continuing to refer to pharmacists' 'transformational work'. Dingwall and Wilson (1995) do, however, call for further research into the nature of pharmacy practice to find out more about the pharmacy profession and the core function that defines it to develop a broader sociological view of pharmacy.

2.4.5 Surveillance, discipline and 'pastoral power'

Dingwall and Wilson (1995) noted the "disciplinary elements of pharmacy" (p.120) by alluding to pharmacists as "disciplinary agents in a Foucauldian sense" (p. 120) although they did not explore this further in their study. Studies since then have

examined pharmacy from a Foucauldian perspective. Waring et al (2016) and Hibbert, Bissell and Ward (2002) found that community pharmacists tried to formalise their professional surveillance of patients' use of medicines either through delivering a New Medicines Service (NMS) or in patients' choice when buying over-the-counter medicines. Hibbert, Bissell and Ward (2002) showed that patients (consumers) challenged the expertise of pharmacists reducing their scope for 'transformational work'. Waring et al (2016) concluded that pharmacists through formalising their surveillance of patients' adherence to newly prescribed medicines and by providing patient education as part of the NMS gave them 'pastoral power', which the authors speculated may result in enhancing pharmacists' status. Waring and Latif (2017) found that patients viewed community pharmacists as a substitute for busy GPs in providing a second opinion with GPs retaining responsibility for their care, and that GPs and community pharmacists were "competing pastors" (p.8) with GPs seeing community pharmacists as assisting them because they have more time available.

Jamie (2014) found that pharmacists view patients' bodies as entities where the pharmacological actions of medicines happen. Jamie (2014) found that pharmacists' practice differed between community and hospital pharmacy, resulting in differences in how they interact with patients' 'bodies'. Hospital pharmacists interact with singular bodies and the toxicity of hospital medication whereas community pharmacists interact with a multiplicity of bodies (i.e., patients and consumers) within their more multifaceted practice resulting in them being uncertain about their roles in healthcare.

2.5 Research question and study aims

The sociology of the professions and the review of the sociology studies of the pharmacy profession informed this study (See *Sections 2.3 Theories from the sociology of the professions* and *2.4 Sociological examination of the pharmacy profession*). The sociology of the professions confirms that professional status is important for professions and that this is linked to the nature and act of practice. (See *Sections 2.3.4 Professional status* and *2.4.1 The nature of pharmacy practice and professional status*).

The majority of sociological analyses of the pharmacy profession have focused on pharmacists trying to enhance their status by extending their pharmacy practice

(See *Section 2.4.1 The nature of pharmacy practice and professional status*). Most sociological analyses of pharmacy have focused on community pharmacists and often are limited to particular aspects of their pharmacy practice (e.g., Medicines Use Reviews) instead of taking a broader view of the profession and the nature of pharmacy practice. As far back as 1995, Dingwall and Wilson called for more research into the “everyday work of pharmacy” (Dingwall and Wilson, 1995, p. 117) including exploring the nature of pharmacy practice recognising that this differs amongst the healthcare settings in which pharmacists work. Since then hardly any sociological studies have explored the pharmacy profession by including both hospital and community pharmacists, despite being part of the same profession. To address this gap in the literature this study involved pharmacists working within four different healthcare settings: community pharmacy, acute hospital, mental health and community health services.

The sociology literature on pharmacy shows that there is relatively little known about the pharmacy profession and the nature of pharmacy practice. Therefore, it was considered vital to explore how pharmacists themselves perceived the nature of pharmacy practice. This informed the title of this thesis to be: *Pharmacists’ perceptions of the nature of pharmacy practice*.

To explore the pharmacy profession further the purpose of this study was to understand and provide insight into pharmacists’ perceptions of the nature of pharmacy practice and the implications this has for them by linking this to their status in society today. This led to the research question: *How do pharmacists working in different healthcare settings perceive their status in society today?*

Four aims of the study were identified to answer the research question. The study by Dingwall and Wilson (1995) aimed to explore the nature of pharmacy practice by looking beyond the act of dispensing to identify the core function that defines the pharmacy profession. Pharmacists’ practice with the exception of the act of dispensing has not been widely theorised in the sociology literature (See *Section 2.4.4 Dispensing and information-giving*). It was an important aim for this study to identify the core function that defines the pharmacy profession. This core function will by implication have to apply across all sectors of the pharmacy profession and not just to community pharmacists.

Pharmacists cannot work in a healthcare setting without interacting with other healthcare professionals including negotiating with them some workable agreement in the workplace regarding activities and relationships (Abbott, 1988; Freidson, 1994). The sociological analysis of the pharmacy profession demonstrates its dependence on doctors and how this affects pharmacists' practice regardless of the healthcare setting in which they work (See *Section 2.4.2 Medical hegemony and jurisdictional uncertainties*). Abbott (1988) explains the importance of how a profession is viewed by others as this affects its practice, which influences its professional status. This led to the second aim, which was to explore pharmacists' views about how others' perceptions of them affected their pharmacy practice.

The majority of the sociology literature on the pharmacy profession is concerned with pharmacists trying to extend their practice to maintain or enhance their status. The third aim was to explore how pharmacists maintain or extend their practice. Abbott (1988) acknowledged that there are internal divisions within a profession, with several authors noting that there are several internal divisions within the pharmacy profession influencing practice (See *Section 2.4.3 Internal divisions*). Dingwall and Wilson (1995) call for sociological studies of pharmacists' practice within the different sectors in pharmacy (i.e., community and hospital pharmacy). The final aim was to explore this further by making comparisons between pharmacists' perceptions of their pharmacy practice in relation to the healthcare setting in which they work.

It was the research question supported by the four study aims that informed the this study in terms of both study design and methodology, the semi-structured interview guide, the data analysis (See *Chapter 4, Methodology and methods*) and the findings which consisted of themes and sub-themes (See *Chapter 5, Findings*) and the final contributions of this study (See *Chapter 8, Section 8.2. Sociological perspectives of the pharmacy profession*).

To answer the research question a qualitative collective case study that consisted of four cases studies was used. Each case study included five pharmacists from community pharmacy, acute hospital, mental health or community health services, respectively. This allowed for comparison of their pharmacy practice across different healthcare settings to identify similarities and differences. A total of twenty

pharmacists were included. The primary data were obtained from one in-depth individual semi-structured interview using an interview guide (See *Chapter 4, Section 4.9.1 Semi-structured interview guide* and *Appendix 6, Semi-structured interview guide*). Semi-structured interviews consist of different prompts to guide the interviews with the main aim of letting participants talk. Below is summarised the rationale or reasoning behind the different prompts used in the semi-structured interview guide based on the working theories on the sociology of the professions and the sociological analysis of pharmacists discussed in this chapter.

The initial interview prompts were designed to allow pharmacists to talk about their pharmacy practice including what aspects were important to them as well as areas they felt less positive about. The aim was to explore the nature of pharmacy practice from their perspective. A profession does not practise as an independent unit but rather within an inter-related system of professions (Abbott, 1988). This led to interview prompts, asking pharmacists to talk about and describe their relationships and interactions with other healthcare professionals and others such as patients, including how they perceived they were viewed by others.

This was followed by prompts related to pharmacists' thoughts about the future including asking them what they thought about the statement "being a pharmacist is a valuable profession" and why or why not. This was to explore pharmacists' thoughts on their own future prospects and those of the pharmacy profession as a whole.

Pharmacists were asked about the possibility of being able to move from working in one healthcare setting to another. This was to assess if they considered there were some practices that were transferable regardless of the healthcare setting. This was an attempt to help identify the core function that defines the pharmacy profession (Dingwall and Wilson, 1995).

The different sociology theories of the professions make the assumption that it is desirable to be a professional and to be registered with a regulatory body (See *Sections 2.3.5 Professionalism as a discourse, 2.3.7 Professional regulation, and 2.4.1 The nature of pharmacy practice and professional status*). Adams (2015) points out that there is limited literature on what it means for individual professionals to be considered a professional. This informed the prompt related to what it meant to pharmacists to be considered a professional.

A prompt was added following the first interview by asking pharmacists about their thoughts regarding their development and career prospects. This is linked with Larson's (2013) assertion that if a profession has a development and a career structure this forms part of privileges that is linked to the status of a profession. (See Section 2.3.2 *The 'power approach'*).

2.6 Summary

The working theories on the sociology of the professions relevant to this study have been discussed in this chapter. It was reasoned that there is no particular sociology theory that sufficiently explains professions and that there are advantages of combining different theories to help generate new insights into the pharmacy profession. It was determined that professional status is linked to a profession's act or nature of practice (Abbott, 1988). Dingwall and Wilson (1995) called for examining the "every day work of pharmacists" (p. 117) with Abbott's (1988) theory focusing on a profession's act or nature of practice within an inter-related system of professions.

The sociological examination of the pharmacy profession demonstrated that there is little known about this profession and the nature of pharmacy practice. Pharmacy practice, with the exception of the act of dispensing, has not been widely theorised in sociology. Pharmacy practice differs according to the healthcare setting in which pharmacists work. Sociological work on the pharmacy profession connects its pharmacy practice to its professional status. It was, therefore, important to explore how pharmacists working within different healthcare settings perceived the nature of pharmacy practice linking this to their status in society today. The research question was determined as: *How do pharmacists working in different healthcare settings perceive the status in society today?*

To address the research question the four aims of the study were determined to be:

- To identify the core function that defines the pharmacy profession.
- To explore pharmacists' views about how others' perceptions of them affects their pharmacy practice.
- To explore how pharmacists perceive they maintain or extend their pharmacy practice.

- To make comparisons between pharmacists' perceptions of their pharmacy practice in relation to the healthcare setting in which they work.

It was the research question supported by the four study aims that informed this study. *Chapter 4, Methodology and methods*, discusses the rationale for using qualitative collective case study methodology to address the research question. This chapter explains the researcher's paradigm, the methods for data collection and analysis and other aspects related to this study.

The sociological examination of the pharmacy profession does not provide the contextual information about the pharmacy profession in England. Therefore, before discussing the methodology and methods for this study, these contextual aspects are covered in *Chapter 3, The case of the pharmacy profession in England*. In addition this chapter also explains some of the factors that determine the nature of pharmacy practice by outlining the historical developments of the pharmacy profession in England, including how it evolved into the profession that is recognised today.

CHAPTER THREE: The case of the pharmacy profession in England

3.1 Introduction

The previous chapters outlined the working theories on the sociology of the professions. The review of the sociology literature relating to the pharmacy profession showed that there is little known about pharmacists and the nature of pharmacy practice which has not been widely theorised in sociology. This chapter aims to provide contextual information about the pharmacy profession in England through referring to various articles, national documents and the 'grey literature'.

Within the neo-Weberian social closure perspective professional groups are viewed as pursuing their self-interests by claiming a monopoly on their activities, which involves pursuing a collective interest by responding defensively to attempts by others to secure an advantage at their expense (Brante, 1988; Witz, 1992; Macdonald, 1995; Andrews and Wærness, 2011; Saks, 2016).

Abbott (1988) contends that it is the history of inter-professional relations and conflicts that determines the history of professions. To understand how the pharmacy profession is perceived today, it is important to first consider its historical developments including its interdependency and struggles with other professions over its jurisdiction. This includes examining how it evolved into the pharmacy profession that is recognised today and the factors that determine the professional status of pharmacists.

3.2 Historical development of the pharmacy profession

Abbott (1988) argues that it is the interplay of jurisdictional links between professions that determines the history of individual professions. In England in the 16th century the medical profession consisted of physicians, surgeons, apothecaries and 'chemists and druggists' where the latter emerged as a separate branch of the medical profession during the 18th century. The boundaries between them were vague and poorly defined with overlapping jurisdictions before they started to separate into their distinct professions in the 19th century (Hunt, 2005).

3.2.1 'Chemists and druggists' versus apothecaries

Apothecaries (who later became general practitioners (GPs)) and 'chemists and druggists' (who became today's pharmacists) evolved together as professions (Kronus, 1976; Holloway, 1991). They have a history of inter-professional conflict.

This included staking out their territories or professional boundaries linked to their respective political, economic and social abilities to influence the State, public and other stakeholders (Holloway, 1991).

The two professions aimed to establish their claims to jurisdiction, monopoly and control over their respective markets in the legal arena through the law (and therefore via the State), by organising themselves into professional associations to further their professions' corporate interests, through strategies of establishing formal education and training and by concentrating on tasks that were crucial to them in protecting and extending their competencies (Wilensky, 1964; Larson, 2013).

During the 1700s and 1800s, patients paid a fee for medical advice and treatment and would shop around based on what they could afford (Holloway, 1991). This patient choice undermined the professional authority of the apothecaries as they felt 'chemists and druggists' were taking their business and income.

According to Abbott (1988) the status of patients served by a profession is proportionate to the status of the profession by relating this to patients' ability to pay and their political influence. Physicians as the super-ordinate profession served high status patients from the upper or upper-middle classes (Kronus, 1976). Apothecaries and 'chemists and druggists', being subordinate to the physicians, served the upper to middle classes and the middle to working classes, respectively (Kronus, 1976). 'Chemists and druggists' were described as the poor man's doctor having a lower status than apothecaries (Holloway, 1991; Anderson, 2015).

'Chemists and druggists' and apothecaries differed in their focus of practice and how they charged for their services but otherwise they offered similar services (Holloway, 1991; Worling, 2005). Apothecaries' focus was medical practice including visiting patients at home. They charged for their medical advice and supplemented their income by compounding and selling medicines (Worling, 2005). 'Chemists and druggists' focused on retail and dispensing with their medical practice confined to the counter in the chemist shop (Worling, 2005). They gave medical advice for free and charged for products sold (Anderson, 2007). Early on in their development 'chemist and druggists' prioritised the retail aspects over their medical practice (Holloway, 1991).

Apothecaries often practised without a shop whereas the retail shop was the defining characteristic for 'chemists and druggists' (Holloway, 1991). The apothecaries' premises were a mixture of a storeroom, surgery, workshop and living room (Holloway, 1991). Chemist shops gave prominence to the retail side enticing their customers into the shop by displaying large glass bottles containing coloured liquid (Holloway, 1991). These bottles became a symbol of the pharmacy trade and can still be seen displayed in some community pharmacies today.

The apothecaries had an advantage over 'chemists and druggists' in that they had already established a professional organisation, the Worshipful Society of Apothecaries by Royal Charter in 1617 due to serving politically influential high status clients with royal connections (Worling, 2005). This meant they had access to resources such as training and libraries and had the ability to corporately work on monopolistic activities including being able to lobby politicians to further their interests (Holloway, 1991). 'Chemists and druggists' were not corporately organised. In the literature they were described as a heterogeneous and diverse group mainly interested in conducting their everyday business with little interference, lacking occupational cohesion and ambition (Kronus, 1976; Holloway, 1991).

Apothecaries aspired to professional status. They were aiming to establish exclusivity of service and privilege as a way of being accepted as medical practitioners by physicians through applying usurpatory strategies (Holloway, 1991; Witz, 1992; Worling, 2005). To achieve this, the Society of Apothecaries was influencing and bargaining with the State as a way of seeking social closure in the legal arena through the law and licensing as a way of developing the apothecary profession (Worling, 2005; Hunt, 2005). Apothecaries were following exclusionary closure and demarcation strategies by not only trying to exclude 'chemist and druggists' but also by aiming to gain inter-professional control over them (Witz, 1992).

The apothecaries fought on two fronts, against the physicians to defend their right as medical practitioners and against competition from 'chemist and druggists' for the right to compound and supply medicines, including restricting the practice of 'chemists and druggists', and implicit in this, fighting over patients (Underhill, 1992). In 1815 the Society of Apothecaries brought in a bill to regulate the practice

of apothecaries and 'chemists and druggists' (Holloway,1991). The bill laid down the training required to practise as apothecaries, which would have an impact on the businesses of 'chemists and druggists' by placing them under the supervision of apothecaries (Hunt, 2005). Some 'chemists and druggists' organised themselves for a short period to work collectively to protect their trade interests and oppose the bill. They were successful. The outcome was that they were exempt from the Apothecaries Act of 1815 allowing them to continue to practise without any proof of training (Kronus, 1976). As a result of this Act, the Society of Apothecaries was given the statutory right to conduct examinations and grant licences to practise medicine (Holloway,1991). This Act indirectly affected 'chemists and druggists' as some of them also practised as apothecaries, while having to decide what profession they would continue to practise in. This Act meant the 'medical profession' had started to demarcate professional boundaries and its jurisdictional claim over medical practice with its function being that of diagnosing illnesses and determining treatments.

It was the apothecaries' link with the trade of selling medicines that was the cause of their intra-professional conflict with physicians and surgeons. It was argued that "if the general practitioner was to gain recognition as a true 'professional', it was imperative to overcome the awful stigma of trade" (Underhill, 1992, p.333) as this was "retarding the status of the wider profession" (Jenkinson, 2012, p.2).

Inter-professionally apothecaries described the 'chemist and druggist' as an "uneducated, ignorant opportunist, guilty of foisting himself off as a medical practitioner on the gullible poor, causing untold injury to the health of his customers" (Holloway, 1991, p 67). This stereotype of uneducated 'chemists and druggists' prioritising their commercial gains over patients' health was meant to undermine them. However, today this conflict between commercialism or trade and professionalism continues to be an issue for community pharmacists, as does the problem of how the pharmacy profession persuades patients and doctors that they have the knowledge, skills and competencies they claim to have (Anderson, 2002; Hughes and McCann, 2003; Collins, 2016).

3.2.2 The Pharmaceutical Society

In 1841 another bill was proposed relating to the medical profession that threatened the business of 'chemists and druggists' (Hunt, 2005). This bill made it

compulsory for 'chemists and druggists' to pass an exam before being able to carry out their business and if they recommended a medicine they would be deemed to be practising medicine as the bill would make 'counter prescribing' illegal. Again a small group of 'chemists and druggists' opposed this bill (Holloway, 1991). The bill was rejected but 'chemists and druggists' realised they had to organise themselves into a professional association to corporately defend their trade and area of practice, realising medical reforms were now firmly on the political agenda (Holloway, 1991; Anderson, 2015).

It was the elite of the profession who were prominent business owners, who established the Pharmaceutical Society in 1841 (Holloway,1991). Initially full membership, and therefore representation on the Council, was restricted to those who owned a business. Employees could only join as associate members (Holloway, 1991). For many years the Pharmaceutical Society placed ownership of a business over educational accomplishment as a condition for full membership (Holloway, 1991). The pharmacy owners felt they occupied a position of status and did not want to dilute their privileges by admitting those in an inferior position to themselves (i.e., employees) as full members even though some of these had higher academic attainment than they had (Macdonald,1995).

This was in contrast to the Society of Apothecaries, which corporately prioritised education and examination and controlling of licences of medical practitioners as a strategy for social closure (Macdonald,1995). 'Chemists and druggists' appeared to want to maintain the status quo by following a 'free market strategy', mainly being reactive to external influences but eventually seeking social closure through having control over selling of poisons and medicines (Holloway,1991).

There were several different Pharmacy Acts issued that influenced the Pharmaceutical Society and its members' status. In 1852 the Society introduced the first statutory register and over time various groups of pharmacists could register as a strategy to regulate the profession, including for a time adding unexamined business owners without any formal qualifications (Holloway,1991). It was only after the Pharmacy and Poisons Act of 1933 that membership became compulsory for all pharmacists and being on the register made them full members (Holloway,1991).

The Pharmaceutical Society's aim was to prevent pharmacy being controlled from the outside, by establishing a self-regulation process and by setting up an examination system and a school of pharmacy (Holloway, 1991). The Pharmaceutical Society, possibly as a way of bargaining with the medical profession over jurisdictional claims, made it clear early on that it would restrict 'counter prescribing' and pharmacists could only recommend medicines to patients in simple cases, and would ensure their customers were aware that they were not 'medical men' (Holloway, 1991). The Pharmaceutical Society was seeking for pharmacists to have a monopoly over the activities of compounding and dispensing of medicines as a way of protecting the profession against competition from others (Holloway, 1991). In the process of gaining and claiming jurisdiction over this they gave up their role of 'counter prescribing' of medicines (Holloway, 1991). Pharmacists became focused on the medical product and less so on patients. In 1841, apothecaries changed their title to 'General Practitioners of Medicine' and the 'chemists and druggists' took on the title of 'pharmacists' (Kronus, 1976). Today pharmacists are still referred to as chemists and a community pharmacy as 'the chemist' or 'the chemist shop'.

Another challenge to the pharmacy profession was when the Pharmaceutical Society believed the Pharmacy Act of 1868 would ensure that only pharmacists could own community pharmacies (Holloway, 1991). The aim of this Act was to protect the rights of qualified pharmacists against non-professionals as owners of pharmacies (Jenkinson, 2012). This Act was challenged in court. It was ruled that it was legal to run a pharmacy business as a limited company provided these companies employed a qualified pharmacist to carry out the sales of poisons (before the Medicines Act of 1968 medicines were classified as poisons) (Anderson, 2015). This decision meant that pharmacy businesses consisting of a large number of branches were now possible (Holloway, 1991). The impact of this was significant as the pharmacy profession's development has been shaped and influenced by business decisions made by large corporate businesses either at an operational level or through influencing political decision makers with their priorities being their profit margin and shareholders' interests (Anderson, 2015). Today there are several large corporate multiples or retailers such as Boots and supermarkets (e.g., Tesco) who own several hundred or more retail pharmacies (Sukkar, 2016a).

The Pharmaceutical Society was granted a Royal Charter in 1843, but it was not until 1988 that it was granted a 'Royal' title (Hudson, 2010).

3.2.3 Introduction of the welfare state and the National Health Service (NHS)

The introduction of the welfare state in 1911 and the NHS in 1948 determined how doctors and pharmacists would be remunerated, which influenced the development of their respective roles (Holloway, 1991). Pharmacists were paid for the number of prescriptions dispensed and GPs for the number of patients seen. The legal distinction between prescribing and dispensing of medicines was made, as politically there was a desire to separate the medicine from the prescribing doctors as it was considered paying them to supply medicines would result in excessive prescribing. Separate arrangements were agreed to allow doctors to dispense in rural areas where there were no community pharmacists available. This arrangement still exists today (Anderson, 2015).

Before the NHS was introduced in 1948, dispensing accounted for less than 10% of the income of most pharmacists (Anderson, 2015). After 1948 over 90% of the population obtained their medicines from pharmacies (Anderson, 2015). Dispensing prescriptions became the major part of community pharmacies' income and therefore workload, which continues today (Holloway, 1991). This increase in prescription numbers moved pharmacists from the front of the shop to the back where they spent the majority of their working day compounding and dispensing prescriptions. Pharmacists began to disappear from the public's view (Anderson, 2015). At the start of the NHS the majority of prescriptions still needed to be compounded with only a small number of medicines being available commercially. From the 1950s and 1960s an increasing number of medicines were being manufactured by pharmaceutical companies, reducing the need for pharmacists to use their knowledge and skills in compounding medicines (Holloway, Jewson and Mason, 1986). This loss of compounding led to discussion about the need for the re-professionalisation of pharmacy (Birenbaum, 1982; Holloway, Jewson and Mason, 1986).

3.2.4 Hospital pharmacy

Prior to the 1850s hospitals employed apothecaries to act as resident medical officers and dispensers. Apothecaries spent most of their time on medical practice

and neglected their compounding and dispensing roles (Holloway, 1991). It was not until the 1960s that major hospitals started to employ pharmacists although the majority of hospitals employed unqualified or inadequately trained and poorly paid staff (Holloway, 1991). Poor pay overshadowed the practice of hospital pharmacists throughout the 1950s and 1960s with the work mainly consisting of dispensing, procurement and manufacturing and the supply of medicines to the wards on the order of nurses and medical staff (Holloway, 1991).

A significant change to hospital pharmacy practice was the presence of pharmacists on the wards in the late 1960s and 1970s to initiate the medicines supply process (Holloway, 1991). Pharmacists' roles evolved as they became more visible on the wards and started to provide pharmaceutical advice on medicines and their use. This later developed into pharmacists making interventions by having patients' medicines changed to more appropriate choices (Cotter, Barber and McKee, 1994; Calvert, 1999). Pharmacists also started to introduce prescribing formularies within hospitals which helped to contain drug costs.

This resulted in a greater recognition of hospital pharmacists' roles. Concerns over the state of hospital pharmacy services resulted in the Hall Report in 1970 (Holloway, 1991). It recommended that pharmacists should no longer be dispensing only but should also be working more with medical and nursing staff to ensure the safe and economical use of drugs. This growth in hospital pharmacy was again acknowledged in the Nuffield Foundation Report in 1986. The prescribing formulary approach was supported by the government in 1988 in a Health Circular aimed at hospital managers stating that implementing clinical pharmacy services would achieve better patient care and financial savings through cost-effective use of medicines (Health Circular, 1988; Child, Cooke and Hey, 2011).

It has been argued that clinical pharmacy within the hospital setting helped to re-professionalise pharmacy. It is now embedded in hospitals although practice still varies (Cotter, Barber and McKee, 1994; McLeod et al, 2014).

3.2.5 Education and training

In the 1880s and early 1900s apprenticeship was the normal method of training for surgeons, apothecaries and 'chemists and druggists' (Holloway, 1991; Anderson, 2015). It was not until the 19th century that certain branches of the legal and medical professions turned to paper credentials as a means of differentiating themselves from the skilled traders. In the 1820s anyone could open a shop and call themselves 'chemists and druggists' without having had any training (Worling, 2005). Most 'chemists and druggists' would, like apothecaries, serve apprenticeships as they were involved in producing the goods that they sold before setting up a business of their own. For 'chemists and druggists' there were no formal assessments or examinations until 1841 (Holloway, 1991).

The Pharmaceutical Society realised that an important way for a profession to build a professional reputation and prestige was through education and training (Macdonald, 1995), which is a way of gaining social mobility through social closure to increase professional status (Larson, 2013).

The first formal qualification for pharmacists was established by the Pharmaceutical Society in 1841, which founded a School of Pharmacy in 1842 (Holloway, 1991).

From 1868 it became compulsory to sit the Pharmaceutical Society's examination, which became the only route to qualify as a pharmacist (Anderson, 2015). The Pharmacy Act of 1908 allowed the Pharmaceutical Society to regulate pharmacy courses and qualifying examinations, with the first Bachelor of Pharmacy degree being approved in 1924 (Anderson, 2015). It was not until 1953 that a single professional qualification for pharmacists was introduced consisting of a three-year course of study, which was either preceded by a two-year 'pupillage' or one-year of pre-registration practice (Hudson, 2010).

The main jurisdiction for 'chemists and druggists' was compounding and dispensing (Anderson, 2015). New chemical entities or medicines were being discovered throughout the 1800s and 1900s. This increased the requirement to assure the quality of raw materials and of final medicines products, together with the compatibility of mixing different compounds, their safety and stability. Science, including chemistry became the main part of the education of pharmacists

(Holloway, 1991). This focus on the pharmaceutical product further severed their links with their 'old' roots by removing them further from being involved directly with patients' medical care.

The Nuffield Foundation Report of 1986 recommended changes to the pharmacy undergraduate course to add more emphasis on communication skills and clinical pharmacy alongside the more traditional science subjects. At that time it was highlighted that unlike other undergraduate courses for healthcare professionals such as for medicine, pharmacists did not undertake practice placements during their degree course (Turner, 1986). The same point is still being discussed today (See *Section 3.3.4.2 Economic autonomy*).

The Nuffield Foundation Report of 1986 was a review of the whole pharmacy profession. When Lord Hunt presented the report in the House of Lords there was no one present from the pharmacy profession to contribute to this debate (Lords Sitting, 4 June 1986). In the transcripts of this debate Lord Ennals noted that:

“When I realised that he [Lord Hunt] had attracted a former assistant director of the Nuffield Foundation, a professor of nursing, two general practitioners, a dentist, and two old politicians, if I may say so, I began to ask myself, "Is there a pharmacist in the House?" We have not actually got a pharmacist but we have got the patron of the dispensing doctors association, so we have done the next best thing”. (Lord Ennals, Lords Sitting, 4 June 1986)

There is animosity between community pharmacists and dispensing doctors, with the Association of Dispensing Doctors wanting GPs to have the option to dispense medicines to their own patients, not just in rural areas. This would take business away from community pharmacists.

Even though the length of training is not always proportional to the rewards it is argued that for a profession the length of training is “a major lever in its struggle for status” (Johnson, 1972, p.59). Professions are knowledge-based occupations, where it is important to build their reputation and prestige through education, training and credentialing. The two major changes to pharmacy education in the last 20 years were the introduction of the registration examination and extending the pharmacy degree. In the UK, the pharmacy degree was transformed from a three-year Bachelor to a four-year Master of Pharmacy (MPharm) degree in 1987. This is followed by a pre-registration year of training in practice after which candidates sit a registration examination set by the General Pharmaceutical

Council (GPhC). The pharmacy degree was increased to 4 years to be in line with the pharmacy education in continental Europe and to address the recommendations in the Nuffield Foundation report of 1986 to enable pharmacists to provide correct pharmaceutical advice to patients.

Eaton and Webb (1979) contend that even with the 3-year Bachelor degree pharmacists are over-qualified for what they do and extending the degree course would introduce more irrelevance. Pharmacists are of the belief that the length of the pharmacy degree is an indicator of their high status (Becher, 1999).

3.2.6 What's in a title?

Initially 'chemists and druggists' shared jurisdiction with other medical professions and for some this also included practising dentistry. The first Dental Act was introduced in 1878 and the first dental register in 1879. Two thirds of those on this register combined the practice of dentistry with that of pharmacy (Anderson, 2015). The Chemist Dental Association, representing the interests of chemists-dentists, was disbanded in 1949 (Holloway, 1991). The dental profession developed into a profession that achieved higher status than pharmacy but slightly lower than medicine (Hean et al, 2006). Professions aim to achieve status through a strategy of establishing exclusive rights as part of seeking the monopoly over practice such as when the State gives them rights to use certain titles and to perform certain functions resulting in a 'contract' between them and the State. Pharmacists have achieved this as it has been a criminal offence since the early 1930s for anyone who is not on the register to call themselves a pharmacist. 'Dentist' is a protected title as is 'doctor of medicine' (Holmes, 2009). Titles such as 'doctor' and 'nurse' are not protected titles and have been in use for many years describing a variety of roles. The doctor title is a courtesy title used by medical doctors and more recently dentists, which is an indication of their professional standing or status (BDA, 2013). This courtesy title is not afforded to pharmacists.

3.2.7 Gender

Women have always been involved in the making of medicines (Holloway, 1991). The Pharmaceutical Society initially banned women from its School of Pharmacy (Holloway, 1991). The Pharmacy Act of 1868 required pharmacists to be

registered with the Pharmaceutical Society resulting in 223 women in business before 1868 being on the register, equating to 1.9% of registrants (RPS, n.d). In 1869 women started to take the Pharmaceutical Society's examinations alongside their male counterparts although they were not allowed to apply for full membership. The Pharmaceutical Society gave in to their pressure and started to admit women as full members in 1879. In 1918 the first female pharmacist became a member of the Council and in 1947 the first female president was elected (RPS, n.d). There has been a continuing feminisation trend in the pharmacy profession. For example in 1905 1.2% of pharmacists on the register were women. In 1945 about 10% on the register were female increasing to 36% in 1984, 52% in 2004 and almost 60% in 2011 (RPS, n.d; Hassell, 2012). In general, professions with a higher proportion of women tend to have a lower status than professions that are male-dominated (Bissell and Traulsen, 2005). Despite the pharmacy profession being dominated by females, they continue to be under-represented in senior positions, either as business owners or at chief pharmacist level in the NHS (Gidman et al, 2007; Coleborn, 2014; Hassell and Symonds, 2015).

3.2.8 Code of ethics and independent regulator

The establishment of the Royal Pharmaceutical Society was a way of legitimising the pharmacy profession through self-regulation to gain social closure (Macdonald, 1995). The aim was to control who could practise as part of gaining professionals status and privileges.

Patients may have no real means of assessing pharmacists' practice but base this on their outward appearance and manner, which fits socially acceptable standards of respectability and repute (Macdonald, 1995). They expect pharmacists to dispense the correct medication as prescribed by the doctor. They may also expect the pharmacist to check their prescription and discuss with the doctor if there is a problem. Patients may also rely on pharmacists to provide them with the correct advice about their medicines, interactions, side effects and how to take them.

A profession needs to establish a 'code of ethics and conduct' standards to reduce the public's fear that it may take advantage of its position in society with Freidson (1988) stating that this is a "prerequisite for being trusted to control the terms of

work without taking advantage of such control” (p.360). In exchange professions are given a certain degree of autonomy over their own affairs (Macdonald, 1995). A profession relies on the public’s trust in its services and the public needs to know that individual professionals are held to account if they do not conform to these standards, including possible loss of practising privileges (Evetts, 2006).

The pharmacy profession was a self-regulating profession until 2010. The pharmacy profession proposed to produce its first code of ethics in 1866 but it was not until 1941 that this was published (Holloway, 1991). The General Medical Council (GMC), the doctors’ regulatory body, did not issue its first Good Medical Practice guidance until 1995 having instead relied on case law as the basis for advising doctors about professional misconduct (Irvine, 2006).

The GMC has a history of protecting doctors and not dealing with poor practice (Irvine, 2006). The political power of the medical profession was questioned by the public in 1997 as a result of the high mortality rate of paediatric cardiac surgery in Bristol (Irvine, 2006). The outcome was that the “social contract between doctors and the State came to be rewritten” (Dixon-Woods, Yeung and Bosk, 2011, p. 1452) These medical failings followed by others resulted in a review of the regulation of the medical profession as well as that of non-medical health professions, including pharmacy (The Foster Review, 2006). The government’s White Paper, *Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century* (DH, 2007) led to an overhaul of the regulation of the medical, pharmacy and allied healthcare professions. The aim of these regulatory changes for the pharmacy profession was to give the public greater influence and control along with helping to build public trust in pharmacists. The General Pharmaceutical Council (GPhC), the independent regulator for pharmacists and pharmacy technicians, was established in 2010 (GPhC, 2017).

Today in the United Kingdom healthcare professionals are technically no longer self-regulating, although they still have a say in the regulatory processes. The power of setting professional standards, monitoring practice and managing professionals has been given to an independent regulatory body outside the profession. Waring, Dixon-Woods and Yeung (2010) argue that the State and NHS are more involved in the control of professions and individual members. Professions may still have some influence as the independent regulatory body’s board or council is usually constituted of about half registrants with the remainder

of members being from outside the profession. The registrants on the Council may not necessarily consist of or represent the main sectors of the profession. The GMC only has registrants who are medical doctors (GMC, 2017) (See *Chapter 2, Section 2.3.7 Professional regulation*).

3.3 Sources of status for the pharmacy profession today

Abbott (1981) links the “acts of professional practice” (p. 40) or the nature of pharmacy practice with pharmacists’ status relative to other professions, intra-professionally, the public and hence society (See *Chapter 2, Section 2.3.4 Professional status*). Pharmacists work in an interdependent system of professions in terms of the division of labour through inter-professional competition impacting on and shaping the nature of pharmacy practice (Abbott, 1988). The pharmacy profession in England is discussed with regards to how it has aimed for social closure (See *Chapter 2, Section 2.3.2 The ‘power approach’*) including covering intra-professional competition (Abbott, 1988) by addressing its professional autonomy including its ability to influence the environment in which it works covering re-and de-professionalisation factors that affect pharmacy including proletarianisation resulting from bureaucratisation (Johnson, 1972; Haug, 1972; Evetts, 2013) (See *Chapter 2, Section 2.3.8 Professionalisation as dynamic processes*).

3.3.1 Intra-professional divisions

The pharmacy profession is not a homogeneous group and is dynamic in terms of roles, status and professional boundaries which are evolving (Bucher and Strauss, 1961; Nancarrow and Borthwick, 2005). Intra-professionally there are different sectors within pharmacy (Holloway, Jewson and Mason, 1986; Jamie, 2014). The two main ones are hospital and community pharmacy, producing different aspects of pharmacy practice (Holloway, Jewson and Mason, 1986; Jamie, 2014) (See *Chapter 2, Section 2.4.3 Internal divisions*). The large number of community pharmacists dominates the general perception of the profession, particularly as the public is mainly familiar with community pharmacy and has limited involvement with pharmacists in other contexts (Morecroft, Thornton and Caldwell, 2015).

Community pharmacists work in a retail environment as opposed to a professional environment. They often work as single practitioners away from regular contact

with other healthcare professionals, spending the majority of their time dispensing medicines and dealing directly with the public (Davies, Barber and Taylor, 2014). Hospital pharmacists are employed by NHS trusts, large bureaucratic organisations, working in a multi-professional environment where they have established roles as clinical pharmacists working on the wards. Clinical pharmacy is described as an area of practice where pharmacists provide patient care that involves optimising medication therapy and promoting health, wellness and disease prevention (Child, Cooke and Hey, 2011).

There is some permeability of the boundaries between the different sectors of pharmacy (Becher, 1999). The transfer between these should be easy as pharmacists have similar university training and are registered with the same regulatory body. The general perception within the profession is that it is easier for hospital pharmacists to move into community pharmacy than it is for community pharmacists to move into hospital pharmacy. This is because the clinical pharmacy demands in hospital are higher than those in community pharmacy (Becher, 1999; Bhakta, 2010).

Hospital pharmacists work in a professional environment concentrating on pharmacists' knowledge systems and can specialise in clinical areas such as cardiology or critical care (Bhakta, 2010). Hospital pharmacists are what Abbott (1988) describes as professional 'purists' as they are able to apply and expand their professional clinical pharmacy knowledge working in a professional environment in collaboration with other pharmacists, doctors and nurses (See *Chapter 2, Section 2.3.4 Professional status*).

Consequently hospital pharmacists have a higher intra-professional status, attributed to their non-routine work, concentrating on their clinical pharmacy knowledge base and working in a professional environment unlike community pharmacists. In the public arena the pharmacy profession is judged based on the image of community pharmacists as according to Abbott (1988) other professions and the public do not understand intra-professional divisions within a profession.

3.3.2 The nature of pharmacy practice

The nature of pharmacy practice is partly influenced by the various regulations pharmacists have to follow, be aware of and comply with or advise others on in

relation to medicines. Pharmacy practice is defined in *The Pharmacy Order 2010 regulation* as: “any work or gives any advice in relation to the preparation, assembly, dispensing, sale, supply or use of medicines, the science of medicines, the practice of pharmacy or the provision of healthcare”. This definition emphasises the technical aspects of medicines supply processes without specifying what is understood by pharmacy practice and implying that dispensing of medicines is not the same as providing healthcare.

Barber (2005) explains that pharmacists’ focus is on medicines as “physical objects that have the potential to help or harm patients” (p.78). This is unlike most other healthcare professionals whose attention is centred on patients and their body or aspects of their body with a view to examine, manipulate, undertake surgery or care for it (Barber, 2005; Mandy, 2008; Jamie, 2014). National policies have supported moving pharmacists’ activities away from focusing on medicine products towards more patient-centred activities based on the assumption that clinical pharmacists in hospitals already undertake these activities (DH, 2008; NHS England, 2013). Studies from Canada and Northern Ireland found that community and hospital pharmacists’ focus was on the medicine products leading to criticism that pharmacy as a profession has not embraced the patient-caring roles (Al Hamarneh et al, 2011, 2012). Lord Carter of Coles (2016) called for hospital pharmacists to spend more time on patient-facing clinical activities than is currently the case. The implication is that hospital pharmacists are not as patient-care focused as previously assumed. Rosenthal and Tsuyuki (2010) speculated that pharmacists’ mind-set or culture act as barriers preventing them moving from product-focused towards more patient-focused practice (See *Section 3.3.2.4 Pharmacists’ mind-set*).

Historically, pharmacists were concerned with improving the quality of medicines, their formulation and how best to deliver the active drug into the human body through developing and utilising their knowledge and skills to improve the quality of medicines products to reduce the risk of these unintentionally harming patients (Holloway, 1991). As more medicines were developed and marketed their efficacy, doses, route of administration, interactions and side-effects became the focus for pharmacists but their aim was still to reduce harm or the risk to patients from medicines. Today pharmacists’ focus is on reducing risk in relation to the safe use of medicines by for example providing information about medicines, ensuring their

economical use, monitoring of prescribing and the distributing, dispensing and administering of medicines (Barber, 2005; Barnett, 2009).

It is the act of dispensing medicines that is the defining aspect of pharmacy (Denzin and Mettlin, 1968; Harding and Taylor, 1997; Davies, Barber and Taylor, 2014). Pharmacists have a near monopoly over the dispensing of medicines and selling of pharmacy-only medicines (POMs) (Anderson, 2002). They have what Abbott (1988) refers to as control over this jurisdiction as this aspect of their practice has been legally established and the public is aware of this. Pharmacy has gained social closure on this aspect of its pharmacy practice (Macdonald, 1995).

In its simplest form dispensing medicines can be described as an act that involves the pharmacist interpreting the prescriber's instructions and checking this, picking the right box of tablets off the shelf, sticking the dispensing label on the box and giving this to the patient with instructions. Denzin and Mettlin (1968), conclude that pharmacists view the medicine as a product to be sold or supplied rather than an object to which they direct their services towards. Dingwall and Wilson (1995) and Harding and Taylor (1997) argue that pharmacists have a role in the symbolic transformation of the medicine by providing patients with added value aimed at their specific requirements by utilising pharmacists' knowledge through 'information-giving' (See *Chapter 2, Section 2.4.4 Dispensing and information-giving*).

For this transformational work to take place there needs to be a dialogue between the pharmacist and patient. This is lost in situations where community pharmacies provide medicines delivery services to patients' homes. This means the only person the patient sees is the pharmacy delivery driver reinforcing community pharmacy as a supplier of medicines. Internet and Amazon-style community pharmacies result in losing the physical face-to-face dialogue. According to McDonald et al (2010) this devalues pharmacists work as it becomes a technical medicines supply process without them seeing the patient.

Phillips (2014a) argues that community pharmacy is well placed to be the first port of call for patients with minor ailments by adding more core services to the national contract which would help to facilitate change. Despite sustained national policy efforts to extend community pharmacists' skills much of their practice remains

unchanged, being driven by dispensing (DH, 2008; Davies, Barber and Taylor, 2014).

The concept of 'pharmaceutical care' was introduced by Hepler and Strand (1990) defining this as "the responsible provision of drug therapy for the purpose of achieving definite outcomes which improve the patient's quality of life" (p. 539) calling for pharmacists to accept this social mandate (See *Chapter 1, Section 1.2 Societal purpose and responsibilities of the pharmacy profession*). Pharmaceutical care was a way of emphasising the caring aspects of pharmacy by aligning this with medical care and nursing care. Although pharmaceutical care was widely embraced within pharmacy the definition by Hepler and Strand (1990) was never completely applied and it was practised in many different ways (Calvert, 1999; Bissell and Traulsen, 2005). Its introduction was viewed as a re-professionalisation strategy with the intention of legitimising pharmacists' jurisdictional claim to clinical pharmacy activities by shifting their practice away from being pre-occupied with medicines as "physical objects" (Barber, 2005, p.78), by emphasising their potential role in taking responsibility for aspects of patient care that would be recognised by society.

Pharmacists have not taken up or embraced this social mandate (Hughes et al, 2010). Pharmaceutical care was followed by the concepts of 'medicines management' and later 'medicines optimisation'. The meaning of these concepts remains poorly understood by pharmacy, other professions and the public (Cutler, 2011; Wilcock and Hughes, 2014). Pharmacists have been unable to fully articulate these concepts in relation to pharmaceutical services delivered to patients including clarifying what aspects pharmacists take responsibility for.

There is a paucity of data on what hospital pharmacists do when on the wards and what impact clinical pharmacy services have on patient care and outcomes (Boardman and Fitzpatrick, 2001). Accessing some of the literature on pharmacists' practice in hospitals often includes studies that measure the number of medication interventions they recommend to doctors with the outcome being the percentage of pharmacy interventions accepted by doctors, which may also include calculating the reduced prescribing costs as a result of these interventions (Fertleman, Barnett and Patel, 2005; Miller, Franklin and Jacklin, 2011). The document by the Royal College of Physicians and Royal College of Nursing

entitled, *Ward rounds in medicine: principles for best practice* (2012), states that hospital pharmacists should be part of multi-disciplinary teams, with their tasks listed as reviewing patients' medication, checking venous thromboembolism (VTE) prescriptions and reviewing patients' drug charts. This shows that doctors and nurses have come to view pharmacists' participation in regular ward rounds as a standard to aim for, describing the pharmacist's role as checking of others' work. Dingwall and Wilson (1995) in their study found that 'information-giving' was the core task that defined the profession based on pharmacists' specialist knowledge of medicines. Mesler's (1991) observational study found that hospital pharmacists act as "quality control agents" (p.319) due to spending the majority of their time finding and correcting medication problems referred to as pharmacy interventions by utilising their drug expert knowledge and skills. Mesler (1991) noted that although this could be perceived as a resource for power the issues around pharmacy interventions were often not straight forward with pharmacists often relying on doctors' final judgement. A large part of pharmacists' practice, regardless of the healthcare setting, involves monitoring or checking in particular doctors' prescribing, or counselling patients on their medicines providing pharmacists with some limited power. As pharmacists' education and knowledge has increased so has their ability to make pharmacy interventions by not only observing:

“...other health care practitioners make mistakes in prescribing or administering medicines but also explain *why* these procedures are in error”. (Birenbaum, 1982, p.875)

It is these aspects that make pharmacists consider themselves to be medicines experts in healthcare (Holloway, Jewson and Mason, 1986; Barnett, 2009). Pharmacists also provide cognitive pharmaceutical services which refers to them utilising their knowledge and skills to take a role in patient care through interacting with patients and other healthcare professionals, examples being Medicines Use Reviews (MURs) or advice around patients' medicines (Roberts et al, 2006). These cognitive services allow pharmacists to check patients' understanding and adherence to their treatment (Latif, Pollock and Boardman, 2011, 2013; Waring et al, 2016) (See *Chapter 2, Section 2.4.5 Surveillance, discipline and 'pastoral power'*).

3.3.2.1 Education as a re-professionalisation strategy

Abbott (1981) and Larson (2013) maintain that education is an important factor in upward collective mobility for a profession and hence its status. They argue that this increase in education and training should be relevant and be represented in the acts of a profession's practice to confer status. As pharmacists' education and training has increased in length their work in community pharmacy has reduced mainly to the act of dispensing, which can be viewed as routine and technical work which is accorded low status. It is unsustainable to have highly trained pharmacists not being fully utilised during a time where the NHS in England is facing a growing elderly population and patients with long term conditions and a shortage of GPs (DH, 2008; Phillips, 2014a).

Hospital pharmacists have followed a re-professionalisation strategy of increasing their clinical knowledge and skills through completing a post-graduate diploma in clinical pharmacy, this being a standard prerequisite for hospital pharmacists who wish to progress in hospitals (Antoniou et al, 2005; Bhakta, 2010). The same is not the case for community pharmacists, adding to the internal divisions within pharmacy.

The consultant pharmacist role, a restricted title in the NHS, was identified in the paper, *A Vision for Pharmacy in the New NHS* (DH, 2003) and introduced into practice in 2005. The aim was for pharmacists to make a greater difference to patient care and build on the successes of clinical pharmacists. The creation of consultant pharmacist posts has not been as significant an opportunity as originally thought (Howard, 2012). In 2015 there were 68 consultant pharmacists with the Chief Pharmaceutical Officer for England calling for a 10-fold increase in consultant pharmacist posts within the next few years (Malson, 2015).

3.3.2.2 Community pharmacy and commercialism

Community pharmacy has a long history of links with 'trade'. There is an ambiguous relationship with the NHS due to community pharmacists being private providers in an essentially socialised health services system (Anderson, 2002).

Community pharmacy gives a mixed image of half profession and half retail shop with concerns that they place commercial interests over individual patient care (Thomas and Plimley, 2012). The question, "Are pharmacists acting as professionals or are they shopkeepers?" (Masongo, 2005, p.16), has plagued

community pharmacists for years implying that it is not possible to combine the two roles of being healthcare professionals and shopkeepers. Employed community pharmacists report sometimes being treated as 'shelf-stackers' due to being asked to undertake normal shop duties by their employer instead of being treated as professionals reinforcing the retail aspects (Sidhu, 2003; Oxtoby, 2014, 2015). Birenbaum (1982) suggests that the entire pharmacy profession is assessed on the worst aspects of pharmacy, which means the public will form their view of pharmacists based on what they are familiar with, namely community pharmacy where they may act as shopkeepers (Hughes and McCann, 2003; Salter et al, 2007). This affects how the whole profession is perceived by the public (Abbott, 1988). The conflict between the roles of healthcare professionals and retail business affects community pharmacists' sense of professionalism (Birenbaum, 1982; Edmunds & Calnan, 2001; Hibbert, Bissell and Ward, 2002; Hughes and McCann, 2003; Bush, Langley and Wilson, 2009). Community pharmacy has had a long history of being involved with providing public health advice at the micro-level to individual patients. In the past community pharmacy sold tobacco products so moving towards providing public health smoking cessation advice was seen as a natural progression (Anderson, 2007). In recent times some community pharmacies started to sell unlicensed electronic cigarettes produced by the tobacco industry against the advice of the Royal Pharmaceutical Society (Wang, 2012; Sukkar, 2014). Jesson and Bissell (2006) argue that expecting community pharmacists to adopt a public health mind-set within a commercial environment is contradictory. Commercial organisations are sensitive to public and commercial shareholders' opinions rather than to public services provided to patients. This conflict was illustrated by a supermarket chain withdrawing from the healthcare scheme to supply emergency hormonal contraception (EHC) to females 16 years and younger due to its customers complaining that this service was provided by this supermarket chain's pharmacies. The supermarket placed their general customers' views and therefore commercial and shareholders' interests ahead of delivering healthcare (Gray and O'Brien, 2002).

The above adds weight to the criticism by Denzin and Mettlin (1968) that the commercial interests of community pharmacies are incompatible with the service ideal of professions and are perceived as a barrier for community pharmacists extending their roles further into healthcare. The counter argument is that in line

with other professions community pharmacists both provide services and utilise their “knowledge and power for economic gain” (Evetts, 2003, p.404).

3.3.2.3 Prescribing

Prescribing rights for pharmacists were introduced, first as supplementary prescribers in 2003, and later as independent prescribers in 2007. This had the potential to re-define new roles for pharmacists by offering opportunities to develop more patient-facing services and to challenge medical authority together with further shifts in professional boundaries in healthcare (Nancarrow and Borthwick, 2005; Weiss and Sutton, 2009; Cooper et al, 2008). Freidson (1970) argues that the dominance of the medical profession not only extends to patients and society in general but also the control over subordinate professions such as pharmacy and nurses through having successfully negotiated state-sanctioned autonomy.

Stakeholders’ views of pharmacists and nurse prescribers highlighted concerns over pharmacists’ lack of training in clinical examination and diagnostic skills as well as their limited contact with patients, whereas the main concern with nurse prescribers was their lack of knowledge of pharmacology and diagnostic skills (Buckley, Grime, and Blenkinsopp, 2006; Cooper et al, 2008, 2012).

A concern raised by both doctors and nurses in primary and secondary care was that pharmacists are not perceived by them as healthcare professionals who actively and directly contribute to patient care and therefore lack knowledge and proximity to patients (Buckley, Grime, and Blenkinsopp, 2006). Patients are apprehensive about pharmacist prescribers as they associate them with retail pharmacy being concerned about inadequate privacy for consultations and being uncomfortable due to their lack of awareness of pharmacists’ education and training instead, preferring to be seen by the GP or nurse prescriber (Hobson, Scott and Sutton, 2010; Cooper et al, 2012). Patients view GPs as being responsible for their care and hierarchically superior, with nurse and pharmacist prescribers undertaking delegated tasks under their supervision (Cooper et al., 2012).

Prescribing has been viewed as “one of the core activities that demarcates the medical profession from other groups” (Britten, 2001, p.479) with the assumption that the status of the medical profession is associated with its dominance and near

monopoly over prescribing. Prescribing by pharmacists and nurses can be viewed as making jurisdictional claims to an area of practice previously under the control of the medical profession thereby threatening the medical profession's dominance. This jurisdictional claim to prescribing rights by pharmacists and nurses was facilitated through interaction with stakeholders within different arenas such as the legal system, public opinion and workplace (DH, 2006).

Cooper et al (2012) suggest that the medical profession's dominance has not been threatened by these new prescribers as pharmacists and nurses can only undertake the prescribing course if they can find a Designated Medical Practitioner (DMP) who will support them. According to Bissell et al (2008) doctors only agree to be the DMP for pharmacists and nurses they already know and trust, thereby in effect controlling who can enter the prescribing training. Although the full prescribing formulary is available for pharmacist and nurse prescribers they can only prescribe within their area of experience and competence, which limits their prescribing to specific clinical areas, in effect imposing a restraint on the breadth of prescribing they can undertake (Weiss and Sutton, 2009).

It can be conceded that doctors' authority and autonomy has not been challenged as they consider prescribing a routine task which has to conform to local prescribing guidelines and patient care pathways and could see the potential for delegating this routine task (Britten, 2001). Instead doctors distinguished routine prescribing from the more complex and intellectual process of diagnosing which requires their unique skills, based on their broad medical training and several years' experience. Doctors have maintained control over diagnostic decision-making and the prescribing process through medical surveillance of pharmacists and nurse prescribers. The indication is that pharmacists and nurses are either not confident or do not wish to challenge doctors' control over diagnostic decision-making (Weiss and Sutton, 2009; Lloyd and Hughes, 2007; Bissel et al, 2008; Weiss, 2011).

The medical profession has accommodated this introduction of new prescribers by maintaining the overall responsibility for patient care enabling them to maintain their jurisdiction and status (Cooper et al., 2012; Allsop, 2006). Another explanation for the medical profession accommodating these changes may be the number of pharmacists and nurses qualified as independent prescribers being too low to challenge medical dominance (Latter et al., 2010). As non-medical

prescribing becomes integrated and embedded into practice and these roles evolve there may be future challenges to the medical profession's jurisdiction of making diagnoses (Weiss, 2011). Although prescribing has created new opportunities for pharmacists there have been difficulties in embedding this into the structure of healthcare in providing sustainable services (Baqir, Clemerson and Smith, 2010). Community pharmacists do not have full access to patients' medical records and are not integrated within multi-disciplinary teams in primary care. In addition, they have to be commissioned to deliver a NHS service requiring them to use their prescribing qualification and be allocated a prescribing budget.

A recent initiative by NHS England in 2015 included making £15 million, (doubling this to £31 million in the autumn of 2015), available for a 3 year pilot programme for groups or federations of GP practices to directly employ pharmacists in patient-facing roles (NHS England, 2017). This pilot ensured that GPs retain control of these pharmacists who will be part of the primary care team unlike community pharmacists.

Pharmacist prescribers find themselves in inter-professional competition with nurses for "extension of territory" (Buckley, Grime, and Blenkinsopp, 2006, p 398) and new clinical roles (Parkin, 2016). This could be a challenge for pharmacists as they view themselves as 'medicines experts' comparing their academic abilities with that of doctors and not with that of nurses (Hean et al, 2006). The pharmacy profession considers itself to be part of the medical profession, historically having to compete with the medical profession for professional jurisdiction and not previously with nurses or other allied healthcare professionals (See *Section 3.2 Historical development of the pharmacy profession*).

Harding and Taylor (1997) argue that pharmacists who extend their clinical roles away from dispensing could be counter-productive and threaten their status which would have a de-professionalising effect. They argue that pharmacists' expansion into prescribing could be damaging to the profession as this would blur the traditional boundaries between pharmacists and doctors. The outcome will be a breakdown of the demarcation between healthcare professionals' roles resulting in pharmacists' knowledge base being indistinguishable from that of other healthcare professionals (Harding and Taylor, 2004).

The introduction of pharmacist prescribers is a break with the traditional roles of doctors prescribing and pharmacists dispensing. Pharmacist prescribers could

threaten the separation of the prescribing and dispensing functions which have been embedded in to practice since the introduction of the welfare system in the 1940s (See *Section 3.2.3 Introduction of the welfare state and the National Health Service (NHS)*). It is imperative that pharmacists and others are clear about what jurisdiction pharmacists have control over within healthcare, particularly as the profession will have to re-define its clinical role and negotiate new jurisdictional claims to encompass prescribing.

Pharmacists are trying to make jurisdictional claims in undertaking 'clinical medication reviews' of patients with problematic poly-pharmacy due to their knowledge as 'medicines experts (Barnett, 2009; Salter et al, 2007; Latter et al, 2010). Other healthcare professionals such as nurses and doctors also claim to undertake clinical medication reviews not considering this to be an exclusive pharmacists' function (Krska, Ross and Watts, 2005).

Extending pharmacists' practice or even there being some synergy with different healthcare professionals' roles would not necessarily result in the loss of the demarcation between different healthcare professionals provided they are all aware of their professional boundaries and competencies. The differences and synergies between healthcare professionals forms part of effective multi-disciplinary teams by bringing these differences together to provide integration and coordinated care that provides a broader and more holistic perspective for patients and their treatment (Rushmer and Pallis, 2003).

3.3.2.4 Pharmacists' mind-set

The reasons for the lack of change in extending pharmacists' jurisdiction in healthcare have partly been attributed to the way community pharmacy is remunerated and to the public's entrenched view and limited expectations of community pharmacy (Zellmer, 2002). Others have speculated that the fundamental barriers come from within pharmacy due to its prevailing culture and mind-set (Bissell and Traulsen, 2005; Jacobs, Ashcroft and Hassell, 2011). They argue that pharmacists are taught to work in a systematic orderly way, paying attention to detail. These are skills required when checking prescriptions and dispensing medicines where the focus is on avoiding making mistakes. This favours a mind-set that is relatively rigid and oriented towards imposing order, following rules and procedures, which are important when having to check prescriptions to prevent errors (Harding, 2007).

Rosenthal and Tsuyuki (2010) speculate this mind-set may result in pharmacists finding it difficult to interact directly with patients in situations where they will have to make decisions without having all the facts or an in depth understanding of all the issues as they struggle with managing ambiguity and risks of clinical practice due to a potential lack of confidence. Instead it is speculated that pharmacists prefer to make their suggestions to doctors thereby deferring the final decision to them as a way of avoiding responsibility (Edmunds and Calnan, 2001). Bissell and Traulsen (2005) argue that pharmacists will need to make a fundamental paradigm shift away from what they refer to as a technically-focused paradigm towards a different paradigm, speculating that otherwise all community pharmacy will be left with is dispensing. These deep rooted barriers may incorrectly have been described as professional inertia (Smith, Picton and Dayan, 2014).

3.3.3 Professional relationships

Abbott (1988) argues that it is the control over work that gives rise to inter-professional divisions and conflict (See *Chapter 2, Section 2.3.3 Professions as an inter-related system*). One of the most important inter-professional relationships for pharmacists is with doctors (See *Chapter 2, Section 2.4.2 Medical hegemony and jurisdictional uncertainties*).

It is ultimately patients and the public who give a profession the power and support it needs to establish or maintain it as a profession, which determines its status (Johnson, 1972; Abbott, 1988; Macdonald, 1995).

3.3.3.1 Patients and customers

Several qualitative studies have found that patients viewed community pharmacists as providing a medicines supply function with patients prioritising a prompt dispensing service (Gidman and Cowley, 2013; Wood et al, 2015). Patients raise issues around the type of information they consider pharmacists should provide and are wary of the pharmacist's role being extended to make decisions about their medication, wanting the GP to be responsible for their health (Varnish, 1998; Abu-omar, Weiss and Hassell, 2000; Bissell et al, 2008; Hughes et al, 2008; Saramunee et al, 2012; Gidman and Cowley, 2013; Twigg et al, 2013; Morton et al, 2015).

The public trusts community pharmacists the least for providing health advice compared to other healthcare professionals (Krska and Morecroft, 2010; Gidman, Ward and McGregor, 2012; Ipsos Public Affairs, 2015). This may be because people are more familiar with their GP and other healthcare professionals who are regularly involved in their care unlike community pharmacists. The public is often unaware that health advice and public health services can be obtained from community pharmacies (Eades, Ferguson and O'Carroll, 2011; Saramunee et al, 2015; Wood et al, 2015). The community pharmacy retail environment has been reported to negatively affect the perception patients and the public have of community pharmacists as healthcare professionals (Latif, Pollock, and Boardman, 2011). Patients feel there is a lack of privacy around confidentiality and the physical space which continues to be an issue with the majority of patient-pharmacist interactions taking place on the 'shop-floor' (Latif, Pollock, and Boardman, 2011). In addition there is a perception that community pharmacists lack relevant knowledge and skills to deliver healthcare (Weidmann et al, 2012; Taylor, Krska and Mackridge, 2012; Morton et al, 2015). Therefore, pharmacists have further work to do in establishing trust between themselves and patients before they are viewed as healthcare professionals.

Patients who spend limited time on an inpatient ward are often unaware that hospital pharmacists are involved in their care (Elvey, Hassell and Hall, 2013). Morecroft, Thornton and Caldwell (2015) found that adult inpatients have limited expectations of hospital pharmacists besides supplying medicines basing this perception on their familiarity with community pharmacy.

The RPS produced a video to promote hospital pharmacy as a career option. This included an interview with an inpatient who stated that the pharmacist ensured he received all his medicines as prescribed by the doctor. The pharmacist and a doctor interviewed in this video implied that pharmacists made the way medicines are managed and used in the hospital safer by reducing the likelihood of errors (RPS, video on YouTube, 2015). This contribution of pharmacists is a difficult message to communicate to patients and the public. It may not be one they wish to hear. Simply put doctors make you better by diagnosing and treating you and nurses will look after and care for you. Pharmacists will ensure you receive your medicines but they are also there to reduce the likelihood of doctors and nurses unintentionally harming you.

Patients have limited experience and therefore expectations of what pharmacists provide in community pharmacy or hospital in terms of input into their healthcare besides dispensing medicines. The public's demand for pharmacists' services is limited to those activities they are aware of, whereas if the public was aware of pharmacists' contributions this would support their jurisdictional claims and their status. The physical space of the community pharmacy influences patients' decisions to raise or discuss health issues with community pharmacists due to concerns over privacy, confidentiality and it being a busy place. Patients are unaware that hospital pharmacists are involved in their care (Morecroft, Thornton and Caldwell, 2015).

3.3.3.2 Doctors and other healthcare professionals

One of the most important and influential relationships for pharmacists is with doctors with this being one of both collaboration and inter-professional conflict (Abbott, 1988).

The *All Party Pharmacy Group Report, The Future of Pharmacy (2007)* stated that professional relationships between GPs and community pharmacists were strained. This inter-professional conflict was attributed to a range of factors including GPs' misconceptions and suspicions about roles and communication.

Studies by Edmunds and Calnan (2001), Hughes and McCann (2003), Bryant (2009) and Bradley, Ashcroft and Noyce (2012) showed that the medical profession continues to exhibit dominance and control over the GP-community pharmacist relationship. Edmunds and Calnan (2001) found that GPs' attitudes in terms of community pharmacists' extension of their role was one of dominance by using 'limitations' and 'exclusions' as GPs saw this as a perceived loss of their autonomy and controls. This dominance by the medical profession resonates with the social closure perspective where one group draws boundaries in order to monopolise resources while closing off opportunities for other groups (Murphy, 1986). Witz (1992) referred to this as a demarcation strategy, which is concerned with the "creation and control of boundaries" (p. 47) by the medical profession (See *Chapter 2, Section 2.4.2 Medical hegemony and jurisdictional uncertainties*).

Pharmacists reinforce their subordination to doctors by avoiding inter-professional conflict by maintaining the existing socially constructed professional boundaries

(Edmunds and Calnan, 2001). Pharmacists follow a strategy that involves blurring the distinctions between task delegation and boundary encroachment in order to reduce any inter-professional tensions due to relying on close working relationships with doctors to expand their pharmacy practice (Mesler, 1991; Williams, Phipps and Ashcroft, 2013). This re-professionalisation strategy allows pharmacists to gain status and power through being associated with doctors by being delegated meaningful responsibilities by them.

Hughes and McCann (2003), using qualitative focus group interviews with GPs and community pharmacists, aimed to examine perceived inter-professional barriers between GPs and community pharmacists. They identified two main barriers for GPs forming closer working relationships with community pharmacists which were their shop-keeper image which makes GPs distrust them, and GPs being unclear about pharmacists' training and skills.

Bradley, Ashcroft and Noyce (2012) examined the collaboration between GPs and community pharmacists basing this on interviewing GPs and community pharmacists. The authors identified that "trust, communication, professional aspects, and 'knowing' each other" (p. 36) were important components in collaboration between GPs and pharmacists. They found that "GPs were found to adopt demarcation strategies" (p. 36) regarding community pharmacy, which were similar to the findings made by Edmunds and Calnan (2001). Bradley, Ashcroft and Noyce (2012) argued that their study took account of the "differentiation and asymmetry of the GP-pharmacist relationship" and this "includes recognition of asymmetry in power and status" (p.44) between the two professions which they claimed had not been identified in previous studies. However, based on the sociology of the professions theories it is implicit that there is asymmetry in power and status between a dominant and subordinate profession (See *Chapter 2, Section 2.3.2 The 'power approach'*).

Since 2005 community pharmacists have undertaken MURs independent of GPs although the latter receive a copy of the report. GPs' responses to MURs has been negative with them placing little value on them, arguing MURs are undertaken in isolation from other aspects of patients' care and may duplicate their work (Wilcock and Harding, 2007; McDonald et al, 2010; Latif, Pollock and Boardman, 2013). GPs have limited control over MURs which may eventually undermine any

attempts to extend this further. Dingwall and Wilson (1995) comment that where “pharmacists come closest to the medical profession are clearly points at which their control over the transformative work on the drug becomes less secure” (p.124).

McDonough and Doucette (2001) developed a Collaborative Working Relationship (CWR) model to explain the different developmental stages of the pharmacist-doctor collaborative relationship where the doctor’s trust in the pharmacist is the most significant factor in achieving collaboration. Building trust becomes a key process which confirms that the power in this pharmacist-doctor relationship is asymmetrical (D’Amour et al, 2005; Bradley, Ashcroft and Noyce, 2012). The CWR model assumes that the pharmacist is proactive in initiating the relationship and will actively pursue and maintain this. This model does not take full account of doctors wanting to retain jurisdictional control by delegating tasks to pharmacists, nor does it fully address inter-professional conflict as part of this collaboration.

The literature mainly discusses pharmacists’ subordination, relationships and inter-professional conflicts with doctors over jurisdiction. Community pharmacists appear to reinforce the traditional healthcare setup with doctors being in charge of patients while taking on delegatory roles and being subordinate to doctors. Another explanation is that pharmacists avoid conflict and direct competition with other professions over jurisdictional claims instead following a re-professionalisation strategy of “slow process of encroachment and delegation” (Mesler, 1991, p325).

3.3.3.3 Pharmacy technicians

The pharmacy workforce also includes pharmacy technicians who are registered with the GPhC. There are differences in educational attainment and background between pharmacists and pharmacy technicians. It takes five years to register as a pharmacist and two years of National Vocational Qualifications (NVQs) to become a pharmacy technician (GPhC, 2013).

Pharmacy technicians, particularly in hospitals, are taking over tasks that previously were carried out by pharmacists (John and Brown, 2017). These tasks have a deskilling or de-professionalisation effect on pharmacists but a re-professionalisation effect on pharmacy technicians. Pharmacy technicians use

words such as “team work” giving the impression they consider that there is an equal status between the two professions whereas pharmacists talk of delegating work to pharmacy technicians who they consider as subordinates (Oswald, 2016). This implies that there is potential inter-professional conflict and competition despite the dual reliance between pharmacists and pharmacy technicians.

It is as if pharmacy has aligned itself with the hierarchy between doctors and nurses in the sense that pharmacists prefer to use their clinical pharmacy skills in discussion with doctors and pharmacy technicians look towards nurses aspiring to run pharmacy technician-led clinics the way nurses do (Oswald, 2016). Pharmacy technicians deploy a re-professionalisation strategy of upward mobility by being registered professionals (since 2011) using this as an argument for having achieved professional status (Middleton, 2006; Oswald, 2016).

This shift has a socio-political and economic impact as pharmacy technicians are cheaper to employ. As they are increasing their education and training they may be able to take on more of the pharmacist’s traditional roles with the aim of freeing up pharmacists’ time to allow them to focus on gaining clinical knowledge and skills.

This is in line with Hughes’ (1958) division of labour where the more ‘dirty work’ is delegated to pharmacy technicians in hospitals, with pharmacists retaining the more desirable work such as the clinical pharmacy roles on the wards. In contrast, community pharmacists appear to be concerned about delegating because they are still dependent on this aspect of their work and concerns over the skills of pharmacy technicians as they feel they are responsible for their own work (McDonald et al, 2010). If community pharmacists delegate their substantive role of dispensing to pharmacy technicians and if new clinical tasks do not materialise or prove not to be financially viable, they will face redundancy. Once a profession has delegated an aspect of its work to another profession, it cannot easily be reclaimed at a later date (Nancarrow and Borthwick, 2005).

When the RPS became a professional leadership body pharmacists voted that pharmacy technicians could not be members. This strengthened the Association of Pharmacy Technicians UK’s (APTUK) (established in 1952) position, placing them in the national political arena. Pharmacy technicians may not only take over roles delegated to them by pharmacists but may politically try to influence stakeholders

to convince them that they are more than qualified to take over tasks traditionally undertaken by pharmacists (Andalo, 2015).

3.3.4 Professional power.

Abbott (1981) refers to power and wealth as factors important to status, where power relates to inter-professional jurisdictional competition involving stakeholders such as other professions, the State and patients. Hughes (1958) and Larson (2013) argue that the power a profession has relates to the licence society grants it to control its own work, including monopoly of practice (See *Chapter 2, Section 2.3.7 Professional regulation*). Freidson (1988) maintains that there are two interrelated dimensions to power, which are autonomy (referring to the ability to control one's own work) and a profession's ability to dominate or control the work of others (See *Chapter 2, Section 2.3.2 The 'power approach'*). The power of a profession is linked to its professional autonomy which are strategies used by a profession to maintain or gain near monopoly of practice by achieving social closure (Macdonald, 1995; Saks, 2016). It is implicit in this that a profession's status is dependent on the political and economic influence it has on the State (Freidson, 1994; Saks, 2016). Elston (1991) explains that there are at least three different forms of professional autonomy: political (ability to influence political decisions), economic (ability to have control over its remuneration), and clinical autonomy (ability to make its own clinical judgements).

3.3.4.1 Political autonomy

Political autonomy is dependent on the pharmacy profession's ability to organise itself into a corporate professional association that can represent it politically. Within pharmacy there are several different professional associations claiming to represent their pharmacy members' interests by trying to exert political influence to further their members' agenda adding to poor professional cohesion (Smith, Picton and Dayan, 2013).

Prior to 2010 the Royal Pharmaceutical Society of Great Britain (RPSGB) had to balance its roles as regulator and professional advocate for pharmacists but also for pharmacy technicians. This limited its ability to provide a clear vision and to advance the political agenda for the pharmacy profession. Members were left with the impression that the RPSGB prioritised its regulatory function over its

professional leadership function (Holloway, 1991). The RPSGB took the view that a pharmacist's name could be removed from the register for any form of 'misconduct' whereas for doctors they had to be found 'guilty of serious professional misconduct' before being removed from the General Medical Council's (GMC) register (Holloway, 1991). Pharmacists felt aggrieved that they were subject to stricter professional regulation than others as this gave the impression that misconduct was more frequent amongst pharmacists than for other professionals (Holloway, 1991). It can be speculated that the RPSGB felt it had to be viewed as using its powers of self-regulation in the public's best interest possibly because of community pharmacy's close links with commerce. In 2010, the regulatory function for pharmacists and pharmacy technicians was taken over by the GPhC. The RPSGB changed its name to the RPS declaring itself the pharmacists' professional leadership body.

This change meant pharmacists no longer had to be members of the RPS. In 2013 about 60% of all registered pharmacists were members of the RPS (personal email from RPS). The reason for this may be the historical legacy where pharmacists felt that their cause was not championed by the RPSGB or due to pharmacists already being a member of another professional association. The RPS, no longer hindered by its regulatory function, has moved forward and established various standards for the pharmacy profession, some of which are in collaboration with the royal colleges, for example the Royal College of Physicians.

There is no indication that the pharmacy profession is any closer to achieving similar political autonomy as the medical profession where, in particular, the British Medical Association (BMA) remains a powerful and vocal pressure group with a prominent profile in public policy debates (Edmunds and Calnan, 2001).

In December 2010, 'Pharmacy Voice' was established by three of the largest community pharmacy associations: Association of Independent Multiple Pharmacies (AIMp) (representing smaller pharmacy chains), the Company Chemists' Association (CCA) (representing larger chains) and the National Pharmacy Association (NPA) (representing independent pharmacy owners), to provide community pharmacy with a stronger and more unified voice politically and in the media. In December 2016 the NPA announced their withdrawal with the result that the Pharmacy Voice will be disbanded in 2017 (Andalo, 2017).

The pharmacy profession continues to have a fractured corporate structure with various associations claiming to represent different factions (Smith, Picton and Dayan, 2013). This makes it challenging for the profession to have a united front in the public and legal arenas including agreeing a clear purpose or vision for the future direction of pharmacy and communicating this message to the profession, public, political decision-makers and other stakeholders. A recent report commissioned by the RPS concluded that the profession would need to take a cohesive, inclusive view of the future direction of the profession by engaging all the different sectors of pharmacy as a way of improving its political autonomy (Smith, Picton and Dayan, 2014). The outcome is that the State, or government, is unclear about who they are negotiating with in terms of representing the pharmacy profession which weakens pharmacists' ability to bargain with the State (Macdonald, 1995).

3.3.4.2 Economic autonomy

In terms of economic autonomy, community pharmacy owners have contracts with the NHS to generate income from delivering NHS services e.g., dispensing NHS prescriptions (PSNC, 2017a, 2017b). The Pharmaceutical Services Negotiating Committee (PSNC) is the recognised negotiation body representing NHS community pharmacies. Community pharmacies also generate income from non-pharmaceutical products such as health and beauty products and 'over-the-counter' sales of medicines. The majority of community pharmacies' income is generated from the NHS due to the number of medicines dispensed (Thomas and Anscombe, 2012; Thomas and Plimley, 2012). The NHS system for fees and allowances mainly pays based on the volume of prescriptions dispensed with a small sum being allocated to pharmaceutical services such as Medicines Use Reviews (MURs) and the New Medicines Service (NMS) (PSNC, 2017b). As commercial businesses, community pharmacies direct their workforce towards the area that generates most income and profit, which is the dispensing of medicines.

There are future economic threats to pharmacy. There has been an increase in the number of community pharmacies, all competing for the same NHS global sum. In December 2015 the Department of Health announced that this overall global sum will be reduced (Torjesen, 2017). The full implication is unknown with the NPA and PSNC taking this to the High Court in early 2017 (Adcock, 2017).

It has been predicted that community pharmacies as a market will be further squeezed due to the larger corporate pharmacy chains (also referred to as multiples) being able to respond more quickly to changes in order to survive, whereas smaller community pharmacies may face a more uncertain future (Thomas and Anscombe, 2012; Thomas and Plimley, 2012).

There has not been and there continues to be no real workforce planning for pharmacy. In England, there has been a significant increase in the number of pharmacy students and new pharmacy schools opening which is set to continue. From 1999 to 2009, the number of pharmacy students more than doubled, from 4200 to 9800, while the number of pharmacy schools increased from 12 to 21 in the same period (Centre for Workforce Intelligence, 2012, 2013). The number of pharmacists qualifying has expanded with no link to pharmacist demand in the workforce.

Unlike medical and dental students, there is no cap on the number of pharmacy students that can enter university. Pharmacists' professional associations responded to a consultation for managing entry to pharmacy schools all recommending the introduction of control of pharmacy student intake. In contrast most pharmacy schools and community pharmacy employers prefer that there is no cap on the numbers of pharmacy students (Health Care Education England and Higher Education Funding Council for England, 2014). The main concerns raised by pharmacists are that there will be insufficient pre-registration places available for pharmacy students on completion of their MPharm degree resulting in some being unable to register as pharmacists with future unemployment and lowering of the entry criteria, possibly affecting the quality of pharmacists, which will eventually have a de-professionalisation effect on the profession (Martini, 2014; Torjesen, 2015).

A recent review of the pharmacy undergraduate course and pre-registration year resulted in a recommendation to change the current degree to an integral 5-year degree consisting of two 6 month practice placements negating the need for a separate pre-registration year, all delivered within the same global sum. This proposal will add some control on the pharmacy student numbers due to the limit of practice placements (Smith and Darracott, 2011).

The reason given for there being no cap on pharmacy students is that pharmacy is funded in the same way as other science subjects, whereas medicine and dentistry attract large amounts of Higher Education Funding Council for England (HEFCE) grant funding than science subjects. Pharmacy students are not subject to a NHS bursary, unlike medical and dental students. This led the pharmacy profession to call for changes to the funding structure for pharmacy training to reflect a similar situation as to the way medical and dental students are funded and trained, emphasising that pharmacy is a healthcare discipline (Lawrence, 2014; Phillips, 2014b). This leaves pharmacy in a paradoxical situation where pharmacy is working at being viewed as a healthcare profession with this being supported by the Department of Health (DH, 2008) and NHS England (NHS England, 2013) but at the same time its university education is viewed by the State as a science degree and not healthcare education. The pharmacy profession has limited economic autonomy, including having limited control over the number of pharmacists being trained to meet the demand.

Doctors and dentists have their own NHS 'Review Body on Doctors' and Dentists' Remuneration' covering medical and dental practitioners employed in secondary care but also those in primary care practices who are commissioned to deliver NHS services, which includes being part of the NHS pension scheme. In contrast pharmacists employed in the NHS-managed sector are on the Agenda for Change (AfC) pay scale together with all other healthcare and non-healthcare staff. Community pharmacists' pay is based on 'market forces' with no clear pay-structure and they are not part of the NHS pension scheme despite delivering NHS services. On average pharmacists receive lower salaries than doctors and dentists (This is Money, 2014). All of these factors have implications for pharmacists' income with a high income being a proxy for professional status (Freidson, 1994; Abbott, 1988).

3.3.4.3 Clinical autonomy

Professions are characterised by their high degree of clinical autonomy, which allows the individual professional to "exercise discretion in their work, to assert their own judgement and responsibility as the arbiters of their activities" (Freidson, 1994, p. 164). Edmunds and Calnan (2001) claim pharmacists have no clinical autonomy over prescribed medicines as, "they have to supply according to the prescriber's instructions" (p. 944). Pharmacists can refuse to dispense a

prescription on legal and therapeutic grounds, which means that there is some clinical autonomy related to this activity. This clinical autonomy may increase once community pharmacists gain access to patients' Summary Care Records (SCRs) (implementation started autumn 2015) as it has been speculated that pharmacists' responsibilities will increase in terms of the clinical or professional checks they undertake of prescriptions and that this will also increase their professional liabilities. In a pilot study of SCRs an average community pharmacy would only access 2.6 SCRs per month (Edmunds and Calnan, 2001; Bissell and Traulsen, 2005; Andalo and Sukkar, 2015).

The dispensing of medicines is where pharmacists feel they exercise their clinical autonomy (Dingwall and Wilson, 1995; Harding and Taylor, 1997). Rapport et al (2010) explain that it is the act of dispensing that is the defining aspect of community pharmacists' professionalism although it has been reported that they have lost pride in this due to increased work pressure and demand, resulting in loss of control and clinical autonomy (Rapport et al, 2010, 2011).

The act of dispensing is under threat from being made routine as this process is increasingly being reduced to its constituent parts which can result in the de-professionalisation of pharmacy as demonstrated in the study by Davies, Barber and Taylor (2014). The authors produced a framework where community pharmacists' activities were broken down into 18 pre-defined activities. These were designated as professional, semi-professional or non-professional activities, and used by research-observers to time how long community pharmacists spent on each of these activities. Community pharmacists spend the majority of their time on technical dispensing as opposed to patient-centred activities, including spending just under half their time on what the authors considered to be professional activities. Davies, Barber and Taylor (2014) implicitly corroborate the view that there are roles and activities undertaken by community pharmacists that are considered as non-professional. Splitting community pharmacists' professional work into different activities to increase routine and standardisation to improve productivity and efficiency has been referred to as '*McDonaldization*', denoting the practices of fast food outlets (Ritzer, 2000). Harding and Taylor (2000) argue that this has permeated into community pharmacy talking of future 'McPharmacists' who are de-skilled only undertaking routine activities (Bush, Langley and Wilson, 2009). This is stripping away community pharmacists' control and clinical autonomy over their work practices and undermining their basis for claiming

professional status with the possibility that some activities are taken over by less skilled staff (Harding and Taylor, 1997; Magirr et al, 2004; Bissel and Traulsen, 2005).

This routinisation of the medicines supply and dispensing processes is also taking place within hospital pharmacy, where it can be argued this has resulted in increased clinical autonomy for hospital pharmacists. New technology and automation for medicines supply and dispensing processes are being developed and introduced within hospitals and it is also being implemented in community pharmacy. This includes robotic dispensing (picking of medicines), advanced vending machines for supply of medicines, electronic prescribing which can be linked directly to medicines ordering and use of 'patient bar-codes' from the process of prescribing, dispensing and administering of medicines to the patient. The introduction of automation of medicines supply processes in hospital pharmacy are to improve medicines safety, to allow pharmacists to spend more time on wards, to improve productivity, efficiency and reduce cost (Green and Hughes, 2011). This has increased hospital pharmacists' clinical autonomy as the routine aspects of the medicines supply and dispensing processes are being delegated to less skilled pharmacy staff (i.e., pharmacy technicians and assistants). On the wards pharmacists are able to undertake extensive prescription monitoring (also sometimes referred to as clinical checks or clinical screens or assessments) (RPS, 2016). They have access to a patient's medical records, the list of patients prescribed medicines and are co-located with medical and nursing staff. This prescription monitoring also includes ensuring prescribers comply with the hospital's prescribing formulary to ensure adherence and containment of medicines costs for the hospital (Child, Cooke and Hey, 2011). Pharmacists are members on the local Hospital Drug and Therapeutics Committees which reviews evidence-based practice and makes decisions about which medicines can be prescribed and under which circumstances. This affords hospital pharmacists more clinical autonomy than community pharmacists (Child, Cooke and Hey, 2011).

Community pharmacists have some clinical autonomy "when making decisions about 'over-the counter' (OTC) sales" (Edmunds and Calnan, 2001, p. 944). OTC refers to medicines deregulated from prescription-only medicines to either a general sale list (GSL) item or pharmacy-only medicines, both referred to as over-the-counter medicines. Patients can only purchase pharmacy-only medicines

under the supervision of a pharmacist. Hibbert, Bissell and Ward (2002) found that community pharmacists were trying to develop their professional role by utilising their clinical autonomy in the medicines sale of pharmacy-only medicines whereas consumers challenged this strategy as they viewed this transaction as buying a product rather than obtaining professional advice. Similarly Stevenson, Leontowitsch and Duggan (2008) found that consumers purchasing GSL medicines, bought from petrol stations and supermarkets, did not perceive that pharmaceutical input was necessary and treated this as any other retail purchase. This reduces the medicine to a commodity where there is no associated expert advice available if required by the consumer. Consumers or patients, when purchasing OTC medicines, are not always looking for pharmacists to add value to this process by tailoring medicines information and advice to the individual patient as previously suggested by Harding and Taylor (1997).

Within community and hospital pharmacy, there are increasing requirements for standard procedures for various routine activities to ensure consistent quality, responsibilities and accountability. Routinisation is considered to reduce professional status. Haug's (1972) de-professionalisation hypothesis proposed that rationalisation and codification of knowledge and expertise into standardised procedures reduce professions' autonomy (Macdonald, 1995; Bissell and Traulsen, 2005). Others have argued that professionals' work is increasingly incorporated into large bureaucratic structures such as the NHS where control and autonomy over their work is gradually being reduced due to increasingly becoming subject to rationalisation through routinisation and standardisation including measuring performance and setting of targets as a way of improving productivity driven by economic factors (Macdonald, 1995). They argued that this in effect makes professionals part of the proletariat (Bissell and Traulsen, 2005). This increase in standardisation and productivity has been interpreted as reducing pharmacists' autonomy due to "standardised pharmaceutical services dictated by company policies" (Harding and Taylor, 1997, p. 556). Abbott (1988) accepts that certain aspects of professionals' work will always be routine. McDonald et al (2010) showed that pharmacists found standardised paperwork and procedures helpful and did not reduce the pharmacist-patient interaction "to formulaic exchanges" (p. 457) as suggested by Harding and Taylor (1997). The use of procedures or guidelines does not remove the need for pharmacists to use their judgement, but has the potential to create tension between maintaining a

“profession as a collective” (Armstrong, 2002, p.1772) by following agreed best practice and the individual practitioner’s clinical autonomy in their dealing with individual patients or situations (Armstrong, 2002).

Others argue that the increasing requirement for performance and productivity within the NHS now forms part of professionals’ work and does not equate to reduced professional autonomy. Moffatt, Martin and Timmons (2014) point out that productivity instead of being imposed on professionals has been reframed to become embedded into the individual’s duty through the rhetoric of professionalism by maintaining the autonomy of the individual professional with the authors dismissing this having a de-professionalisation effect as previously discussed by others (Haug, 1972; Macdonald, 1995; Bissel and Trauslen, 2005). A more balanced view is that increasing productivity in bureaucratic organisations such as the NHS, for example in the case of introduction of new technology, provides opportunities and threats and can have both re- or de-professionalisation effects on pharmacists and therefore their autonomy (Pettrakaki, Barber, and Waring, 2012) (See *Chapter 2, Section 2.3.8 Professionalisation as dynamic processes*).

3.4 Summary

The contextual information about the pharmacy profession in England provides the historical background for why and how pharmacists have ended up with near monopoly of the act of dispensing and why this is no longer sufficient to sustain their future practice in today’s healthcare. It has been proposed over the years for pharmacists to move away from dispensing towards more clinical roles as healthcare professionals, yet pharmacists find it difficult to leave their past behind. Pharmacists struggle with how they are perceived by the public, patients and other healthcare professionals. They have tried to improve their inter-professional status but there remains uncertainty over what the core function is that defines the pharmacy profession today, which continues to be the act of dispensing although politically this has been assessed as no longer being sustainable.

Pharmacists find it difficult to articulate the value and contributions they bring to healthcare, leaving the public continuing to place pharmacists in a medicines supply role, perpetuating the images of pharmacists as ‘shopkeepers’. The issues of pharmacists having to extend their clinical roles are debated in the professional

arena but it remains unclear whether the pharmacy profession recognises the need for change and is prepared to embrace these or if it considers that the status quo can continue.

Pharmacists consider themselves an authority on medicines but it is unclear how they perceive this being manifested and understood by themselves, other healthcare professions, patients and the public. The pharmacy profession has corporately failed to clearly articulate a clear vision and definition of pharmacy by not communicating to the public how pharmacy has developed its practice into clinical roles and contributions to healthcare. It can be argued that pharmacists' licence in society is in dispute.

The status of the pharmacy profession is determined by the nature of pharmacy practice characterised by its esoteric knowledge, autonomy in influencing practice, social, political and economic factors, authority over patients, intra-professional divisions and inter-professional competition over jurisdictional claims. The dynamic processes for pharmacists' re- or de-professionalisation strategies are assessed by the degree to which these characteristics are increased or diminished for the pharmacy profession. Important factors for the status of the pharmacy profession are how it maintains and extends or loses its practice.

Pharmacists' practice, with the exception of dispensing, has not been widely theorised in sociology. This study will focus on pharmacists' perceptions of the nature of pharmacy practice including how they contribute to healthcare.

This study aimed to address the research question: *How do pharmacists working in different healthcare settings perceive their status in society today?*

The next chapter will discuss why an exploratory qualitative collective case study methodology was used to address the research question.

CHAPTER FOUR: Methodology and methods

4.1 Introduction

The preceding chapters justified the rationale for undertaking this study. The theoretical framework or working theories were discussed based on theories from the sociology of the professions. It was determined that there was a gap in the literature in examining the pharmacy profession from a sociological perspective, and where undertaken, these studies had mainly focused on community pharmacy or aspects thereof and often did not include hospital pharmacists. The justification for exploring the nature of pharmacy practice from the perspective of pharmacists for those working in four different healthcare settings in England was made. A broader contextual discussion of the pharmacy profession in England was made to increase the understanding of how it is viewed today and how it got there by outlining its historical development. This culminated with the research question: *How do pharmacists working in different healthcare settings perceive their status in society today?*

To address the research question the aims of the study were:

- To identify the core function that defines the pharmacy profession.
- To explore pharmacists' views about how others' perceptions of them affects their pharmacy practice.
- To explore how pharmacists perceive they maintain or extend their pharmacy practice.
- To make comparisons between pharmacists' perceptions of their pharmacy practice in relation to the healthcare setting in which they work.

Having framed the study within its contextual and conceptual framework in the preceding chapters, this chapter explains the rationale for choosing qualitative collective case study methodology to answer the research question.

The qualitative collective case study consisted of four cases studies. Each case study included five experienced pharmacists from community pharmacy, acute hospital, mental health or community health services, respectively. A total of twenty pharmacists were included in this study. Data were obtained from one face-to-face in-depth individual semi-structured interview using an interview guide covering how pharmacists viewed their practice, contributions made, how others

viewed pharmacy and the future. Each pharmacist was asked to complete a diary for five days to include any positive contributions or frustrations experienced. The data for each case were analysed using inductive thematic analysis and a cross-case analysis undertaken.

This study was guided by a constructivist researcher paradigm influencing all aspects of the research process. This chapter includes a discussion of the researcher's role and position in the research. This is followed by justifying the choice of the qualitative collective case study methodology, including the research design, the rationale of the sample decisions, the use of data collection and analysis methods. The ethical implications of the study are considered as are the rigour and quality of the study.

A Researcher Journal was maintained throughout this study with quotes from this being included where relevant (See *Chapter 7, Reflexivity and reflection*)

This chapter seeks to capture the research process within the study although it should be recognised that these were more fluid and iterative than the structure suggests as it was difficult to fully encapsulate and articulate that, "research is often confusing, messy, intensely frustrating, and fundamentally nonlinear" (Marshall and Rossman, 2015, p. 65). The chapter ends with a concluding summary.

4.2 Rationale for a qualitative research design

The purpose of this study was to understand and provide insight into the nature of pharmacy practice linking this to pharmacists' status in society today (See *Chapter 2, Section 2.3.4 Professional status*).

There was relatively little known about pharmacists' professional work or the nature of their practice and it was therefore vital to obtain their perspective when exploring this. The key was to understand the perspective of experienced practising pharmacists. A qualitative research approach was used to explore this further as pharmacists in their everyday lives have a subjective understanding of the world in which they live and work (Creswell, 2009). The research questions in qualitative research tend to start with 'what' or 'how' and are open ended implying an emerging research design (Creswell, 2007; Merriam, 2009).

A quantitative research approach would not adequately address the research topic, an approach that is associated with objectivism. It can be argued that if

researchers only relied on objectivism for gaining new knowledge then there would be a social world out there that we would know little about (Crotty, 1998). To gain knowledge about this social world, researchers would need to embrace qualitative research approaches. As Yardley (2000) explains:

“One of the primary reasons for adopting qualitative methodology is a recognition that our knowledge and experience of the world cannot consist of an objective appraisal of some external reality, but is profoundly shaped by our subjective and cultural perspective, and by our conversations and activities...thus ‘truth’, ‘knowledge’ and ‘reality’ are actively created by the communal construction and negotiation of meaning”. (p. 217)

Bogdan and Biklen (2007) define qualitative research as “an approach to social science research that emphasises collecting descriptive data in natural settings, uses inductive thinking, and emphasises understanding the subject’s point of view” (p. 274), whereas Glesne (2011) defines qualitative research as, “a type of research that focuses on qualities such as words or observations that are difficult to quantify and lend themselves to interpretation or deconstruction” (p. 283). Creswell (2009) maintains that qualitative research, particularly an exploratory approach, is useful where there is little known or understood about a topic and where the researcher seeks to understand the research topic to be studied within the natural setting without the manipulation of any variables or a prediction about the research outcomes. This is in contrast to controlling and manipulating the research setting, creating a context that is artificially constructed and removed from every day social reality.

Several authors have identified various factors that are important for choosing to undertake a qualitative study, because the research question requires it, to better understand an area where little is known, to make sense of complex situations, contexts and settings, to learn how participants construct their worlds, to gain deep, rich and detailed descriptions of cultural scenes, to help empower individuals to share their stories and enact meaningful social change and to generate theory where little exists (Creswell, 2007; Richards and Morse, 2007; Merriam, 2009).

Review of the literature and the contextual information discussed in the preceding chapters demonstrated that there were gaps in the sociology literature about the nature of pharmacy practice, particularly that of hospital pharmacists, including linking the nature of pharmacy practice to pharmacists’ status in society today. As

far back as 1995, Dingwall and Wilson called for more research into the “everyday work of pharmacy” (Dingwall and Wilson, 1995, p.117), including calling to explore the nature of pharmacy practice recognising that this differs depending on the healthcare setting. Since then limited sociology research has been undertaken on the pharmacy profession, mainly focusing on community pharmacists and then often concentrating on particular aspects of their practice (McDonald et al, 2010) instead of exploring all aspects that experienced pharmacists consider forms part of the nature of pharmacy practice in delivering healthcare to patients (See *Chapter 2, Section 2.4 Sociological examination of the pharmacy profession*). Pharmacists work in various healthcare settings resulting in differences in the nature of pharmacy practice contributing to intra-professional divisions making this a complex topic to explore (See *Chapter 2, Section 2.4.3 Internal divisions* and *Chapter 3, Section 3.3.1 Intra-professional divisions*).

A qualitative research approach allowed the researcher to enter the world of experienced pharmacists delivering healthcare in an attempt to achieve a more holistic rather than a reductionist understanding of the social world in which they practise as pharmacists (Bogdan and Biklen, 2007; Merriam, 2009), with the main data collection method being a one-to-one semi-structured interview.

4.3 Researcher role and position

Research can be described as a systematic investigation whereby data are collected, analysed and interpreted in an effort to find out something that is not known in the wider world and to contribute to a body of knowledge (O’Leary, 2004). The main aim of research is to generate new knowledge. Therefore, consideration needs to be given as to what constitutes knowledge and how this is produced.

4.3.1 Researcher paradigm

Qualitative research methodology is a broad term encompassing a wide range of research approaches that are influenced by different philosophical traditions or research paradigms (Creswell, 2007). In the literature ‘methodology’ and ‘method’ are often used interchangeably, whereas others distinguish between the terms ‘methodology’, ‘strategy’, ‘method’, ‘plan’ and ‘prototype’ (Crotty, 1998; Mason, 2002). Crotty (1998) says that these terms are often “thrown together in [a] grab-bag style as if they were all comparable” (p.3).

Denzin and Lincoln (2005) explain the link between paradigm and research methodology. They state that a paradigm includes the concepts of ontology, epistemology and methodology. Ontology and epistemology are philosophical assumptions concerned with theories related to the nature of reality and knowledge, respectively. The distinction between ontology, epistemology, methodology and methods is a porous one (Crotty, 1998). See Figure 2.

Ontology ⇒ Epistemology ⇒ Methodology ⇒ Methods
What's out there to know about? (ontology)
What can we (hope to) know about it? (epistemology)
How can we go about acquiring that knowledge? (methodology)
What procedures or techniques do we use to collect the data? (methods).

Figure 2. Ontology, epistemology, methodology and methods. Adapted from Hay (2002)

A researcher's ontological and epistemological positions shape what they are doing, the questions they ask, how they go about answering them and the claims they can make about their findings (Crotty, 1998; Furlong and Marsh, 2002).

In the context of this study, 'methodology' was viewed as the overall approach, plan or strategy taken with the study, where the researcher's paradigm inherently lies behind or underpins the methodology (Crotty, 1998). Methods are procedures or techniques used for collecting and analysing data (Crotty, 1998).

A researcher's paradigm or 'worldview' is often referred to in the literature as the philosophical stance or epistemological or theoretical perspective (Hatch, 2002; Denzin & Lincoln, 2005; Bogdan & Biklen, 2007; Creswell, 2007; Glesne, 2011) with a researcher's ontological position being conflated with epistemology (Crotty, 1998). This theoretical perspective, as distinct from theory (i.e. theories on the sociology of the professions) or theoretical framework, is in the context of this study referred to as the paradigm influencing the way knowledge is studied and interpreted within research (Bogdan and Biklen, 2007).

It is the researcher's paradigm that sets down the intent, motivations and expectations for the research. Without nominating a paradigm there is no basis for

subsequent choices regarding methodology, design or methods. Burr (1995) explains that:

“No human being can step outside their humanity and view the world from no position at all, which is what the idea of objectivity suggests, and this is just as true for scientists as for everyone else”. (p.110)

Kuhn (2012) in *The Structure of Scientific Revolution* from 1962 found that scientists worked and undertook research from a background of theory, which comprises a set of beliefs about science and scientific knowledge, which he referred to as a paradigm. Denzin and Lincoln (2005) describe a paradigm as “the net that contains the researcher’s epistemological, ontological, and methodological premises” (p. 22) explaining that all research is interpretative regardless of the paradigm of the researcher.

Creswell (2009) equates a researcher’s paradigm to a philosophical worldview describing this as “a general orientation about the world and the nature of research that a researcher holds” (p.6). Morgan (2007) agrees that a researcher’s paradigm relates to the nature of research, but disagrees with using the term ‘worldview’ as it implies a much broader and all-encompassing paradigm that influences a person’s perspective of the world including for example religious concerns such as “beliefs about morals, values, and aesthetics” (p.50). In this study, a researcher’s paradigm is limited to the nature of research.

Kuhn (2012) explains that a paradigm refers to “common possessions of the practitioners of a particular discipline” (p. 181). The inference is that a discipline or group of practitioners share the same paradigm. Guba and Lincoln (1994) explain that paradigms are human constructs that are established by communities of researchers with shared beliefs about the nature of reality and knowledge construction. A community of researchers from the same paradigm would, for example share assumptions, concepts, values and practices about research.

Creswell (2007, 2009) elaborates further by explaining that researchers are introduced into particular professional research paradigms through educational and professional socialisation processes. The pharmacy degree is science-based with clinical pharmacy which involves making recommendations on evidence-based medicines and having the knowledge and ability to evaluate randomised controlled clinical trials.

It is considered that pharmacists, through their undergraduate and postgraduate education, are taught and trained within the post-positivist paradigm. It is this scientific background of pharmacists that has been criticised for resulting in the lack of pharmacy practice researchers engaging with social science theories that could help place pharmacy practice research in a social context to enhance the “explanatory capacity and sophistication” (Bissell and Traulsen, 2005, p.x) of pharmacy practice research.

Researchers working from a post-positivist background acknowledge that reality is not perfect and that research may not provide the absolute truth as opposed to researchers from a positivism paradigm. Instead post-positivists set out to test a hypothesis based on a set of variables. The hypothesis is rejected or accepted based on statistical probabilities. They believe researchers should not interact with the research subjects or objects since this may influence their behaviour (Appleton and King, 2002). The basic principle is that social systems consist of structures that exist independently of individuals. The researcher and study subjects are considered to be two separate independent entities. Researchers within the post-positivist paradigm infer that research is objective from the inception of the research idea, design, methods used, the analysis and the interpretation of results. They attempt to reduce sources of bias to maintain validity and reliability of the research. Researchers strive not to impose their own or the local research community’s values on to the research (Weaver and Olson, 2006).

The researcher, a pharmacist, acknowledges being from a post-positivism paradigm but cannot reconcile qualitative research within this paradigm. In undertaking this study, the researcher entered and became part of a community of researchers from other disciplines, from outside the pharmacy profession, undertaking qualitative research not aligned with the post-positivism paradigm. This community influenced the researcher’s orientation early on due to being introduced and influenced by researchers with different paradigms. This started to open up new and different perspectives related to social science that included qualitative research approaches. Initially many of the discussions, perspectives and presentations of qualitative research findings were ‘incomprehensible’ to the researcher. Later as she became more familiar with qualitative research approaches this started to make sense and it felt like “entering a different world and learning a new language” (Researcher Journal).

The researcher, being a pharmacist, considered that this qualitative research study was grounded in a constructivist paradigm. This was because the study was concerned with how complexities of the social world were experienced, interpreted and understood by experienced pharmacists (i.e., the study participants) in a particular healthcare setting context in today's society. Constructivism seeks to understand the research in the natural setting providing the researcher the opportunity to "...examine in detail the labyrinth of human experience as people live and interact within their own social worlds" (Appleton and King, 2002, p.642).

Based on the above interpretation of post-positivism, the researcher considered that qualitative research studies do not belong within a post-positivism paradigm, although others may disagree with this notion depending on how they define post-positivism. Widely used definitions of post-positivism most commonly aligned this paradigm with quantitative methods of data collection and analysis with Mertens (2005) stating that "although qualitative methods can be used within this paradigm, quantitative methods tend to be predominant" (p. 12) (Crotty, 1998; Guba and Lincoln, 2005; Weaver and Olson, 2006; Creswell, 2007, 2009).

Constructivists believe that reality is socially constructed and that there is no real world out there independent of our knowledge. Constructivists do not claim that there is no physical reality such as mountains or trees but argue that this reality has no social role independent of society's understanding of it. They believe that there are multiple realities, including that the researcher and area under study are inseparable (Guba and Lincoln, 1994, 2005; Crotty, 1998; Weaver and Olson, 2006). In addition, the concepts related to the sociology of the professions are all socially constructed (See *Section 2.3 Theories from the sociology of the professions*).

Constructivist researchers acknowledge that their own backgrounds shape their interpretation and they position themselves in the research. In constructivism the researcher is the research instrument, interprets the data and understands and acknowledges that his or her actions may affect participants that are being studied. Researchers also understand that participants in turn may affect them. Therefore, the researcher and participants are interdependent. The process of recognising the role of the researcher as part of the research is in contrast to post-

positivism where the researcher aims to be a detached observer in search of some objective truths (Appleton and King, 2002).

It is acknowledged that researchers cannot divorce themselves from their previous research experience, their professional education and background or from macro-issues such as socio-cultural, historical, environmental, technological, political and economic contexts in which their research is undertaken. The researcher felt, as a result of entering this qualitative researcher community that her position moved from a post-positivist paradigm towards a constructivism paradigm. Creswell (2007) for example explains that; "I would not characterise all my research as framed within a post-positivist qualitative orientation" (p.21) but instead clarifies that he also uses the constructivist approach. This raises the question, if it is possible to move from a post-positivist to a constructivist paradigm or span both?

Guba and Lincoln (1994, 2005) are known for their approach in identifying alternative paradigms to positivism. They developed a system for comparing different research paradigms used in social science research by tabulating these according to their ontology, epistemology and methodology. This system for comparing paradigms is helpful for novices to this area of social sciences but also implies that each paradigm is separate, having clearly defined boundaries that do not overlap, and is incommensurable (i.e., incompatible) with other paradigms. The implication is that accepting one paradigm means rejecting all others including rejecting knowledge produced through these other paradigms (Morgan, 2007; Niglas, 2010).

In the literature the number of different researcher paradigms has increased, possibly because more researchers have engaged in these discussions including the growing trend for the use of mixed methods (i.e., combining quantitative and qualitative methods) with researchers feeling constrained by the existing paradigms (Guba and Lincoln, 2005; Morgan, 2007). For example Guba and Lincoln in their earlier comparisons included two competing paradigms: positivism and what they initially referred to as 'naturalistic inquiry' which later became known as constructivism (Guba and Lincoln, 2005; Morgan, 2007). They later expanded on positivism and constructivism to also include comparing other paradigms: 'post-positivism', 'critical theory' and 'participatory'.

This development in itself indicates that paradigms are not static but evolve over time. This happens for example when an existing paradigm proves inadequate when findings and issues occur that cannot be explained within this current paradigm resulting in a conflict that calls for new ways of viewing reality (Crotty, 1998; Kuhn, 2012). This has led to discussions regarding if some paradigms are commensurable or not. Furlong and March (2002) argue that a paradigm is "a skin not a sweater" (p.17), meaning it is not possible to change between or use multiple paradigms. Guba and Lincoln (2005) however raised the following question and answer:

"Is it possible to blend elements of one paradigm into another, so that one is engaging in research that represents the best of both worldviews? The answer, from our perspective, has to be a cautious yes. This is especially so if the models (paradigms) share axiomatic elements that are similar, or that resonate strongly between them."
(p. 201)

Guba and Lincoln (2005) argue that positivism and post-positivism are commensurable whereas post-positivism and constructivism are not. They base their argument by introducing 'axiology' (values and ethics) as another philosophical concept. This means that they have added a further concept that forms part of a researcher's paradigm in addition to ontology, epistemology and methodology. Morgan (2007) argues that this goes against the majority of scholars thereby rejecting Guba and Lincoln's argument. This is not the same as rejecting the concept of axiology but rather challenging how this concept was applied. Instead Morgan (2007) argues that traditionally paradigms are determined starting from ontological assumptions about reality which then impacts and constrains the subsequent epistemology about the nature of knowledge. Guba and Lincoln (2005) raised the possibility of paradigms overlapping as long as the key ontological assumptions are maintained.

The ontological position according to Lincoln and Guba (2000) for positivism is "Naïve realism" (p. 168) whereas for the post-positivism paradigm it is "critical realism - "real" reality but only imperfectly and probabilistically apprehendable" (p.168). They state that the ontological position for constructivism is "relativism - local and specific constructed realities" (p.168). Cupchik (2001) questions Lincoln and Guba's (2000) assertion that positivism and constructivism are incommensurable. He argues that positivist and constructivist ontologies are

compatible by proposing an alternative ontology of 'constructivist realism' that accommodates positivism and constructivism and their methods by focusing on similarities instead of differences:

"Getting rid of concerns about truth and apprehension is a good place to start. Constructivists take for granted the notion that truth is relative to individuals and communities. But what about "scientists"? While they may be in search of first principles of "nature", scientists also know that individual events are indeterminate and that theories are always being replaced over the course of time". (Cupchik, 2001)

The point being made here is that increasingly scholars are questioning the previous assumptions that paradigms are incommensurable with Kuhn (2012) stating in his post-script from 1969 that those who support the incommensurability of paradigms cannot "communicate with each other at all" (p.198) thereby limiting the generation of new knowledge. Niglas (2010) points out that there is a gradual shift towards the idea of a continuum of research paradigms, whereby these overlap (i.e., moving towards these being commensurable):

"Most of the paradigm positions on these issues are now described as partly overlapping and forming a continuum rather than a dichotomy". (Niglas, 2010, p. 219)

As part of undertaking this study the researcher entered a qualitative researcher community where post-positivism was not the prevailing paradigm, learning more about qualitative research approaches and the social science 'world'. This resulted in a shift in her perception of research which differs from post-positivism. The researcher explains this shift as a move from post-positivism towards constructivism, acknowledging that some scholars argue that such a fundamental shift is not possible whereas others indicate that it is.

In line with the explanation given by Niglas (2010) the researcher has come to view that there is an overlap of paradigms resulting in a continuum between paradigms where a researcher is positioned. If that is not possible then how is it possible for researchers to expand perceptions and learn about new research methodologies (e.g., qualitative research approaches) without also 'shifting' their belief and practices within research?

In this continuum from post-positivism to constructivism the researcher is positioned within the constructivism paradigm, but towards the post-positivism end of this continuum as opposed to being towards post-modernism as illustrated in Figure 3.

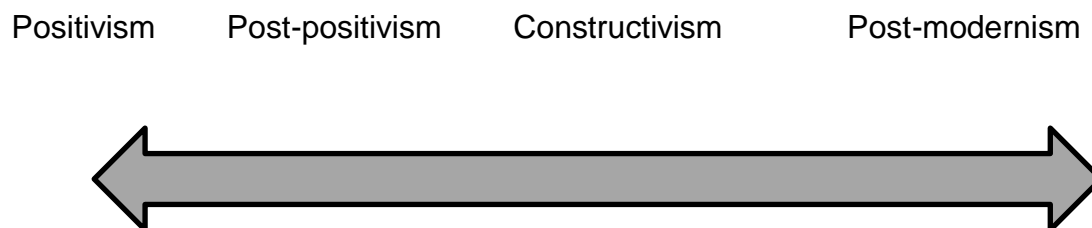


Figure 3. Researcher paradigm continuum.

4.3.2 Sociological theories and paradigmatic divides

Some of the sociology of the professions theories referred to in this thesis span several different paradigms, which differ from the researcher's constructivist paradigm.

Burrell and Morgan (1979) argue that the paradigms of sociology theories and that of the researcher should be aligned and that it is not possible for a researcher to apply sociology theories that fall outside their paradigm. In contrast other scholars argue for eclecticism stating that it does not constitute an alternative research model but is rather an intellectual stance with the aim of addressing a problem from a wider scope "in order to fashion more useable and more comprehensive forms of knowledge" (Sil and Katzenstein, 2010, p.412). It can be argued that drawing on sociology theories from different paradigms has disadvantages. Burrell and Morgan (1979) argue that this is because sociology theories are formulated based on distinct ontological and epistemological assumptions that are specific to the terms and concepts used in a particular theoretical approach, which are not interchangeable with those used in sociology theories developed in a different paradigm. This could result in integrating terms and concepts from sociology theories from different paradigms resulting in superficial application of these sociology theories. Sil and Katzenstein (2010) disagree with this argument pointing out that even within a single paradigm the same terms and concepts may be defined and used differently and that scholars tend to focus on inter-paradigmatic debates, which limits researchers' practice. Instead the authors argue that researchers should consider the advantages of eclecticism by downplaying

paradigmatic divides and use what works in practice to aid understanding of the messiness and complexity of the real-life world. This view assumes that different paradigmatic sociology theories can be used to answer different parts of the same research question or problem which implies that these different sociology theories sit alongside each other rather than being from competing paradigms. Parsons (2015) in his paper justifies that ontologically and epistemologically constructivists should be utilising non-constructivist theories because these contrasting theories can be viewed as 'mind-opening tools' that allow new and critical ways of increasing their interpretative abilities. Parsons (2015) argues that this approach is accommodated within the constructivist paradigm as researchers will utilise and apply these theories from within their own paradigm. Parsons (2015) argues that researchers can only examine the socially constructed world if they relate these to other theories, even if these are non-constructivist, as different accounts form the basis for all social research. Parsons justifies this further by stating that research only becomes meaningful if this is contrasted with different theories or explanations.

It is therefore the researcher's paradigm that provides the angle of interpretation and analysis in utilising different sociology theories, even when these span various paradigms from positivism to post-modernism such as the trait approach, the system of professions, neo-Weberianism or Foucauldianism, as a way of "stimulating fresh thinking" (Saks, 2016, p.8) about the pharmacy profession (O'Neill, 1986; Macdonald, 1995; Saks, 2016). These different sociology theories can be viewed as heuristic aids in increasing and expanding the sociological understanding of the pharmacy profession in answering the research question (Bissell and Traulsen, 2005; Saks, 2016).

4.3.3 Methodologies considered

In *Section 4.3.1 Researcher paradigm*, it was explained that a methodology should be congruent with the researcher's research paradigm. This section explains different methodologies considered by the researcher before determining that a collective case study research methodology was appropriate in answering the research question. This was an iterative and evolving process.

In the initial stages, in between undertaking literature reviews, identifying the topic area for the research and formulating the research question, engaging with research paradigms and determining that qualitative research was the most appropriate approach to answer the research question, different research methodologies were considered (See *Section 4.2 Rational for qualitative research design*).

Early on in the research process collective case study research was explored mainly with reference to Yin's (2009) work. There were compelling reasons for choosing this such as facilitating an in-depth study with the result being 'lessons learnt'. At the time it was considered that collective case study research as outlined by Yin (2009) was mainly applied as an exploratory method for pilot studies to support the generation of a hypothesis to be tested utilising a different research methodology. It was considered that Yin's case study research was within the post-positivist paradigm (Hyett, Kenny and Dickson-Swift, 2014). This led to a diversion where in particular phenomenology as well as grounded theory and ethnography were considered before returning to exploring collective case study methodology again but with the researcher arriving at a different place, with a different perspective, than when this process started.

Grounded theory is concerned with studying "actions, interactions and social processes of people" (Creswell, 2007, p.63). Grounded theory developed by Glaser and Strauss (1967) addresses the positivist concerns with hypothesis testing. Instead of starting with a theory and then testing this through empirical data, they made the radical proposition at the time that the data collection should precede the theory formulation, with the theory being 'grounded' in the data. Glaser (1992) explains that:

"The grounded theory researcher, whether in qualitative or quantitative data, moves into an area of interest with no problem. He moves in with the abstract wonderment of what is going on that is an issue and how it is handled". (p.22)

Glaser's presupposition is that grounded theory is an inductive process where the researcher has few preconceived ideas about the research area. The aim is to reduce any biased interpretation of the data if the researcher was influenced by the literature. Cutcliffe (2005) agrees that today researchers cannot approach research from a general 'wonderment' due to requiring ethics and research

approvals, but should instead declare using a modified grounded theory. It is difficult to understand that something so abstract as approaching a research topic from general 'wonderment' can be accommodated within its "positivists' underpinnings" (Charmaz, 2006, xxiii), although it is acknowledged that this ensures the researcher enters the research with few preconceived ideas although this notion is disputed as it is argued that researchers do not approach research "from no position at all" (Burr, 1995, p.110) (See *Section 4.3.1 Researcher paradigm*). Grounded theory by Glaser and Strauss (1967) sets out guidelines and step by step processes that guide the research whereby the researcher discovers theory based on emerging data. This places the researcher as an almost passive participant in the research process undertaking no interpretive work giving the impression that 'data speaks for itself' (Braun and Clarke, 2006). Grounded theory was further developed by Strauss and Corbin (1998) with the critique being that researchers often focus too much on the procedures of data analysis diverting attention away from the actual data resulting in a poorly integrated theoretical framework (Backman & Kyngäs, 1999). Charmaz (2000, 2006) moved grounded theory towards constructivism by developing an approach that is less prescriptive consisting instead of principles and practices with the researcher being active in constructing the data and theories which is more congruent with the researcher's research paradigm. Charmaz (2006) explains that grounded theory "serves as a way to learn about the worlds we study and a method for developing theories to understand them" (p.10). Grounded theory is a move away from the description produced by the 'lessons learned' from collective case study research, in that the outcome is to generate or discover a substantial theory. The aim of this study was not to examine social processes or to generate a substantial theory but understand and provide insight into pharmacists' perceptions of the nature of pharmacy practice and the implications this has for the pharmacy profession by linking this to its status in society today.

Phenomenology was explored as a possible methodology for this study. Phenomenology focuses on participants' "lived experiences" (Van Manen, 1990, p.9) asking them to interpret their experiences (Starks and Trinidad, 2007). The founder of phenomenological philosophy was Husserl (1970) who was followed by several other phenomenologists who contributed to different versions or developed

some further elements of this philosophy such as Heidegger, Gadamer, Satre and Merleau-Ponty (Dowling, 2007; Langridge, 2007).

The interpretive phenomenological approach based on the philosophy of Heidegger was explored as it was considered to be congruent with the researcher's research paradigm and research question at the time. Heidegger (1962) believes that humans are hermeneutic (interpretative) beings who are able to find meaning in their own lives. Heidegger differs from Husserl's view of the importance of description rather than an understanding of the phenomenon. Heidegger's philosophy is founded on the ontological view that lived experience is an interpretative process. Heidegger (1962) also proposes that consciousness is not separate from the world of human experience. Heidegger's philosophy builds on the hermeneutic tradition that is concerned with interpretation of text, which would have been the interview transcripts. He argues that it is not possible to investigate phenomena and identify their essence in a neutral and detached way because people are inseparable from the world they inhabit and it is therefore not possible to bracket off one's way of seeing and identifying the phenomenon (LeVasseur, 2003). Instead the way of our existence must be seen in a historical, social, political and cultural context and understood with regard to the role of language and must be interpreted and not simply described. Therefore, the researcher must explore the phenomenon from a position in relation to whatever they want to understand. It is not possible to be detached and take an overview as advocated by other phenomenologists such as Husserl (Dowling, 2007; Langdrige, 2007; Smith, Flowers and Larkin, 2009). Heidegger (1962) questioned the possibility of any knowledge outside of an interpretive stance. This implies that knowledge is a result of having a reflective awareness. Because interpretations are varied, there is no single reality. Subjectivity is valued, context is important in explanations, biases need to be articulated and ideas evolve and change over time.

The method for data analysis that was explored was based on Smith, Flowers and Larkin's (2009) Interpretative Phenomenological Analysis (IPA). IPA follows an idiographic approach to analysing each interview and then across the sample. The best way to collect data is through face-to-face semi-structured interviews (Smith, Flowers and Larkin, 2009). IPA is criticised by Langdrige (2007) for not fully engaging in theoretical underpinnings of IPA although Smith, Flowers and Larkin

(2009) argue that IPA is mainly based on Heidegger's philosophy but acknowledge that they draw on wider philosophies from phenomenology. Willig (2013) argues that there are limited differences between IPA and grounded theory, which Smith, Flowers and Larkin (2009) acknowledge. The problems with distinguishing between phenomenology and grounded theory have been documented elsewhere in the literature (Baker, Wuest and Stern, 1992; Wimpenny and Gass, 2000). Smith, Flower and Larkin (2009) acknowledge that IPA focuses on the micro-details of social life and does not seek macro explanations of how the world works. Phenomenology as a methodology was subsequently rejected as this study was not about participants' lived experiences and did not address the research question.

Ethnography was only briefly considered. It has its origins in anthropology, and is used to study "social interaction, behaviours and perceptions that occur within groups, teams and communities" (Reeves, Kuper and Hodges, 2008, p.512). The aim of ethnography research is to document the culture, the perspectives and practices of the people in these settings (Hammersley, 1992). The purpose is for researchers to 'get inside' or to 'immerse' themselves in the way each group of people sees the world with van Maanen (1982) explaining that "the result of ethnographic inquiry is cultural description" (p. 103) with Merriam (2009) explaining that culture refers "to the beliefs, values, and attitudes that structure the behavioural patterns of a specific group of people" (p.27). This study was never about exploring the culture of pharmacists. Practical issues were also considered with ethnography, which is associated with observation methods such as difficulties in gaining approval to observe pharmacists in their place of work (e.g., hospital setting) (See *Section 4.9 Data collection methods*). The researcher, a practising pharmacist, cannot enter a 'culture sharing group' of pharmacists as a 'stranger'. This would have moved the study towards researching one's own 'back-yard' leading towards auto-ethnography, which sits outside the researcher's research paradigm (Creswell, 2007). This was never the intention of this study. The researcher chose not to undertake the study within her workplace for ethical reasons (See *Section 4.8 Research ethics and governance*).

Grounded theory focuses on social processes whereas ethnographers are interested in understanding cultures and traditions. Phenomenology focuses on participants' lived experiences and asks about how they interpret their experience.

In phenomenology social processes or culture may be part of those experiences, but are not the focus of interest whereas the meaning and experience is (Starks and Trinidad, 2007; Creswell, 2007).

The researcher's research paradigm was constructivism (See *Section 4.3.1 Research paradigm*). An alternative to the above methodologies is qualitative collective case study methodology mainly applied following the interpretations of case study research by Stake (1995, 2006), Merriam (2009) and Simons (2009). It is considered that these authors are based within the constructivist paradigm, which is about research that describes, understands and interprets and views reality as multiple realities that are context-bound (Hyett, Kenny and Dickson-Swift, 2014). This is congruent with the researcher's research paradigm. However, other case study research authors are also referred such as Yin (2009), being based within post-positivism, particularly where this helped to explore or develop an argument further (Hyett, Kenny and Dickson-Swift, 2014). Having identified the researcher's research paradigm as constructivism, led to formulation of the research question and a decision on using a qualitative collective case study research methodology integrating these components in a "consistent manner so that all parts interrelate" (Creswell, 2007, p.101). The next section will explain the rationale for this chosen methodological approach, which addresses how the researcher gathered knowledge in order to answer the research question (Appleton and King, 1997).

4.4 Collective case study design

Case study research continues to be applied extensively in a variety of academic disciplines, such as political sciences and nursing research (Simons, 2009). In this study a qualitative exploratory collective case study methodology within a constructivist inquiry provided an alternative to other qualitative research approaches by emphasising experienced pharmacists' perspectives.

Simons (2009) argues that most researchers, prior to undertaking research, would enter the field with pre-formed ideas, pre-understanding, prior information or intelligence and that their thinking would have been informed by general knowledge, engaging with the literature on the topics of interest, theories and concepts. Simons refer to this process as framing the case through 'foreshadowed issues' or problems offering the researcher "a guide as to what to explore"

(Simons, 2009, p.32). The research process is not constrained to these foreshadowed issues only but instead they help to establish some clarity at the outset of the research. There are intra-professional divisions within the pharmacy profession such as that between pharmacists working in the hospital and community pharmacy settings, the implication being that the nature of pharmacy practice varies according to the healthcare setting in which pharmacists practise (See *Section 3.3.1 Intra-professional divisions*). This intra-professional division within the pharmacy profession was foreshadowed by deciding to adopt a collective case study design.

Qualitative collective case study methodology allowed for exploring pharmacists' perceptions of the nature of pharmacy practice, which Abbott (1981) maintains is linked to their professional status in order to answer the research question. To take account of the foreshadowed issue of intra-professional divisions within the pharmacy profession this qualitative collective case study was designed to include four separate case studies with each case study representing a healthcare setting in which pharmacists undertake their professional work in delivering healthcare. These four case studies related to the following four healthcare settings: community pharmacy, acute hospital, mental health and community health services. The four individual case studies that constituted the collective case study were:

- The Case of Community Pharmacists (Case of CPs)
- The Case of Hospital Pharmacists (Case of HPs)
- The Case of Mental Health Pharmacists (Case of MHPs)
- The Case of Community Health Services Pharmacists (Case of CHPs)

Pharmacists working within community pharmacy were included because they were the largest pharmacy group. Community pharmacies are privately owned businesses providing some NHS services for which a community pharmacy is remunerated. The other three healthcare settings are all directly NHS-managed. All four healthcare settings provide NHS patient care (See Appendix 2).

Utilising collective case study methodology allowed for exploring the pharmacy profession as a whole, whilst also being able to identify the differences and similarities between pharmacists working within four different healthcare settings

representing the majority of registered practising pharmacists thereby taking account of potential differences in the nature of pharmacy practice and of intra-professional divisions (Abbott, 1988).

The research question that guided this collective case study is as follows:

How do pharmacists working in different healthcare settings perceive their status in society today? Each individual case study consisted of 5 pharmacists working within community pharmacy, acute hospital, mental health and community health services healthcare settings, respectively. The collective case study endeavoured to address the following aims:

- To identify the core function that defines the pharmacy profession.
- To explore pharmacists' views about how others' perceptions of them affects their pharmacy practice.
- To explore how pharmacists perceive they maintain or extend their pharmacy practice.
- To make comparisons between pharmacists' perceptions of their pharmacy practice in relation to the healthcare setting in which they work.

Table 1 summarises the collective case study design.

Case study:	Collective case study			
	<i>Case of CPs</i>	<i>Case of HPs</i>	<i>Case of MHPs</i>	<i>Case of CHPs</i>
Healthcare setting:	Community Pharmacy	Acute Hospital	Mental Health	Community Health Services
Number of pharmacists recruited:	5	5	5	5
Pharmacists recruited from: (South of England)	5 separate community pharmacies (retail)	2 acute hospital NHS trusts	2 mental health NHS trusts	2 community health services (NHS trusts)
Data collection:				
Primary data:	Semi-structured interviews	Semi-structured interviews	Semi-structured interviews	Semi-structured interviews
5 – day diary (contributions/frustrations):	5 – day diary	5 – day diary	5 – day diary	5 – day diary

Table 1. Summary of the collective case study including the four separate case studies

This thesis covered the qualitative collective case study exploring the pharmacy profession as a whole.

4.5 Rationale for using collective case study methodology

The collective case study was considered to be the 'collective case' of the pharmacy profession with the focus being on the nature of pharmacy practice linked to pharmacists' professional status (Abbott, 1988). The four individual case studies that formed part of this collective case study were selected based on the healthcare settings in which pharmacists undertake their professional work. This allowed exploration of the differences and similarities of the nature of pharmacy practice between pharmacists working in these four different healthcare settings.

There are a range of definitions of case study research which are understood in multiple ways and its application remains ambiguous in the literature (Zucker, 2001; Anthony and Jack, 2009). It can be argued that what they all have in common is a focus on an in-depth exploration of a case within a bounded real-life context, viewing life in its complexities where it is not possible to identify all the different variables and where the boundaries between the case and the context are unclear along with the use of one or preferably more methods for data collection (Stake, 1995; Yin, 2009; Merriam, 2009; Simons, 2009; Thomas, 2011). Simon's broad definition of case study seems to encapsulate what the study was trying to achieve:

"I shall refer to case study research more broadly - that process of conducting systematic, critical inquiry into a phenomenon of choice and generating understanding to contribute to cumulative public knowledge of the topic". (Simons, 2009, p.18)

Case study research has a wide research application making it flexible in that it incorporates different paradigmatic positions, study designs and methods (Luck, Jackson and Usher, 2006; Hyett, Kenny and Dickson-Swift, 2014). It does not stipulate specific data collection or analysis methods. It is possible to utilise multiple methods selected according to the case and the research question (Luck, Jackson and Usher, 2006; Creswell, 2007). These methods can span a wide continuum from holistic inductive qualitative methods at one end to reductionist quantitative methods at the other. The implication is that for case study research the methods selected depend on the researcher's paradigmatic position with Luck, Jackson and Usher (2006) and Hyett, Kenny and Dickson-Swift (2014) maintaining

that it is this aspect that maintains the “creativity and flexibility that is valued in this methodology” (Hyett, Kenny and Dickson-Swift, 2014, p.9). Several authors such as Stake (1995), Merriam (2009) and Simons (2009) emphasise the qualitative research approach of case study research as this provides an in-depth exploration and understanding of a specific research topic. Collective case studies are often about people, policies and histories describing multiple perspectives supporting the pluralism and multiple realities found in constructivism (Simons, 2009). The researcher considered that utilising a qualitative collective case study research methodology was aligned with her paradigmatic position as a constructivist being placed close to the post-positivist paradigm.

Miles and Huberman (1994) define the case as “a phenomenon of some sort occurring in a bounded context” (p. 25). It is important to define the case to decide what makes up this “bounded system” (Simons, p. 29). This bounded system forms the boundaries that are placed around the case which supports the direction and extent to which the research will go (Creswell, 2007). Crowe et al (2011) point out that these pre-defined boundaries indicate what will and will not be studied to avoid the case study research becoming too large and unwieldy. Miles and Huberman (1994) represent a case graphically with a circle (being the case) with a heart inside the circle, which is the focus of the case study. See Figure 4. The illustration demonstrates that within a case only part of it will be studied (the heart). The case has a broken line to denote that the boundaries between what is within and outside the case are not solid but a porous one.

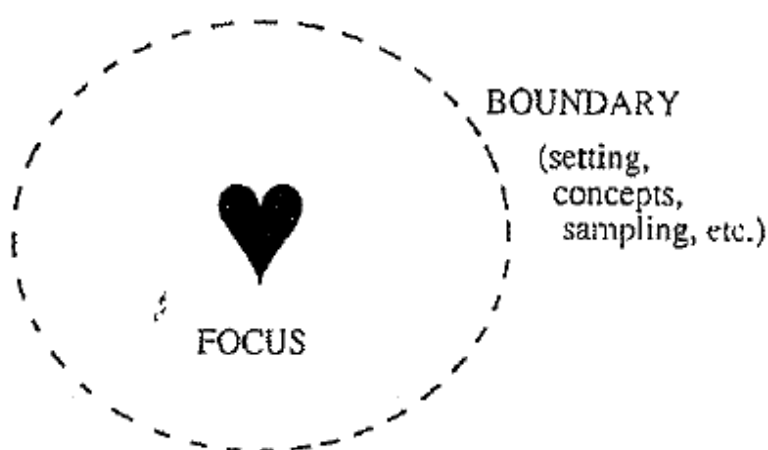


Figure 4. Case study boundaries (Based on Miles and Huberman, 1994, p. 25.).

For each case study the focus was the nature of pharmacy practice ('the heart'), which was located within imprecise case boundaries (Miles and Huberman, 1994). For each case study, pharmacists working in a particular healthcare setting were chosen as the case with the healthcare setting providing the context in which to interpret the nature of their practice as perceived by them (e.g., the case of community pharmacists (Case of CPs) or the case of hospital pharmacists (Case of HPs)). The aim was not to conduct a detailed study of the healthcare setting in which pharmacists worked but rather the nature of pharmacy practice (the focus or 'heart') in a particular healthcare setting.

Miles and Huberman (1994), Stake (1995), Merriam, (2009), Simons (2009) and Yin (2009) argue that the boundary of a case is one of the defining factors of case study methodology. It is important to state the boundaries of each case as this tells the reader what the case is about and it also helps when comparing different cases (Stake, 2006). In this collective case study, each of the four individual case studies had similar boundaries with the exception of the healthcare setting, and were all constructed to form part of this collective case study as opposed to being identified from, for example previous case studies published in the literature.

There were other factors than the healthcare setting and pharmacists, which determined what constituted the boundaries of each case. Miles and Huberman (1994) and Hyett, Kenny and Dickson-Swift (2014) explain that describing physical or institutional boundaries are not sufficient and that conceptual factors also form part of establishing the case boundaries. The consensus from the literature is that a case is relatively bounded which can be theoretical, empirical or both (Ragin, 1992a). As a minimum a case is specifically bounded to time and space (Creswell, 2007), by definition and context (Miles and Huberman, 1994), conceptual factors (Hyett, Kenny and Dickson-Swift, 2014) and time and activity (Stake, 1995). It is what is happening within the boundaries that is considered vital and determines what the case study is about.

Each individual case study was conceptually based through the understanding gained from the historical development of the pharmacy profession, the socio-political context of the pharmacy profession and through engagement with the literature, the research question, study entry criteria, healthcare setting, the sampling method and the nature of the data collection. Each case study was also

defined geographically being located in England, in particular the South of England, and the time period bounded by when the data collection was undertaken.

Merriam (2009) and Yin (2009) explain that the 'case' can be an individual, a group, an organisation, a community, a process, a project, an activity, an event or policy and that the case is not the same as the topic or focus under investigation. In contrast Ragin (1992b) argues that although it is important to define a case this concept is not well defined in the literature. Yin (2009) and Merriam (2009) explain that if the case is a small group then it must be possible to differentiate between those who are in this group and those who are outside. It can be argued that in this collective case study it was not possible to distinguish between pharmacists who were in the case and outside it. Each case study was not a naturally bounded system in the sense that Yin (2009) and Merriam (2009) explained this as each case study was not a natural group (i.e., it was not intrinsically bound) as there is no end to the number of pharmacists who could be part of a case. Nor did this study include an intrinsically bounded programme or process (Merriam, 2009; Yin, 2009; Simons, 2009).

This collective case study research was about exploring the nature of pharmacy practice linking this to pharmacists' status in today's society through gaining the individual pharmacist's views related to the professional work that they do, against the context of the healthcare setting in which they worked. It was not about exploring interactions or relationships between pharmacists within each case study. This study did not require each case of pharmacists to be intrinsically bounded. This was never the intention nor was it ever included in the initial design of the study.

Instead each case study in this collective case study was constructed. It was not a natural group except that pharmacists all belonged to the pharmacy profession, had similar university degrees, were registered with the same regulatory body and worked in the same healthcare setting. It is unclear why it is imperative that a case is intrinsically bound for it to be considered a case study, as within this natural boundedness there will always be some areas that will and will not be studied as shown by Miles and Huberman (1994). Verschuren (2003) concurs with this view in that "there is no methodological reason why clarity of boundaries is a criterion either for choosing or not choosing the case study as a research strategy" (p.124),

pointing out that researchers may say they are looking at a case study as a whole whereas the reality is that they are always only looking at part of a case (Miles and Huberman, 1994). Stake (2000) explains that a case can be “whatever bounded system is of interest” by “giving prominence to what is and what is not in the case” (p.23).

In the literature there are different terms used for undertaking research involving more than one case such as comparative case studies, collective case studies or multiple-case studies (Baxter and Jack, 2008; Merriam, 2009). The researcher refers to this study as a collective case study to denote that collectively all the cases are bounded together as they included pharmacists who all are part of the same profession, delivering healthcare to patients.

Stake (2005) refers to collective case study which includes more than one case "in order to investigate a phenomenon, population, or general condition" (p. 437) with the aim of helping to improve understanding. A collective case study is a grouping of case studies. In this collective case study, each single case was of interest because it formed part of a “particular collection of cases” (Stake, 2006, p.5) with the four cases in this collection being “categorically bound together” (Stake, 2006, p.5).

Stake (2006) explains that a potential problem is when each case within a collective case study has its own separate research question or when the researcher pays too little attention to what binds the individual cases together. In this collective case study, each individual case had similar research questions, study entry criteria, study design, data collection and analysis methods and the participants formed part of the same profession all which served to bind the four cases together into a collective case study.

A criticism of this collective case study design could be that each case study could be viewed as an experiment where there are many variables that cannot be quantified or identified but where broadly speaking the only difference is the healthcare setting, which could appear to assimilate a replication approach to multi-case studies as described by Yin (2009). This is not how the researcher viewed this as there are many identifiable and unidentifiable variables relating to the professional work that pharmacists do other than the healthcare setting in which they work and there was no intention to replicate the case studies in order to

“(a) predict similar results (a literal replication), or (b) predict contrasting results but for anticipatable reasons (a theoretical replication)” (Yin, 2009, p.54) as suggested by Yin (2009).

In contrast, the purpose of this collective case study was to broaden the understanding and insight of how pharmacists perceived the nature of pharmacy practice linking this to their professional status including focusing on similarities and differences. The aim of this collective case study was not to replicate findings or strengthen a particular theory. The study therefore did not lend itself to the multiple-case study approach as described by Yin (2009).

Stake (2003) warns that comparison of cases is a “a grand epistemological strategy, a powerful conceptual mechanism” (p.148), which focuses the attention on the main attributes that are being compared across cases with the consequence that other knowledge gained from the individual cases is obscured if it fails to facilitate comparison. It can be argued that in a collective case study the focus moves away from the individual case, which becomes less important, instead placing the emphasis on the comparison. Whereas Khan and VanWynsberghe (2008) argue that it is also a way of mobilising knowledge through the process of reasoning about the similarities and differences between cases, revealing new information. As mentioned previously, in this thesis it is the collective case study that is of interest.

Another criticism is that each case study within a collective case study may not include as many participants or data as it would have if the study had been a single case study implying that some depth can be lost from each case within a collective case study (Hammersley, Gomm and Foster, 2000; Stake, 2003; Thomas, 2011). Creswell (2007) suggests that no more than four cases should be examined as part of a collective case study arguing that researchers who include more cases may do so to increase the generalisation, which “holds little meaning for the qualitative researcher” (p.76).

This collective case study was strengthened by containing four case studies, which built on the uniqueness of each individual case, with a need to examine similarities and differences across case studies. This resulted in a better understanding and insight of pharmacists’ perceptions of the nature of pharmacy practice that occur across the cases studied.

4.6 Limitations of case study research

The literature on case study research demonstrates that the terms 'methodology' and 'method' are used interchangeably adding to the ambiguities and confusion (Anthony and Jack, 2009; Hyett, Kenny and Dickson-Swift, 2014).

Case study research has been confused with case reports or case studies, which are used for example to present medical or business cases for illustrative or educational purposes. Sandelowski (2011) argues that case study research is not a methodology as the boundaries are blurred between case study reports and case study research whereas Merriam (2009) and Hyett, Kenny and Dickson-Swift (2014) dismiss this argument pointing out that case reports do not meet the criteria for research as they lack methodological grounding.

Tight (2010) argues that what has been written on case study research is an examination of the typology resulting in no more than a guide to undertaking basic social research explaining case study research is used "when we can't think of anything 'better'" (p.337) by trying to give the research some respectability but that in reality case study is no more than a "small-sample, in-depth study" (p.338). Creswell (2007) and Merriam (2009) place case study research alongside other qualitative research methodologies. Merriam (2009) points out that qualitative case study research is a methodology as it searches for meaning and understanding, utilising the researcher as the primary instrument for the data collection and analyses and that it is "an inductive investigation" (p39).

Yin (2009), Stake (1995) and Merriam (2009), who have been cited, are considered to be situated within different paradigms by Hyett, Kenny and Dickson-Swift (2014). Referencing these different authors could be viewed as not following a clear paradigmatic and methodological approach. The researcher makes the counter argument that citing these authors adds to the discussion of different aspects of case study research and helps to justify the approach taken in this collective case study.

In the literature the main criticism of case study research seems to be that it is not possible to generalise the outcomes, which may be something that could be considered to be the motivation for undertaking a collective case study. For most qualitative researchers generalisation is not the aim of the research (Creswell,

2007; Merriam, 2009). Stake (1995) explains that the aim of case study is “particularization not generalization” (p.8), Yin (2009) points out in case study research that generalisation is made to theory and not to populations based on statistical analysis and Flyvbjerg (2006) argues that formal generalisation is overvalued. Just because knowledge from this case study research cannot be generalised does not mean that the knowledge generated cannot form part of knowledge accumulation about the pharmacy profession and sociology of the professions. Stake (1995) explains that undertaking case study research is “both the process of learning about the case and the product of our learning” (p. 237) with Lincoln and Guba (1985) stating that the meaning from case study research comes from the ‘lessons learned’. The researcher considers that it is important that the “findings may be transferable to other contexts or used by others” (Simons, 2009, p. 164) as opposed to making generalisations.

4.7 Participants

The majority of research published on the pharmacy profession includes pharmacy students or community pharmacists. In this study only experienced practising pharmacists were included based on the assumption that they had developed a mature understanding of their professional work and the nature of pharmacy practice in relation to the healthcare setting in which they worked.

The word ‘participant’ or ‘pharmacist’ was used, instead of for example ‘study subjects’, to denote that the researcher engaged with the participants and as a way of acknowledging that it was their “experience – their ‘realities’” (Simons, 2009, p36) that were documented.

4.7.1 The research sample

There is no clear guide for determining the sample size in qualitative research. The sample size of five participants for each of the four cases, thus a total of 20 participants, was based on what was thought to be a big enough sample to provide enough breadth and small enough so not to lose much depth.

The sampling method for selecting participants was purposive. This was a deliberate non-random method of sampling as the purpose was to understand and gain insight into each case (Bowling, 2002). The sampling strategy did not aim to identify a statistical presentation of the participants to be included (Pope, Ziebland

and Mays, 2000; Barbour, 2001). By including four case studies, each representing pharmacists working within a particular healthcare setting, provided what Patton (2002) refers to as “information-rich” (p.230) cases.

Participants were selected from the South of England.

Two NHS organisations were selected for each of the healthcare settings: acute hospital, mental health and community health services. This was a risk-reducing strategy in case the researcher was unable to recruit participants from one trust and to aid the anonymity of participants within one case study by not all being from the same trust. One mental health trust was approached but declined to be involved stating that this study did not align with their research strategy.

Community pharmacists were not selected according to the type of community pharmacy they worked for (e.g., small independent or large multiple pharmacies) as this was not considered essential for this study.

4.7.2 Entry criteria

Participants were experienced pharmacists and all fulfilled the entry criteria by:

- i. Working in community pharmacy, acute hospital, mental health or community services healthcare settings.
- ii. Having been registered with the General Pharmaceutical Council (previously the Royal Pharmaceutical Society of Great Britain) for a minimum of 5 years.
- iii. Having a minimum of 2 years' current experience of working within a community pharmacy or acute hospital, mental health or community health services healthcare setting.
- iv. Spending the majority of their working week* within community pharmacy, acute hospital, mental health or community services healthcare settings. *(Pharmacists who worked for different employers had to spend the majority of their week within the pharmacist case they represented. Pharmacists working part-time were included).

The limiting time frames of 5 years and 2 years, respectively, were decided upon to ensure pharmacists had adequate experience as a pharmacist and of their

healthcare setting. The purposeful sampling allowed for samples across the various sectors or the healthcare settings of pharmacy.

This study excluded pharmacists working within other settings for example academia, the pharmaceutical industry and primary care trusts (PCTs). (Primary care trusts (PCTs) were abolished on 1 April 2013 when changes took place within the NHS in England; PCTs were replaced with new types of organisations called Clinical Commissioning Groups (CCGs) and NHS England). This exclusion was because pharmacists within these areas are generally not directly involved in delivering healthcare.

4.7.3 Recruitment of participants

The recruitment and interview of participants took place from May 2012 to the end of November 2012 after the relevant local research governance approvals had been received.

For the Case HPs, Case MHPs and Case CHSPs the chief pharmacist from each NHS trust was emailed a brief summary of the study together with the study information sheet and consent form. Pharmacists contacted the researcher by email or telephone if they wished to discuss the study further or to participate. Participants were asked to book a meeting room locally to allow for privacy during the interview. Participants were interviewed at their place of work except one who chose to be interviewed at the researcher's place of work. The interviews took place in work-time.

In the Case of CPs, the University of Brighton's tutor group of community pharmacists, providing practice placements to pharmacy students, were sent a letter from the university to their work address. This letter outlined the study with information to contact the researcher for further information. The letter also informed them that the researcher might contact them to check if they had received the letter. A total of 25 letters were sent out. Four participants were interviewed at their place of work and one at the University of Brighton.

Twenty participants were recruited and interviewed: five participants from five different community pharmacies, five participants from two different acute hospital trusts, five participants from two different mental health trusts and five participants from two different community health services organisations (three pharmacists

where the community health services had integrated with an acute hospital trust and two pharmacists from a separate community NHS Trust).

4.8 Research ethics and governance

This study involved one-to-one in-depth semi-structured interviews with 20 participants. Allmark et al (2009) and Kvale and Brinkmann (2009) point out that interviews can give rise to ethical issues and concerns, which the researcher should aim to address prior to and during the study process.

All participants were provided with the study information sheet (Appendix 3) and signed the consent form (Appendix 4) prior to any data collection. Participants had the opportunity to ask further questions prior to and after the interviews. Participants were asked to agree for the interviews to be voice recorded. They were made aware that they could withdraw consent at any time, also without giving a reason why.

The interviews followed a formal structure (Appendix 5). This was to ensure there were clear boundaries set at the beginning of the interview emphasising that these were professional research interviews and not a friendly chat or conversation. As participants were registered healthcare professionals they were reminded that confidentiality would be breached if they exposed any professional misconduct based on the GPhC's *Standards of conduct, ethics and performance* (GPhC, 2012) or issues of a criminal nature. None were disclosed. Participants were provided with university contact names in case they had any complaints about the researcher's conduct. No complaints were received.

Prior to the commencement of the study the researcher needed to determine whether or not to include pharmacists working within the researcher's employing healthcare organisation. Hanson (1994) and Brannick and Coghlan (2007) presented an argument in support of researchers undertaking research within their employing organisations due to perceived benefits such as the researcher already having an insight and relevant contacts. They suggest the reason researchers chose not to undertake research within their own organisation was due to concerns of being unable to maintain distance and objectivity, which could impact on the validity of the study. They argue that this view belongs within a positivism paradigm claiming that researchers can address validity through a process of

reflexivity. Whilst it is acknowledged that a researcher's paradigm may influence their decision on undertaking research within their employing organisation or not the authors failed to address ethical issues that could occur in situations where the researcher has close working relationships with potential participants, which may not be addressed by researcher reflexivity alone. In this situation it was felt undertaking research in the researcher's employing organisation would be incompatible with her role as an employee. The researcher's view is that the decision to undertake research within a researcher's employing organisation should be risk-assessed on an individual study basis.

The researcher decided to exclude pharmacists from her employing organisation including pharmacists delivering services under contract to the researcher's employing organisation. The reason was that these pharmacists were in a dependent working relationship with the researcher. This avoided participants feeling obliged to participate because of their relationship with the researcher and the potential for the role as researcher and work colleague becoming blurred, placing both the researcher and participants potentially in an untenable position.

Allmark et al (2009) suggest when using one-to-one in-depth interviews, that it may not be possible to determine the effect this may have on participants, therefore making it impossible to provide participants with all the information about the study at the outset. This is because the aim of using open-ended questions is to access information that participants may not disclose in any other way by for example using surveys. The semi-structured interview guide for this study (Appendix 6) was a balance of being detailed enough for the Ethics Committee to assess the types of questions participants were asked and flexible enough to afford participants the opportunity to elaborate on their perceptions.

Most research assumes that the researcher and participants are anonymous to each other and unlikely to meet again. This may not be the case when the participants are fellow professionals (Coar and Sim, 2006). Participants and the researcher needed to consider future professional relationships, which could affect the interviews.

Allmark et al (2009) mention that there may be power asymmetry between participants and the researcher with the latter influencing the direction of the interview deciding what questions to ask and in the data analysis deciding the

quotes used and how these are interpreted. It can be argued that the interviewer's role should be neutral during the data collection. The researcher cannot be neutral by the fact that she is also a practising pharmacist, having to balance dual roles as a researcher and a pharmacy colleague. The participants decided what information they were prepared to divulge during the interviews. A couple of participants during the interviews were explicit in stating that they had disclosed what they felt the researcher should know. Implicit in this was that there was information they did not wish to share.

Prior to data collection the researcher expected that experienced pharmacists were prepared to discuss their professional work. The researcher was concerned that the interviews would mainly include professional rhetoric providing limited insight. Hewitt (2007) and Kvale and Brinkmann (2009) assert that the qualitative researcher should be sensitive to similarities between research interviews and therapeutic interviews. It was anticipated that the interviews would not cause distress or be misconstrued as therapeutic interviews as participants were aware that they were participating in a research study by a pharmacist. During the interviews two participants became visibly distressed. Both declined to terminate the interview. The reasons for this were multi-factorial but both implied that the interview made them reflect on their work and the frustrations they encountered on a daily basis. This was not something they had previously reflected on. This changed the direction of these interviews as the researcher tried to reiterate positive aspects of their professional work although she did not fully succeed in turning the interviews around. This was discussed with the academic supervisors.

During one interview a participant mentioned that directors in the healthcare organisation did not act when pharmacists raised concerns over risks associated with medicines. It had not been anticipated that this kind of disclosure would be made. The researcher had to consider this carefully as the interview was confidential. The researcher reflected that this participant reported to a more senior pharmacist and appeared to be aware of the process within the healthcare organisation for raising concerns. This was also discussed with the academic supervisors.

Hewitt (2007) states that participants in qualitative studies are vulnerable to being identified. Prior to the study consideration was given to preserve anonymity and

confidentiality. This included not divulging the gender of the participants so that any males within a female-dominated profession could not be identified, hence pseudonym names were not assigned but instead pharmacists were identified using the codes e.g., CP1 (community pharmacist 1) or HP1, MHP 1 or CHSP1. Participants were informed that verbatim quotes or information from their diaries would be included in the thesis or publications.

Even after the interview transcripts in this study were anonymised they still contained hints and clues as to the identity of the participant, which could allow individual pharmacists or others to identify who they were. Identification also becomes more likely when using small sample sizes and when participants are all from the same region (Ford and Reutter, 1990). To reduce the likelihood of this happening demographic or similar information such as participants' actual job titles were not included nor were they reported in such a way that they could be linked to the individual participant. Instead these data were presented collectively. There were no full interview transcripts or diaries attached to this thesis. *Section 4.10.3 Moving from data to theme*, provides an example of the data analysis which includes copies of sections from the interview transcripts. Diary raw data were all hand written and are not shown to preserve anonymity of the individual participants (See *Section 4.9.4 Diary*).

Prior to the study it was decided that the interviews would take place at the participant's place of work as this permitted the researcher to enter their workplace as a guest. It also caused the least impact on participants' time. Alternative sites were the University of Brighton or at the researcher's place of work. Eighteen interviews took place at participants' places of work, one at the University of Brighton and one at the researcher's place of work.

The research protocol was approved by the University of Brighton's Faculty Research Ethics and Governance (FREGC) (Appendix 8). It did not require NHS Research Ethics Committee (REC) approval as it involved professional staff being interviewed about their professional work. Research governance approval was obtained on behalf of the researcher's employing NHS Trust. Local research governance approvals and 'NHS to NHS Letters of Access were obtained from six NHS trusts from which participants were recruited. These approvals were not included in this thesis to preserve the anonymity of participants.

The micro-disc containing the digital voice recordings, the digital recorder, written diaries, interview transcripts, signed consent forms, FREGC approval, research governance approval letters, NHS to NHS letters of access, the approved research protocol including the signed study participant information sheets and thesis, will be archived for 10 years by the researcher’s employing NHS Trust’s Research and Development Department after completion of this study. The raw data and documents as listed above can be accessed via the Research and Development Manager from the researcher’s employing NHS trust.

4.9 Data collection methods

As this was an exploratory case study it was important not to restrict the study to a few characteristics, but to gather as much information about pharmacists’ professional work from their perspective. This was achieved by the main data collection method for this study being a one-to-one and face-to-face semi-structured interview and the data analysis using inductive thematic analysis (Braun and Clarke, 2006). A semi-structured interview focuses the direction of the interview on the research topic. It was insightful and provided participants with the opportunity to express their views and perceptions about the nature of their practice. The data obtained during the interviews were based on retrospective descriptions, recollections and perceptions. Following the interview, participants were asked to complete a Five (5) Working Day Reflective Diary (Appendix 7) in real-time related to their professional work regarding contributions and frustrations experienced during their working day. Table 2 below summarises the number of pharmacists recruited and the data collected for this study.

	<i>Collective case study</i>			
Case study:	<i>Case of CPs</i>	<i>Case of HPs</i>	<i>Case of MHPs</i>	<i>Case of CHSPs</i>
Healthcare setting:	Community Pharmacy	Acute Hospital	Mental Health	Community Health Service
Number of pharmacists recruited:	5	5	5	5
Number of semi-structured interviews completed:	5	5	5	5
Number of completed diaries returned:	4	4	4	3

Table 2. Summary of data collection.

Hyett, Kenny and Dickson-Swift (2014) criticise some published case study research arguing that they could have been improved by including several different types of data. This criticism stems from Yin (2009) and Stake (1995) advocating data collection from multiple sources to add different perspectives to the case research study. Yin (2009) refers to this as the “data needing to converge in a triangulating fashion” (p18). This can lead to the temptation to collect a large volume of data. Too much data can adversely impact the depth of the data analysis (Crowe et al, 2011). This can be managed by deciding from the outset what data to collect in line with the research question. In this study the data collection for the four case studies was limited to one face-to-face interview and participants being asked to complete a five-day diary.

Other data collection methods were also considered. Formal observational data is often associated with case study research (Simons, 2009; Merriam, 2009). There are different observational data collection methods (Thomas, 2011). Engaging in observations would have provided a good picture of how participants behave and act in their work place but would not reveal the motives for their behaviour (Simon, 2009). Decisions about what should guide the observations would have had to be made, including what aspects of participants’ work would be observed, which would have been contrary to this study where the focus was to explore the nature of pharmacy practice and not to limit this from the outset to pre-defined tasks. Participants may not have wished to commit to having another pharmacist observing them. They may have found this inconvenient and intimidating. Additional barriers would have been needed to be negotiated such as gaining the relevant permission for this type of observational data collection method within NHS trusts where pharmacists interact with patients, medical staff and other colleagues. This method would not take account of pharmacists’ perceptions. Informal observations and impressions were made during the study in the form of notes when attending pharmacists’ workplaces to undertake the interviews including noting participants’ body-language if that seemed to matter at the time. These notes helped when undertaking the data analysis (Simons, 2009).

According to Kitzinger (1995) a focus group is particularly useful for exploring the participants’ knowledge and experiences. One of the practicalities would be to arrange a focus group and for pharmacists to attend this group, which would involve them having to travel. The researcher considered that individual interviews

would allow the individual participant the opportunity to express their own views under confidential conditions.

Early on in the research process the researcher considered a qualitative questionnaire-based survey. This would have been useful for obtaining data of a general nature allowing for gaining broad information of pharmacists' opinions. It would have left little room for the finer details or to explore a particular issue further. In addition there was limited information available within the literature to base and develop a questionnaire on.

4.9.1 Semi-structured interview guide

The primary data was a semi-structured interview with each participant. A semi-structured interview guide was used, which is suggestive rather than prescriptive allowing the participant and researcher to engage in a dialogue.

A semi-structured interview was selected as the primary method for data collection. It was felt this method would be of most use for this study because it had the potential to elicit rich-thick descriptions. It also provided the researcher with the opportunity to clarify statements, assumptions and probe for additional information. One of the benefits of collecting data through individual, in-depth interviews was that it captured the participant's perspective of the nature of their practice.

Kvale (1996) describes the qualitative research interview as an "attempt to understand the world from the subject's point of view, to unfold the meaning of people's experiences, to uncover their lived world" (p1). Patton (1990) maintains that, "qualitative interviewing begins with the assumption that the perspective of others is meaningful, knowable, and able to be made explicit" (p.278).

The aim was to encourage participants to talk about the topic with as little prompting as possible. Kvale and Brinkmann (2009) point out that a semi-structured interview is a professional interview with the purpose of answering the research questions. The format is relatively unstructured, and the emphasis is on listening to what the participants have to say as opposed to guiding and controlling the conversation.

The interview guide listed the topics or questions covered during the interview (Appendix 6). Other questions were also asked when a particular issue was raised by a participant.

The interview started off with basic questions to obtain background information about the participant. The following areas were identified and covered based on the initial engagement with the literature early on in the study. Interview prompts related to professional development and career prospects were added on the request of the first study participant interviewed (See *Section 4.9.2 The interview*):

- i. Contributions made to healthcare.
- ii. Aspects of their professional work, which the participant enjoyed.
- iii. Frustrations, challenges or negative aspects related to their professional work.
- iv. Relationships and interaction with others.
- v. Considerations of how others viewed them.
- vi. What it meant to participants to be considered a professional.
- vii. The participant's thoughts with regard to the statement 'being a pharmacist is a valuable profession'.
- viii. The future.
- ix. Possibilities of moving between different healthcare sectors.
- x. Professional development and career prospects.

The limitations of the interviews were that not all participants were equally cooperative, articulate and perceptive during the study interviews.

Study interviews are not natural tools of data gathering. They are the result of interaction between the researcher and participant and the context in which the interview takes place at that time.

4.9.2 The interview

Participants received the study information sheet and consent form in excess of 24 hours before the interview (Appendices 3 and 4). Participants signed the consent form prior to the interview. The interview session followed an interview schedule (Appendix 5).

The interview concluded with inviting the participant to add anything or if they had any concerns during the interview (Kvale & Brinkmann, 2009).

After the interview each participant was emailed thanking them for their time and to remind them to complete the Five (5) Working Day Reflective Diary (Appendix 7). In most cases one further email was sent reminding the participant to complete the diary. After each interview the researcher would write some brief notes about her initial impressions of the venue and interview in the Researcher Journal.

Nineteen (19) of the interviews were voice recorded on a digital recorder. One participant asked for this not to be recorded. Instead notes were taken. These were emailed to the participant as requested.

The interviews took place during the participant's working day and the time available for this was limited. The researcher had to be mindful of the time whilst trying to cover the main points in the interview guide, which could have adversely affected emerging insights taking place during the interviews.

Almost half of the interviews were disrupted. In the case of CPs, one participant was interrupted repeatedly with queries from the pharmacy dispensary. In the case of HPs, case of MHPs and case of CHSPs, a total of 8 interviews were interrupted by others trying to access the meeting room, participants having to respond to their bleep or work mobile phone, being told to terminate the interview due to the participant having to attend an unscheduled urgent meeting and a pharmacist entering the room during an interview to ask the participant to cover the pharmacy dispensary during lunch. These interruptions were frustrating and stopped the flow. It also signalled that these research interviews were not considered important or generally there was a lack of respect for the fact that the participants were attending a meeting which should not be interrupted or that the participants did not have the time in their working day to fit in a study interview, but tried to do that anyway.

There were a total of 17.5 hours of interview data with the average (range) time for each interview being 53 minutes (36 – 67 minutes) (Appendix 9).

4.9.3 Transcribing

The researcher transcribed all the voice-recordings from the interviews. This aided the process of becoming familiar or being immersed in the data (King, 2004). This also allowed the researcher to reflect on interview style, to improve and learn from this (Kvale and Brinkmann, 2009).

The transcription process was an interpretive process with the researcher having to make decisions such as what to transcribe and how to present the voice recordings in the transcripts (Davidson, 2009).

The interviews included features of speech and interactions that were impossible to capture on a voice recorder. The voice recording was a reduction of this actual interaction. The voice recording was further reduced when being transcribed into a written format as Kvale and Brinkmann (2009) explained:

“A transcript is a translation from one narrative mode – oral discourse – into another narrative mode – written discourse”. (p.178)

This meant the researcher followed the rules of communication drawn from the written discourse when transcribing the interviews from voice recordings.

The aim of the transcript was not to undertake a conversation or discourse analysis (Kvale and Brinkmann, 2009). The researcher decided not to code the transcripts with the tone of voice, laughter, sighs, overlapping speech or hesitations. Pauses were not timed but indicated with “...” this helped when reading the transcripts as a participant could start a sentence, then pause and then restart the sentence or another sentence. Full stops were added where it appeared to make sense by continuously listening to the voice recording and avoiding placing a full stop where this would have changed the meaning of the sentence. Participants’ anonymities were maintained by changing names and locations if these were mentioned during the interviews.

This reduction or selectivity of the data that took place during transcribing was a necessity as it would have been impossible to include all interactions from the recordings into the transcripts. The transcripts were a balance of not including irrelevant information while still ensuring they served the purpose of the study (Lapadat and Lindsay, 1999).

Transcribing required concentrated listening to the voice recordings often going over the same recording several times to capture what was said. It was a time-consuming process. Due to practical reasons, the majority of the transcribing of the interviews took place after the completion of all the interviews.

4.9.4 Diary

All 20 study participants were supplied with a paper Five (5) Working Day Reflective Diary (Appendix 7) immediately after each semi-structured interview. The reason for using paper diaries was to allow participants to record their reflections related to their feelings and experiences when events happened or shortly after at a time convenient to them (Bowling, 2002; Snowden, 2015). Richardson (1994) suggests diaries have the potential for participants to report events that are important to them when diaries are relatively unstructured. Each paper diary consisted of 'one working day per one A4 page' with additional blank pages allowing participants to record further information. For each working day participants were encouraged to record positive contributions and frustrations in relation to their pharmacy practice. It was left to the individual participant to determine what they considered to be positive contributions or frustrations including how they wished to record these. They were reminded not to state any patients' names or to identify others by name.

Participants were also asked to comment on the exercise of completing the diary. It was anticipated that these diaries would provide different and additional perspectives to the semi-structured interview data (Bowling, 2002). Recognising the commitment required for busy professionals the data collection was limited to 5 working days, which could be spread over 3 weeks in order to place a time-limit on collecting this data.

The diary was anonymous and only identified the healthcare setting the participant worked in. Participants were provided with a self-addressed pre-paid envelope to post to the researcher after completion. It was anticipated that the study participants might find it difficult to keep a diary alongside a busy working day. In total 15 completed hand-written diaries were returned.

Examples of positive contributions were: clinical pharmacy interventions made (e.g., related to drug-drug interactions), advice given to a patient, providing information to a newly qualified nurse prescriber on internal governance arrangements and providing training. Examples of frustrations were: computer system not functioning, problems with obtaining medicines supply, not having sufficient time during the working day, having a business case rejected and hospital pharmacists being asked to work in the dispensary.

The data recorded in the diaries had already been raised by participants during the semi-structured interviews. The diary data did not provide any further insight or different perspectives than had not already been obtained from the semi-structured interviews. In comparison to the interview data the diary data was less insightful. This is contrary to other studies where it has been reported that diary data provided “insightful in-depth qualitative data” (Thomas, 2015, p.25).

The reason for this could be that participants in this study were asked to complete the diary after the completion of the semi-structured interview, which may explain why similar issues were included.

Four participants (two MHPs and two CHSPs) out of fifteen commented on how they felt about completing this diary. These comments were mixed. One participant felt that writing down frustrations just reinforced these, whereas another felt writing about both positive contributions and frustrations helped to place these in context thereby being able to focus on positive aspects of their pharmacy practice. The two other participants took the opportunity to reiterate a particular point they had already made during the semi-structured interview.

4.10 Data analysis method

As this is a collective case study, it is only the findings from the collective case study that are presented rather than each of the individual case studies in order to answer the research question.

The researcher felt that this was justified both in terms of the nature, purpose of this study and the research questions and in relation to the importance of

maintaining participant anonymity and confidentiality (McDonnell, Jones and Read, 2000; Morse and Coulehan, 2015).

The challenge throughout the data collection and analysis was to make sense of a large amount of data, reduce the volume of data by de-constructing these and to identify common patterns and differences. Merriam (2009) cautions researchers to make the data collection and analysis a simultaneous activity to avoid the risk of repetitious, unfocused and overwhelming data. Unfortunately, due to time constraints this was not possible.

The interview transcripts and diary data do not in themselves provide an explanation. It is the researcher who interprets these data (Pope, Ziebland and Mays, 2000). In collective case studies there are two stages of the analysis: the within-case analysis and the cross-case analysis (Miles and Huberman, 1994; Merriam, 2009).

The researcher considered utilising a data management software tool to manage the data and data analysis and attended a two-day Nvivo course, but decided not to use it. The most difficult part of the data analysis was to identify codes and themes, which the software did not provide. Pen, paper and normal word-processing was used to manage the data, together with thematic maps, which helped to conceptualise the themes.

4.10.1 With-in case analysis

The data for each individual case study was analysed before undertaking the cross-case analysis (Stake, 1995; Crowe et al, 2011).

The transcripts and diary data were analysed by thematic analysis using inductive coding, both descriptive and interpretative (Braun and Clarke, 2006; Miles and Huberman, 1994; Merriam, 2009). The inductive thematic analysis was cyclical and iterative with having to continually return to the data. It was not a linear process. Thematic analysis as described by Braun and Clarke (2006) was used. The authors point out that this thematic analysis does not tie a researcher into any pre-existing paradigm and is compatible with constructivism.

The six phases for inductive thematic analysis as described by Braun and Clarke (2006) was followed for each case:

Phases	Description
Phase 1:	Familiarising. Reading and re-reading of the transcripts. Going back listening to the voice recordings. Taking initial notes and marking initial ideas for coding. This phase allowed for familiarisation of the data.
Phase 2:	Initial coding. Starting to organise the data into a meaningful way by producing initial codes from the data. The coding of the data was inductive, i.e. 'data-driven'.
Phase 3:	Searching for themes. All codes were identified. The aim was to start taking a broader view by sorting the various codes into potential overarching themes or categories. Tables and mind-maps were used. The main themes and sub-themes were identified.
Phase 4:	Reviewing the themes. The transcripts and diary data were re-read to (i) check that the themes related to the data and (ii) to code any data that were missing during the coding phase. Re-coding took place.
Phase 5:	Defining and naming the themes. This phase started once a thematic map was in place. Further defining and refining of themes and further identification of sub-themes within the over-arching themes took place. The data within each overarching theme was analysed and a written detailed analysis was drafted. By the end of this phase all overarching themes and sub-themes were identified. However, the various phases of the data analysis were revisited throughout the analysis.
Phase 6:	Reporting. The data analysis section for each case was written.

The analysis started during data collection and as part of the process of transcribing the interviews (Braun & Clarke, 2006; Merriam, 2009). The researcher took notes following the interviews and during the various phases of the data analysis process to capture thoughts, reflections, impressions or ideas which were revisited at various stages.

Analysing the first case was daunting. It was difficult reducing the interview data. Miles and Huberman (1994) explain that the process of data reduction forms part of the data analysis:

“Data reduction is a form of analysis that sharpens, sorts, focuses, discards, and organises data in such a way that ‘final’ conclusions can be drawn and verified”. (p.10)

Other authors argue that referring to ‘data reduction’ implies some is lost, with Simons (2009) arguing that data transformation has a “qualitative different ring to it than data reduction” (p.121), whereas others used the term ‘data condensation’ as

a way of articulating that data quality is not lost but merely concentrated. The thematic analysis was initially data driven but later included more interpretative work.

The transcripts were read and re-read and codes assigned. A code is a word, short phrase or sentence that is symbolically assigned to a portion of the data. A sub-theme or a theme is a phrase or sentence that helps to describe more subtle and tacit processes. Braun and Clarke (2006) explain that a theme can either come from a collection of codes or sub-themes or it can be identified from standing back from the data to identify what the data is about or what the common thread is and then return to the text to identify the codes or sub-themes to support this theme. In reality it was a combination of the two as it was not always easy to know if a theme came from the codes or from standing back from the data and then identifying the codes. Braun and Clarke (2006) refer to a theme as capturing:

“Something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set”. (p. 82)

Merriam (2009) and Willig (2013) explain that a theme should be recognisable, meaningful and systematic in capturing some recurring pattern, indicating that there is some quantifiable element to identifying a theme, whereas Braun and Clarke (2006) argue that a theme is more about “capturing something important in relation to the overall research question” (p.82), which can also involve something not said or something only said once, with Simons (2009) referring to researchers also using their intuition.

It was not possible to analyse one case and move on to the next case as they were all bounded together (Stake, 2006). Although one case was analysed before moving to the next case, the researcher would continuously go back to the case or cases already analysed as new information or perspectives were found in the next case being analysed.

The diary data was included in the data analysis but because these data covered similar areas that were included in the semi-structured interviews, they mainly added to some of the themes or sub-themes obtained from the semi-structured interviews (See *Section 4.9.4 Diary*). These themes and sub-themes would have been reached without having had the diary data.

4.10.2 Cross-case analysis

Miles and Huberman (1994) argue that researchers undertaking cross-case analysis should avoid simple aggregation of cases under common variables summarising similarities and differences. They state the importance of undertaking within-case analysis prior to undertaking the cross-case analysis. Each case was analysed separately before aggregating the findings across the different cases, although this also involved going back to the individual cases and back to the cross-case analysis (Ayres, Kavanaugh and Knafli, 2003).

The cross-case analysis was undertaken by comparing themes and sub-themes identified for each of the four case studies identifying similarities and differences between them. Initially the cross-case analysis mainly focused on the commonalities across the cases and less so on differences. This was due to the cases being bounded together by pharmacists being part of the same profession, which is something Stake (2006) noticed with collective case studies:

“I generally find that researchers doing cross-case analysis are emphasizing the common relationships across cases”. (Stake, 2006, p.36)

Khan and VanWynsberghe (2008) and Stake (2006) point out that undertaking cross-case analysis reduces the data from all four cases further with the main focus becoming the comparison, thereby losing elements of the individual cases. As it was foreshadowed before the study that there were intra-professional divisions within the pharmacy profession the researcher also focused on identifying differences.

This study did generate new information due to comparing the four cases, which would not otherwise have been revealed. The writing up of the findings from the data analysis during the various stages helped to define and refine the data analysis. Writing itself was a way of aiding the researcher's thought processes, facilitating the data analysis further. Richardson (2000) explains that the writing up itself can be seen as a tool to help with the data analysis:

“Writing is also a way of “knowing” – a method of discovery and analysis. By writing in different ways, we discover new aspects of our topic and our relationship to it”. (p.923)

The themes and sub-themes identified for the collective case study were (See *Chapter 5, Section 5.1 Introduction*):

Theme one: *The hidden healthcare profession*
(Sub-themes: *Lacking visibility, The unrecognised healthcare professional and Delivering healthcare in a shop*)

Theme two: *Important relationships*
(Sub-themes: *Working with doctors and Helping patients*)

Theme three: *Pharmaceutical surveillance*
(Sub-themes: *Surveillance of other healthcare professionals, The medicines police and Influencing patients' behaviour*)

Theme four: *Re-professionalisation strategies*
(Sub-themes: *Professionalism, Delegation, education and supporting doctors and Competing with nurses for new jurisdictions*)

Theme five: *Two different professions*
(Sub-themes: *Community pharmacists as dispensers, Limited mobility between healthcare settings, No collaboration across healthcare settings and Clinical versus community pharmacists*)

4.10.3 Moving from data to theme

The aim of this section is to demonstrate how the researcher went about analysing the data for the theme: *Pharmaceutical surveillance* (See *Chapter 5, Section 5.4 Theme three: Pharmaceutical surveillance*).

The researcher being from a constructivist paradigm took an active role in the data analysis in moving from data to this theme. This involved moving from a data driven data-analysis towards interpretative work going beyond what participants had said. This included going back to the literature (See *Chapter 2, Sociology of*

the professions and pharmacy) for further inspiration and ideas in moving the data analysis forward to different levels of abstraction.

It is important to note that these processes were not linear but more recursive, moving back and forth from the data, Researcher Journal, the literature, the theme then back again to the data, throughout the six phases (Braun and Clarke, 2006).

In the preliminary with-in case data analysis in the case of CPs a sub-theme “Policing and preventing GPs from making mistakes” was identified. All the preliminary findings for the case of CPs were presented to an external audience (Altman, MacAdam and Stew, 2014).

For example, in the preliminary within-case data analysis, in the case of HPs a theme was “Improving medicines safety and reducing risks” due to hospital pharmacists having a broader scope of practice compared to community pharmacists. This is because hospital pharmacists are clinically involved in ‘checking’ prescriptions on inpatient wards as well as for example developing policies and procedures to be followed by other healthcare professionals including providing them with training.

It was only when undertaking the cross-case analysis that it became apparent that there was no clear common theme across the four cases related to the core function that defines the pharmacy profession.

It should be noted that the aim of identifying the core function that defines the pharmacy profession was not fully articulated at the outset of this study. It was only through further engagement with the literature, data analysis and revisiting the Researcher Journal that it became clear that this aim had always been there but not been fully articulated (See *Chapter 7, Section 7.2.3 Research question*).

The initial data analysis had been data driven by looking at pharmacy practices between the different cases at the superficial level and not going “beyond what a participant has said” (Braun and Clarke, 2006, p.84).

In the case of CPs, community pharmacists were dispensing medicines, developing relationships with their customers/patients, undertaking MURs and NMS and working in professional isolation. This was in contrast to the cases of HPs, MHPs and CHSPs where pharmacists may or may not be involved in

dispensing of medicines, working in multi-professional organisations, being part of multi-disciplinary teams, seeing patients on wards, having access to patients' notes and also often in possession of post-graduate qualifications.

In the cases of HPs, MHPs and CHSPs pharmacists articulated they had little in common with community pharmacists, yet they are all part of the same profession.

In the cases of MHPs and CHSPs, there were some NHS trusts where the dispensing of medicines had been contracted out to another external provider, hence the core function that defines the pharmacy profession was not 'dispensing' as suggested by Harding and Taylor (1997). However, the task of dispensing still constitutes a central part of community and hospital pharmacists' practice so should be contained within this core function that defines the pharmacy profession. In the cases of CPs and HPs they still view dispensing and supply of medicines as their core function.

Hospital pharmacist:

532 Because we will just get too bogged down with dispensing and discharges
533 and discharge medication. I would love to develop my role into a bit more of a
534 specialist role but at the end of day the service calls and we have got to
535 provide a core service with providing medication and I think we and I think that
536 sometimes we just about cope doing that. So how we are suppose to push
537 ourselves forward as a respected profession when we are stored away in the

Handwritten notes: *supply*, *away from*, *core service*, *Medicines ready*

Hospital pharmacist:

540 R: OK. You are talking about core functions. What would you describe as...
541 HP1: ...dispensing
542 R:core function
543 HP1. ...and supplying medication. That is what I do. That is what I consider to
544 be core function. Um and obviously our clinical team we provide ward based

Handwritten notes: *from med. supply*, *core function of pharmacists*

Hospital pharmacist:

549	R: So you in a way....am I right?....You can correct me.... You do not view the	<i>core services not ward rounds but medicines supply</i>
550	clinical input on the ward as a core function?	
551	HP1: No. And I do not think that our clinical team management do either.	
552	R: When you say clinical management team..	
553	HP1: So...my boss and my bosses. Our line managers have always ...have	
554	always said, you know, <u>actually screening of TTOs and getting that</u>	
555	<u>medication supplied that is our core service and then you get to go on the</u>	<i>clinical</i>
556	<u>ward round.</u>	

Eaton and Webb (1979) and Dingwall and Wilson (1995) suggest the core function is 'giving information'. The data analysis in this study did not suggest that 'giving information' was the core function of pharmacists. (See *Chapter 6, Section 6.2 The core function that defines pharmacy*).

Dingwall and Wilson (1995) explain that the core function for a profession is understood as an activity that distinguishes and defines one profession from other professions. This core function is based on the profession's knowledge, skills, abilities and expertise and working methods or techniques that are unique to that profession (Abbott, 1988; Freidson, 2001). Therefore, theoretically there should be a core function that is similar across all four cases despite the differences in pharmacy practices between the cases of HPs, MHPs and CHSPs (NHS pharmacists) as opposed to the case of CPs (community pharmacists).

When undertaking the cross-case data analysis it was difficult to find this common core function across the four cases besides pharmacists 'acting as a safety net' or that they 'provide and protect' regardless of which healthcare setting they were working in. The metaphor of 'acting as a safety net' gives a mental picture of pharmacists 'catching' problems or errors just before they are about to happen but it does not explain that pharmacists are also proactive in addressing potential problems before they happen or in preventing them. The 'provide and protect' function seems to be more about the outcome of the core function.

Mental health pharmacist:

355 MH1: ...The core business...of the service or of the pharmacy? Well
356 okay...well.....yeah...I mean...I kind of break it down into ...two bits really.
357 There is um...medicines and the kind of...I would say there are kind of two
358 risks with medicines...um...that people don't either don't take them so they
359 don't get the benefits from them...um or they do take them and then there is
360 the kind of risks around the side-effects or what-ever...so I would say the role
361 of pharmacy is to kind of support both of those areas so ...making sure
362 people take medicines...there is all the work around adherence and ...that
363 goes all the way back to making sure you get a timely supply and um...you
364 know in the right form that people can take so that .. you know so there is all
365 that kind of ...provision work...um and then there is that um...there is ...all
366 yeah ...all that stuff kind of ...protection...I suppose...yeah in another word
367 looking at seeing is... that we provide and we protect ...so we provide
368 medicines in all the kind of clinical services...but we also seek to protect
369 people to get their ...from any problems that they may encounter with their
370 medicines....um....so I would say...so I would say...you know I ...I would sell
371 pharmacy as being veryum you know...it is very...you know...90% of our
372 people use medicines...for their mental health problems...so...anywhere

Addressing Risks

Supporting

Adherence

Protection

Provide & protect

Mental health pharmacist:

606 MHP2: I think if there were no pharmacists it would make a big difference with
607 you know...with a lots around prescribing errors.. recentlywe monitor that
608 as a trust and we monitor our own therapeutic interventions...um..on ward a
609 large chunk is um...is prescribing errors um...if we weren't there that is
610 another is another little bit of safety net that the system wouldn't have...um...I
611 think you need...you need that whole chain of people really you need the
612 doctors the nurses ...the doctors, pharmacists, the nurses and the patients all
613 ought to be aware ...I mean I am focusing on an areas as an example but
614 if...if we weren't there an awful lot of things could go wrong. Um a number of
615 things are picked up by pharmacists and technicians ...medicines
616 reconciliation um...um...it makes a huge difference plus the supplies just
617 making sure the right things are there at the right time...um...we are...as I

particular
picking up errors
safety net
safety
medicines
intervention
policy
anomaly

Community health services pharmacist:

67 ..there is I go to the bedded units I see the patients and I talk to the patients, I
68 discuss stuff and treatments with doctors and with the nurses, and monitoring
69 and that side of things and that is direct patient contact and there is the other
70 side of it...What systems do we have in place to reduce the risk to patients?
71 so for example CD reconciliation that may or may not be a legal requirements
72 but there is all....all this legal stuff around CDs so I would help facilitate that
73 and as a byproduct of that would be patient care and patient safety.. I think
74 and getting involved in policy writing and um developing services. It might not

Monitoring
correcting
social order
result in
↑ patient safety

The sociology literature on the pharmacy profession was revisited again. Mesler (1991) describes hospital pharmacists as “quality control agents” (p.319). This led the researcher down a path of considering if pharmacists’ core function was to act as ‘quality control agents’ or ‘quality assurance agents’ due to pharmacists referring to ‘checking’ and ‘screening’ and being viewed as the ‘medicines police’ by other healthcare professionals. Again this did not seem to fully cover the core function.

In all the cases, pharmacists talk of having a 'mind-set' that nobody else has. Initially these data did not fit into the preliminary themes. Simons (2009) describes this problem of intuitively knowing that there is a theme that seemed to elude the researcher:

“Instinctive feelings or insights you have that certain issues are significant, the puzzles in the observations and data that do not fit into emerging themes, the metaphors, images and other artistic ways in which you gain an intuitive grasp of what the data mean”. (Simons, 2009, p.126)

It was when revisiting the data again that it became clear that pharmacists were trying to articulate that their undergraduate pharmacy degree had provided them with, not necessarily the actual knowledge, but rather something more fundamental that they are able to apply regardless of the healthcare setting in which they work. This can be described as an approach, a process or technique for finding problems or gaps and for solving or addressing these. The degree to which they are able to apply this 'fundamental approach' depends on their current pharmacy knowledge and skills, and the healthcare setting. This 'fundamental approach' also to a large degree dictates how pharmacists apply their knowledge and skills.

Community pharmacist:

The image shows a transcript snippet with handwritten annotations. On the left, 'ways' is written above a circle containing 'that development'. On the right, there is a large bracketed note: 'If in an approach where of more approach hearing cause PROBLEM SOLVING.' Below this, another note says '? Approach to pharmacy practice.' The transcript text is as follows:

got taught on the degree course back then. I know that it has changed a bit since then. Um ...I think that while you may not use directly the knowledge that you have the process of learning it and having it in the background makes you think differently and therefore makes you problem solve and ...think outside the box and perceive things differently to perhaps other members of staff. So while it may not be a direct application the knowledge I think you use it in a more loose sense if that makes sense sometimes. That actual physical learning knowledge I think probably about 30% perhaps.

Hospital pharmacist:

153 R: So what in particular is it that you enjoy in terms of..?

154 HP4: Making a difference

155 R: Ok. And what difference do you make?

156 HP4: It is making.. it is actually making changes... it is actually fixing things

157 really. You know, so you and it is finding something that is not quite right and

158 being able to fix it ...so that is...you know, that is it. The thing for me that

159 really makes it... what I want to do. I know that I could probably do that in

160 other jobs as well. But I do also like the medical side of it. You know. I like

161 having... I like having knowledge that no one else has really!... I can say I like

Handwritten notes and diagrams on the transcript. A circle labeled "Gaps" is connected by a line to a box containing "it is finding something that is not quite right and". Another box contains "being able to fix it". A large oval contains "Problem finding solutions" with an arrow pointing to "Knowledge" written below it.

Dingwall and Wilson (1995) describe that there were “disciplinary elements of pharmacy” (p.120) and that “maintenance of social order in the social world” (p.125). It was found that pharmacists were trying to create some type of social order in terms of medicines management or medicines-use by trying to change or influence the behaviour of other healthcare professionals and patients’ medicines-taking.

Community health services pharmacist:

300 R: Okay. Um how do you think other healthcare professionals may view
301 um the professional role of pharmacists?
302 CHP4: They consider us police men.
303 R: Right.
304 CHP4: Um because we are the people who tell them they cannot or shouldn't
305 and that ...I mean that has been my whole professional life and not just here.
306 R: Right
307 CHP4: That ...you are the person who comes in with the big stick preventing
308 them from what they want to do. Because a lot of what we do as professionals
309 in my experience anyway we look at risk a lot, risks around medicines um and
310 the legality so we will be picking things up that are very risky and saying
311 clinically this is a risk or you know, umlegally this is a risk or legally this is
312 illegally...this is the legal and they say...but, you know, the patient needs the
313 treatment and then you have to go through the conversation 'yes but what if
314 the treatment is dangerous? Because you do not know what you do not know'
315 and theynurses are particular don't like to be told because ...I do not have
316 in this role ... I do not have much to do with doctors. Um but everybody
317 seems to think they are experts in medicines when they are not. Especially if
318 ...especially if it is a real problem is the behavior has gone on for a long time
319 unchallenged...'well we never have had a problem before and you are coming
320 here and it is going to take all this time uh uh uh' so I think we are viewed as
321 the spoilers ...spoilers is what we are.there are a number where we have
322 actually supported nurses in particular with issues that they have had. They

Hibbert, Bissell and Ward (2002) referred to pharmacists' professional surveillance in selling Over-the-Counter medicines to patients but did not explore this 'surveillance' further. Dingwall and Wilson (1995) and Hibbert, Bissell and Ward (2002) both made reference to Foucault but without elaborating any further on this (See Chapter 2, Section 2.4.5 Surveillance, discipline and 'pastoral power').

However, it was only when the researcher read the book *Power, pain and dentistry* by Nettleton (1992) followed by the book *Discipline and Punishment: The Birth of the Prison* by Foucault (1977) and revisited the data again that it was clear that the core function that defines the pharmacy profession is 'pharmaceutical surveillance' regardless of the healthcare setting (See *Chapter 7, Section 7.2.5 Analysing and making sense of the data*).

Once this theme of *Pharmaceutical surveillance* had been identified the rest of the data analysis for the sub-themes seemed to fall into place. The work pharmacists do in terms of 'checking' or 'screening' prescriptions, whether in a community pharmacy or hospital ward, comes under the sub-theme *Surveillance of other healthcare professionals*, as would producing policies and procedures or prescribing guidelines within NHS trusts for other healthcare professionals to follow and where pharmacists monitor or audit their practice. As pharmacists are surveilling other healthcare professionals it is easier to appreciate why they feel they are viewed by others as the 'medicines police', with the *Medicines police* being the second sub-theme. Pharmacists see themselves as having a role in providing patients with information about medicines and in community pharmacy also around checking patients' medicines-use and providing health living advice with the aim of influencing patients' medicines-taking behaviour and life style. This fits within the sub-theme *Influencing patients' behaviour*.

4.11 Rigour and quality

Researchers' paradigms influence their fundamental views of the type of research topic they choose to undertake, but also how they evaluate research. The researcher's position in this study was one of constructivist. If this study is evaluated using criteria attuned to post-positivist rather than constructivist, then this study will appear subjective and lacking validity (Furlong and Marsh, 2002). However, Paley and Lilford (2011) argue that declaring a qualitative researcher's philosophical framework or paradigm, in particular constructivism, is an unacceptable way of justifying the subjectivity of qualitative research implying that researchers are not accountable to anything other than themselves. They state that qualitative research should not be allowed to enter the literature unless it conforms to the same standards and scrutiny as quantitative research. The

authors presented their argument and judgement of qualitative research from a post-positivist position.

There is much debate within the literature surrounding the quality criteria used to ensure the rigour and quality of qualitative research approaches (Rolfe, 2006; Merriam, 2009) in line with the criteria of validity and reliability used in quantitative research approaches. The criteria used to judge quantitative research approaches which are based on an “objective phenomenon waiting to be discovered, observed, and measured” (Merriam, 2009, p.213) are not directly applicable to qualitative research as the underlying assumptions are that “reality is holistic, multidimensional, and ever-changing” (Merriam, 2009, p.213) as there is no objective ‘truth’. Instead qualitative researchers can address the issue of ‘trustworthiness’ appealing to constructivist paradigm criteria of credibility, transferability and dependability (Koch, 1994; Merriam 2009).

Researcher ‘bias’ is inherent in qualitative research as the researcher is the primary instrument for data collection and data analysis. Bias, as presented in the literature, is about eliminating subjectivity and refers to a negative influence on a study as something that prevents the knowledge generated being genuine (Simons, 2009). It implies that the reality researched is separate from the researcher whereas in a constructivist inquiry there are multiple realities that are socially constructed where the aim is to understand different perspectives, not to eliminate these. The researcher is not separate from the research. It therefore does not make sense to discuss ‘bias’ in the same way one would for research undertaken within a post-positivist paradigm (Kuper, Lingard and Levinson, 2008). The subjectivity of a constructivist inquiry is managed by researchers using reflection and reflexivity to show they are aware of the multiple influences they have on research processes and on how the research processes affect them. The principle of reflexivity is to help rationalise the relationship between the researcher and the research process. It is a way of trying to manage subjectivity or ‘bias’ within the research process and allows the reader to ‘validate’ the study. Reflections and reflexivity have been incorporated within the thesis but also addressed in *Chapter 7, Reflexivity and reflection*.

Merriam (2009) and Yin (2009) argue that one way of ensuring ‘internal validity’ is to use multiple methods of data collection by triangulation, which appears to be based on the assumption that three or more measurements will converge to within

one point to verify findings made. However, Barbour (2001) points out that different data collection methods (i.e., interviews and observations) generate data in different forms that may be difficult to compare. Barbour (2001) maintains that different findings made from different data collection methods do not provide a basis for rejecting the findings but merely provide a partial view of the research topic explaining that there are multiple views which may all be equally valid. Therefore, triangulation cannot serve to verify a study, but instead may enable the researcher to broaden their perspective and may help to achieve a more “rounded, multi-layered understanding of the research topic” (Yardley, 2000, p. 222).

An argument against using several data collection methods is that this can generate large amounts of data that may be difficult to manage. Instead, Crowe et al (2011) argue that researchers should focus on analysing data collected to allow enough depth to answer the research questions.

Koch (1994) suggests that participants should be involved in discussing the findings from the data analysis to achieve credibility. Barbour (2001) views this as mainly being valuable where researchers work with participants on an ongoing basis but suggests that where the data collection is a one-off encounter obtaining participants’ validation may “be more trouble than it is worth” (p.1117). This study did not obtain participants’ validation of the findings. The researcher did not wish to draw any further on their time. Instead the findings from this collective case study were presented to two different groups of experienced practising pharmacists as a way of ‘sense’ checking or checking the credibility of the findings to see if they ‘rang true’ (Simons, 2009). (See *Chapter 7, Section 7.3, Strengths and limitations of the study*).

Constructivist inquiry seeks to capture multiple realities and utilises both a descriptive and interpretive approach. Verbatim excerpts from the transcripts and diaries were used to strengthen and clarify the themes, and to deepen the understanding and relationship between the data and the interpretations (Corden and Sainsbury, 2006). Quotations from the transcripts, diaries and Researcher Journal were a way of helping the reader to get closer to the research processes and the participants, including their different accounts and perceptions of the nature of pharmacy practice in relation to the healthcare setting in which they worked and in the context of today’s society. It was not always easy to choose which quotations to use and how to blend or integrate these within the narratives

in the findings. The researcher was influenced by reading other researchers' work to determine the prevailing practice or method for presenting the findings (See *Chapter 5, Findings*).

As a way of offering transparency, the researcher maintained a Researcher Journal and aimed to reflect this in the thesis as a way of describing the evolution of her thinking, including the rationale for choices and decisions made during the research processes. The readers of the thesis will approach and read it from their own particular perspective. They may not share the researcher's interpretations but they should be able to follow the way in which the researcher arrived at these (Koch, 1994; Holliday, 2007). The researcher aimed to enhance the credibility of this study by being aware of and communicating her position within the study by keeping the Researcher Journal and through reflection and reflexivity (See *Chapter 7, Reflexivity and reflection*). This should allow the reader of this thesis to judge the degree of transferability of the findings from this study and from one context to another.

4.12 Summary

Engaging with qualitative collective case study methodology within a constructivist inquiry allowed the exploration of pharmacists' perceptions of the nature of pharmacy practice and to answer the research question: *How do pharmacists working in different settings perceive their status in society today?*

This chapter justified the reason for using qualitative collective case study methodology grounded in the constructivist paradigm including taking a reflexive approach to the research, which required continuous critical examination of the whole research process and the researcher's position within it to address the inherent subjectivity of this qualitative research approach.

There were tensions between the different aspects of the research process as outlined in the literature compared to how these were applied in practice. This included having to make decisions and address some of the problems encountered often pragmatically to allow the research process to move forward whilst still retaining accountability for the research.

The researcher aimed to provide a transparent account of the research processes in this thesis including addressing the issue of the rigour and quality of the study.

The actual research process was not linear, but rather evolving and iterative, which the researcher has tried to articulate although it should be acknowledged that it is difficult to fully capture this.

By presenting the researcher's reflexivity and reflection allows the reader to evaluate the researcher's position within the research processes and the different ways this may have been influenced (See *Chapter 7, Reflexivity and reflection*).

The data collection and analysis were discussed. The result of the data analysis culminated in the findings, which consisted of five themes: *The hidden healthcare professional, Important relationships, Pharmaceutical surveillance, Re-professionalisation strategies* and *Two different professions*.

An example was given for the theme *Pharmaceutical surveillance* about how the researcher moved from the data to this theme. This included going back to the literature (See *Chapter 2, The sociology of the professions and pharmacy*) for inspiration in order to undertake the interpretative work to move the data forward to different levels of abstraction.

The findings from the qualitative collective case study are presented in *Chapter 5, Findings*.

CHAPTER FIVE: Findings

5.1 Introduction

The previous chapters outlined the context for this study and the methodology including the approach to the data collection and analysis. This chapter presents the findings from the collective case study based on the cross-case analysis of the four cases: the case of CPs (Community Pharmacists), the case of HPs (Hospital Pharmacists), the case of MHPs (Mental Health Pharmacists) and the case of CHSPs (Community Health Services Pharmacists). The interpretative cross-case analysis gave rise to five overarching themes for the collective case study. Each overarching theme has been further subdivided into subthemes. These are outlined in Table 3.

Themes	
5.2 Theme one:	The hidden healthcare profession
	5.2.1 Lacking visibility
	5.2.2 The unrecognised healthcare professional
	5.2.3 Delivering healthcare in a shop
5.3 Theme two:	Important relationships
	5.3.1 Working with doctors
	5.3.2 Helping patients
5.4 Theme three:	Pharmaceutical surveillance
	5.4.1 Surveillance of other healthcare professionals
	5.4.2 The medicines police
	5.4.3 Influencing patients' behaviour
5.5 Theme four:	Re-professionalisation strategies
	5.5.1 Professionalism
	5.5.2 Delegation, education and supporting doctors
	5.5.3 Competing with nurses for new jurisdictions
5.6 Theme five:	Two different professions
	5.6.1 Community pharmacists as dispensers
	5.6.2 Limited mobility between healthcare settings
	5.6.3 No collaboration across healthcare settings
	5.6.4 Clinical versus community pharmacists

Table 3: Themes and sub-themes

The themes enable the findings to be presented in an organised way providing an explanatory framework. The five themes address the different aspects of how pharmacists themselves perceive their pharmacy practice and offer insight into the

nature of pharmacy practice as understood by pharmacists themselves, also in terms of how they perceive the status of their profession.

Appendix 9 summarises basic demographic information on the study participants. Selective quotations are included from the interview transcripts and 5-day diaries as a way of illustrating the findings made with reference to each individual pharmacist. Notes from the Researcher's Journal are also included.

In the text 'NHS pharmacists' refers to the cases of HPs, MHPs and CHSPs, as they are all employed by NHS trusts. 'All cases' refers to the cases of CPs, HPs, MHPs and CHSPs.

5.2 Theme one: The hidden healthcare profession

This theme is about how pharmacists believe that they are perceived by the public, patients, and other healthcare professionals. In all cases, pharmacists articulate that there is limited understanding of what pharmacists do besides dispensing and supplying medicines. NHS pharmacists associate this activity with a historical perception of pharmacists being hidden away in the pharmacy dispensary. Conversely, both hospital and community pharmacists (the cases of HPs and CPs) describe using a significant part of their working day on dispensing medicines, with this act of practice reinforcing others' views of pharmacy.

The data analysis shows that the actual act of pharmacy practice, which is what others see, influences how pharmacists are perceived. Pharmacists are an underutilised resource whose contribution to healthcare is poorly understood and remains hidden to others.

5.2.1 Sub-theme: Lacking visibility

Pharmacists (in all of the cases) felt that the public, patients and other healthcare professionals often were unclear about what pharmacists do and that, "*There is still a "we do not know what pharmacists do"*" (CP1) attitude.

The public's view is that all pharmacists work in community pharmacies (or retail shops) as this is what most people associate pharmacists with. It is where they come across pharmacists. A pharmacist explains that:

I think people usually think of pharmacy as a shop (MHP3)

NHS pharmacists (in cases of HPs, MHPs and CHSPs) indicate that inpatients are unaware that pharmacists work on wards. Inpatients assume pharmacists only work in community pharmacies and are surprised to be approached by a pharmacist on a ward. A pharmacist explains that:

Patients turn around and say; 'Oh I didn't know they had pharmacists in hospitals'. (CHSP1)

Patients and the public do not consider that NHS pharmacists form part of the team of healthcare professionals who care for them on the wards. The implication is that pharmacists remain an invisible healthcare professional to patients and the public.

Pharmacists (in all of the cases) express concern about the lack of pharmacists' presence in the media. They recognise this is important for their image in order to raise awareness of what pharmacists actually do so the public has a better understanding of their contributions to healthcare. Instead, the perception was that the media does not depict pharmacists' contribution to healthcare, mirroring the public's view of pharmacists being linked to retail shops:

Pharmacy as a profession doesn't get much press in my opinion. You often hear about doctors and nurses in care related situations but pharmacy to a degree is just considered sort of a 'retail shop'. (CP2)

Pharmacists (in all the cases) feel part of the problem stems from politicians, when talking about the NHS by not mentioning that pharmacists are part of delivering NHS healthcare. This leaves the public, some healthcare professionals and other NHS stakeholders unaware of what pharmacists' contributions to healthcare are. A pharmacist says :

Wherever you hear the NHS talked about by David Cameron [the Prime Minister] and anybody else the only people who work for the NHS are apparently doctors and nurses, so rarely do you hear pharmacists mentioned. So I think it starts at the top and it radiates down. (MHP2)

This results in it being difficult for the public and other healthcare professionals to understand where pharmacists fit into healthcare and what they contribute. This makes pharmacists feel less important compared to other healthcare professionals, which they find demoralising.

A pharmacist explains that:

Within healthcare we [pharmacists] are sometimes the poor relation and quite often forgotten about and not quite sure where we would fit in. (CHSP5)

Pharmacists (case of MHPs) employed by mental health NHS trusts raise the issue that the public's view of them as almost invisible healthcare professionals is reflected in NHS staff surveys where they are not listed as a separate professional group:

[In NHS] staff surveys, you are not even recognised as a professional group. That can be a bit demoralising. (MHP1)

Pharmacists (in all of the cases) feel that as a profession pharmacists are too much in the background and invisible. They think these perceptions take a long time to change. A pharmacist states:

I just think we are too much in the background from years gone by. (HP5)

This historical view involved NHS pharmacists (cases of HPs, MHPs and CHSPs) being hidden away in the pharmacy dispensary in the basement of the hospital supplying medicines without being seen on the wards, whereas today hospital NHS pharmacists feel they are visible on the wards. This means other healthcare professionals have an increasing awareness of the contributions pharmacists make to patient care:

It is not like the 'good old days' where you were trapped in the basement and never came out...because we are actually out and about on the wards. A lot of people do realise that we do more than just sitting there and sending out bags full of drugs...I say it has certainly moved on from those days. (MHP4)

Pharmacists (in all the cases) reflect that in the past community pharmacists would hand the dispensed medicines to patients without any real interaction. Pharmacists think that this attitude is slowly changing:

I think a faceless 'here you go here is a bag of drugs I will see you in a month', that kind of attitude is changing slightly. (CP2)

A community pharmacist reflects that if the public has had a negative experience of pharmacy it will be difficult to change this perception:

If the general public has in the past had a fairly negative experience, a kind of faceless experience of pharmacy, no amount of publicity can change that. (CP2)

This community pharmacist considers that it is the act of pharmacy practice that the public, patients and other healthcare professionals see and experience that determines how they perceive pharmacists. If pharmacists wish to change these perceptions others have of them then it is up to pharmacists themselves to demonstrate what they can do:

It is for us to show ourselves, that we do other things than that. That will certainly help. (CP2)

This community pharmacist feels that the changes to community pharmacy and the services they now deliver have taken a long time for the public to become aware of. This community pharmacist deduced from this that it could take many years to change the public's perception of pharmacy:

Changing the view of the public is a very difficult thing. It will obviously take a very long time. (CP2)

Pharmacists (in all of the cases) recognise that to change the public's, patients' and other healthcare professionals' perceptions of the pharmacy profession they will have to act out their professional practice in such way that they are visible to others to increase their understanding and experience of what it is pharmacists do.

Pharmacists (in all of the cases) talk of the pharmacy profession itself lacking a strong national voice adding to the problem of others not fully understanding what pharmacists do:

The voice of the profession is a quiet voice. (MHP1)

Pharmacists as individuals or pharmacists as a profession, the need for the [Royal Pharmaceutical] Society in days gone by has not shouted loud enough about what we do. It is a little pathetic. (HP5)

5.2.2 Sub-theme: The unrecognised healthcare professional

Pharmacists (in all of the cases) feel that the public, patients and other healthcare professionals associated them mainly with dispensing of medicines including how this was linked to the view that pharmacists spent most of their time working in the pharmacy dispensary, making them less visible to others.

Pharmacists (in all of the cases) feel they are perceived by the public, patients and other healthcare professionals as “counting tablets” (HP3) or “putting labels on boxes” (HP5). This can be interpreted as the public having observed pharmacists’ physical act of dispensing medicines, which appears to them as a simple process. This process consists of the pharmacist taking receipt of the patient’s prescription, taking the medicine box from the shelf, adding a pharmacy label to this medicine box and handing the medicine to the patient:

From a public point of view certainly I have heard people say it is ‘putting tablets in boxes’. (CHSP1)

Pharmacists talk of other healthcare professionals also seeing pharmacists as undertaking a simple act of placing pharmacy labels on medicines boxes disregarding and undervaluing the ‘checking’ process pharmacists undertake of prescriptions when supplying a medicine. Two pharmacists elaborate on this by explaining that:

Anybody who does not deal with pharmacists on a regular basis would not really understand about the role [of pharmacists] and therefore their opinion may be very much like that of the general public. So we just stick labels on boxes kind of thing. (CP2)

Our interventions and input do actually help improve patient care whereas others see us as putting labels on boxes. (HP5)

NHS pharmacists (cases of HPs, MHPs and CHSPs) thought the reason for this was that in the past hospital pharmacists were working the majority of their time in the pharmacy dispensary and not being present or visible to other healthcare professionals on the wards instead “concentrating on the core role of dispensing medication” (HP3).

To illustrate the importance of being physically visible to other healthcare professionals, a hospital pharmacist explains that previously when there were only few pharmacists on the hospital wards other healthcare professionals did not contact the pharmacy department for medicines advice. Once pharmacists started to attend wards more frequently they became visible to other healthcare professionals who started to contact the pharmacy department for medicines advice, whereas prior to that the pharmacy department was hardly contacted at all. This hospital pharmacist explains:

You can tell the MI (Medicines Information) enquiries they are increasing. Before then the phone did not ring that much. Actually we are becoming more visible....I understand why they did not contact pharmacy because there was a low response and a low visibility. On the ward there were no pharmacists...they tended to be down in the dispensary, dispensing all the time. (HP5)

Although, pharmacists (in all of the cases) consider that their role and practice consists of much more than dispensing and supplying medicines, they all describe being involved in the medicines supply processes. In particular, community and hospital pharmacists talk of spending a large part of their time on supplying medicines. This reinforces others' views of them that as "*putting labels on boxes*" (HP5).

NHS pharmacists (cases of HPs, MHPs and CHSPs) explain that when they are on the wards, other healthcare professionals and inpatients continue to link them with supplying medicines. Pharmacists understand this as it is this aspect of their practice that provides other healthcare professionals and inpatients with the benefit they want, namely to receive patients' medicines on time from the pharmacy dispensary:

I think there are people who think you are purely supply because that is what worries them. (MHP5)

Hospital pharmacists (case of HPs) explain that they are checking discharge prescriptions, referred to as TTOs (To Take Out), on the wards and will need to get these to the hospital pharmacy dispensary for the medicines to be dispensed to ensure the prompt discharge of patients. Hospital pharmacists explain that they are bleeped during the day by ward nurses to sort out and order patients' discharge medication:

Wards are not happy with us when TTOs get delayed and patients are not discharged as quickly as they should be. (HP2)

Hospital pharmacists (case of HPs) describe this activity as 'sorting out medicines' and in particular discharge medication. This part of the medicines supply process, which involves the checking or screening of discharge prescriptions by a pharmacist was previously carried out in the pharmacy dispensary. This activity is now undertaken on wards where pharmacists have access to patients, their medical notes and existing medication and other healthcare professionals if they have to resolve any issues or discrepancies when checking the discharge

prescription. Hospital pharmacists describe this as a pharmacy-based ward service:

We provide ward based services but, you know, that is supply and this is TTOs. (HP1)

Hospital pharmacists explain that sorting out TTOs always takes priority over other activities. The impression is that the majority of hospital pharmacists spend their time on 'sorting out medicines'. A hospital pharmacist says that:

Our line managers have always said, you know, actually screening TTOs and getting that medication supplied, that is our core service and then you get to go on the ward round. (HP1)

Other healthcare professionals view pharmacists as tablet counters, so to speak. They are only interested in pharmacy when a patient needs to be discharged and the drugs need to be sorted out. (HP3)

This demonstrates that others' perception of pharmacists (in all of the cases) is that the act and nature of pharmacists' practice is to dispense and supply medicines to patients. A hospital pharmacist says:

Clearly medication [supply] is a core part of our business or you can say profession. I would like it to be more skewed to the more professional aspects as in advice of medication. That is what I prefer. (HP5)

5.2.3 Sub-theme: Delivering healthcare in a shop

Community pharmacists (case of CPs) talk of being viewed by others as shopkeepers. This has the negative connotation of devaluing their contributions to healthcare, including acting as a barrier for patients viewing them as delivering healthcare and for establishing relationships with general practitioners (GPs).

During the interviews, community pharmacists refer to the community pharmacy as "the shop" (CP1) reinforcing the shop-keeper image. This shopkeeper image is further emphasised by the physical appearance of community pharmacies. Four of the study interviews took place in a community pharmacy of which three were in the patient consultation room. The physical appearance of community pharmacies gives the impression of being a blend of a retail shop, selling over-the-counter medicines to customers whilst also delivering NHS funded healthcare services, mainly dispensing medicines. This visually results in a lack of clarity around the

pharmacist's role as healthcare professionals perhaps from the public's perspective but also that of other healthcare professionals and possibly also community pharmacists themselves:

When I initially was entering the community pharmacies to undertake the study interviews, I first entered the sales area where several sundry products (e.g., toys, umbrellas, food products, sweets, clothes) were on display unrelated to healthcare. This sales area occupied the largest proportion of the shop encroaching on to the dispensing area, which was located at the back. The pharmacy dispensary counter consists of displays of a mixture of confectionary and medicines, by moving from sweets, to cough sweets to medicines. It was also noted in two of the community pharmacies that perfumes were presented in locked glass display cabinets close to the pharmacy dispensary counter possibly because of their high monetary value. In contrast medicines were on display further away from the pharmacy dispensary counter, being of less monetary value although they could potentially pose more risks to customers in causing harm if used incorrectly. This gave the impression that sundry products are more important to the community pharmacy than the medicines, thereby marginalising the healthcare element.

In one community pharmacy, it was unclear to me if all the people that stood behind the pharmacy dispensary counter were pharmacy staff or not, as some of these staff members were dressed in casual clothes including jeans, sitting on the dispensing counter chatting and laughing. I felt uncomfortable in having to approach them as this meant they would be interrupted and they would all be looking at me to find out what my business was. In this case it was to ask to see a pharmacist by name, but what if it was something that I felt was a more confidential or sensitive issue? In that case I would probably have left this particular community pharmacy and gone elsewhere. This community pharmacy was so packed with sundry products that I accidentally knocked some products on the floor that were attached to the door-frame leading into the patient consultation room where the study interview was to take place. This patient consultation room had three doors leading into it. As the community pharmacist and I were about to sit down, I heard a toilet being flushed and a man opened a door appearing in the consultation room. I glimpsed into this toilet room, which had a toilet and cleaning equipment inside. The consultation room contained what appeared to be garden furniture with the plastic garden chair having a dirty floral cushion on it. The impression was not one of a pharmacy space where professional healthcare was being delivered. (Researcher's notes).

Community pharmacists (case of CP) are aware of this conflicting image of community pharmacy as a retail shop versus a place where NHS healthcare is delivered:

People have a really poor idea of exactly how pharmacy works and how it fits into the NHS, while we [community pharmacy] have some NHS branding. As far as they are concerned they are walking into a shop and I think this dichotomy sometimes causes problems because they do not quite understand, are we part of the NHS in the same way as the hospital is or are we a shop? (CP1)

Community pharmacists were trying to reiterate, as if to dispute a common assumption, that not every encounter they have with patients or customers seeking healthcare advice would result in them recommending a product to be sold to the patient to increase their sales:

A visit to the pharmacy shouldn't end with a sale necessarily. (CP1)

Community pharmacists talk of being expected to provide healthy living advice to their customers. They will often choose what health issues to address with their customer to preserve a good relationship over the health needs of the customer:

The idea that we are meant to tackle people's weight with them...is unrealistic if you wish to have good customer relations...the pharmacy... is not a place for that. (CP1)

This pharmacist justifies this further by stating that customers “*don't accept it the same way as if the GPs asked*” (CP1), implying that patients do not perceive retail pharmacies to be places where healthcare is delivered but is rather a place to receive their medication and some informal advice about their medicines or minor ailments.

Although community pharmacists talk about the public, customers and patients, the impression is that anyone who enters a retail pharmacy is a potential customer as community pharmacists think of the community pharmacy as a business that has to generate profit:

It is important to give people the chance [to talk] and also it helps to build a good rapport with the regular customers that we see...it is good for the business too. (CP2)

Community pharmacists talk of sometimes being viewed as sales assistants by customers. One community pharmacist explains that being viewed as a sales assistant was not as bad as when having provided customers with professional pharmaceutical advice, having them ignore this advice. Instead customers prefer to follow their friends' or relatives' incorrect advice, thereby devaluing the pharmacist's advice:

Then there are people that don't respect your kind of professional role. They are even worse for me than the people who just think that you are some kind of sales assistant and whatever I say to them gives them no value at all. That is probably the biggest frustration. (CP 2)

Community pharmacists also talk of their hybrid roles as a pharmacist delivering healthcare and a pharmacy manager managing a retail business. A pharmacist explains:

I think that is two separate things [being a pharmacist working as a healthcare professional versus being a pharmacy manager] as much as the two collide. (CP1)

The impression is that community pharmacy is a retail shop selling various sundry products unrelated to healthcare, with some customers sometimes viewing pharmacists as sales assistants. Community pharmacy does not appear to be a place where healthcare is delivered but mainly a place where customers can pick up their prescription medicines, buy medicines and receive informal advice.

The implication is that the public may not view pharmacists as professionals who deliver healthcare because of the image of being in a retail shop, although advertising some NHS branding. Community pharmacists can be considered hidden or underused healthcare professionals, particularly as most of their time is taken up with medicines supply as opposed to delivering healthcare to patients.

5.3 Theme two: Important relationships

This theme is mainly about pharmacists' relationships with doctors and patients.

The most important relationship for pharmacists is with doctors. Pharmacists describe having to earn doctors' trust at an individual level. Pharmacists, depending on the healthcare setting in which they work, describe different levels or stages of these pharmacist-doctor relationships from almost non-existent to collaborative working.

Pharmacists' (in all of the cases) motivation for their practice is to make a difference to patient care. They all enjoy direct patient contact and feel good if they are able to help patients, for example with information about their medicines. It is only community pharmacists (case of CPs) who talk about building and establishing a rapport with patients to gain their confidence, explaining that this

regular contact with patients is one of the reasons for choosing to work in community pharmacy.

5.3.1 Sub-theme: Working with doctors

It is important for pharmacists (in all of the cases) to establish and maintain working relationships with doctors. Pharmacists feel that their pharmacy degree consisting of science and clinical elements placed them in a strong position academically. Pharmacists feel that professionally they have more in common with doctors than with any other healthcare professionals, explaining that *“with the medics there is a synergy of agendas”* (MHP1).

Pharmacists (in all of the cases) explain that the pharmacist-doctor relationship takes time to build and establish.

For community pharmacists (case of CPs) relationships with GPs are important in terms of solving queries around prescriptions but also as part of ensuring prescriptions generated by a GP practice will come to them, explaining that *“is kind of important to build local relationships”* (CP2).

A community pharmacist (case of CPs) explains that relationships with GPs are built over time, *“that is the advantage of having been somewhere a long time”* (CP4). Community pharmacists mainly communicate with GP practices via the telephone. The type of communications described by community pharmacists are simple exchanges such as querying individual prescriptions or the GP practice asking if the community pharmacy has a particular medicine in stock. The communication exchanges are often not directly between the pharmacist and GP but mainly relayed through the receptionist or practice nurse at the GP practice. A community pharmacist explains that, *“prescription clerks we deal with a lot, GPs they are not so easy to talk to”* (CP5). Another community pharmacist clarifies that GPs often do not contact the pharmacist directly. The community pharmacist will:

Usually [receiving medicines queries] indirectly from the GPs, asking if I can find something out for them or if I can relay something to the patient or enquire about a specific drug”. (CP2)

This community pharmacist further explains that:

From my perspective we often go to the nurses...enquiry over prescription or we want a bit of clarification on some things. (CP2)

For community pharmacists a good relationship with GPs means they are able to contact the GP directly (i.e., the practice receptionist would put the pharmacist through to the GP). These pharmacist-GP relationships appear to be based on a general professional awareness of each other:

GPs I have worked with for years, I expect 2 to 3 phone calls per day from GPs related to medicines issues, around availability or advice on what to prescribe or they are not sure about something. (CP4)

This community pharmacist explains that:

Just having the relationship to pick up the phone and your opinion is listened to and valued, the reception staff will always put me straight through [to the GP]. (CP4)

In turn the GP may contact the community pharmacists with what often are simple medicines queries:

We have good relationships with most local [GP] surgeries. One GP in particular rings me constantly if he cannot find his BNF [British National Formulary]. (CP1)

Community pharmacists talk about how they often try to assess the mood of the GP tailoring their conversation accordingly including generally apologising for contacting them:

There are still some GPs, I think, that do feel any phone call is a criticism of what they have done or not done. I mean I always apologise anyway for disturbing them and try to not make it sound as if you are causing a criticism. (CP1)

Community pharmacists also describe situations where the pharmacist-GP relationships are almost non-existent. They talk of situations where GPs will make themselves unavailable “to get to speak to them [GPs] is impossible...it is like Fort Knox” (CP5) describing this as “battling with the [GP] surgeries” (CP5).

Difficulties in having their queries on prescriptions resolved promptly by the GP or GP practice is a source of frustration for community pharmacists as this affects the service they are able to provide to patients in terms of timely dispensing of their medicines. It also impacts on them in terms of how they feel treated by GP practices. Community pharmacists explain that there have been instances where they have returned the actual prescription to the patient because they have been unable to speak to the GP and that sometimes a GP will refuse to talk to them. One community pharmacist became visibly upset during the interview when

reflecting on the daily difficulties and barriers in place in trying to communicate with GP practices. A community pharmacist explains:

You just feel like ...that you are some sort of annoying pestering person when all you are trying to do is help their [GP] patients. (CP5)

Community pharmacists feel there are barriers in place such as the regulations that force them to query minor prescribing issues with GPs regarding decisions which they feel, *“that in my professional judgement I am more than capable of making” (CP1)*, explaining that hospital pharmacists will make these decisions without contacting the prescriber. This community pharmacist further elaborates, *“I have not come across one case where we have contacted them [GP] where they have not said ‘yes it is fine to go back to the other generic” (CP1)*.

Community pharmacists feel that GPs do not value the Medicines Use Reviews (MURs) undertaken by them. They feel that GPs dismissing MURs devalue their professional work:

A lot of the [GPs] are anti-it [anti-MURs] just seeing it as an annoying bit of paper. Don't even respond most of the time. (CP5)

Community pharmacists employ different strategies to improve their relationships with GP practices. They agree to GP trainees spending time in the pharmacy dispensary. Some of them will also visit GP practice managers to introduce themselves.

Pharmacists in NHS trusts (cases of HPs and CHSPs) spoke of some doctors being *“pro-pharmacy” (HP1)* which meant they did not have *“to break-down any barriers” (CHSP5)* as these doctors are approachable and will listen to pharmacists' advice.

NHS pharmacists (cases of HPs, MH and CHSPs) explain that working with doctors is about *“building relationships” (HP4)* and that *“it is us who need to develop the relationship that makes it a partnership” (CHSP1)*. NHS pharmacists accept that they will have to work at earning doctors' trust by demonstrating they are competent before the doctors will fully listen and accept their advice and that it takes time to establish this trust:

When you have worked with a doctor for the best part of a year then maybe you have already established that trust or that relationship, but I think it just takes time. (HP1)

It is a case of proving your worth and so demonstrating what you can do. (HP2)

NHS pharmacists explain that once this trust is earned it enables a closer working relationship between them and the doctor. This sometimes means that a doctor will “*take what I say as gospel*” (HP1) or “*adopts my suggestions whole-sale*” (HP4). Pharmacists do not talk about doctors having to gain their trust, instead they talk of supporting and helping them with their prescribing.

A pharmacist reflects that when doctors do not even consider the advice given by dismissing this, “*makes me think, hang on a second may be I am not this important member of the [medical] team as I think I am. It really does depend on the individual doctor*” (HP1).

Hospital pharmacists (the case of HPs) enjoy working closely with consultants to discuss treatment options for individual patients or to work on different projects such as prescribing guidelines on medicines. Hospital pharmacists themselves consider that they are fully integrated with the medical teams:

Me and the consultant sort of work together. (HP2)

Nice feedback from consultant – recognised as part of the team.
(Hospital pharmacist, diary)

Hospital pharmacists (the case of HPs) talk about ward rounds. They explain that they do not always attend due to other work priorities such as having to clinically screen discharge prescriptions to facilitate prompt discharge of patients or having to work in the pharmacy dispensary. Attending ward rounds is something hospital pharmacists will do if time and other priorities permit. This is despite describing that ward-rounds are where they are able to intervene prospectively in prescribing decisions. Hospital pharmacists do not appear to communicate with the multi-disciplinary teams (MDT) if they are unable to attend the ward rounds:

I am supposed to be there every day. I do not make it every day but I am supposed to be there every day. It is prime time for doing things so I just do not attend them all [ward rounds]. (HP4)

Hospital pharmacists explain they feel they are fully integrated members of the multi-disciplinary team (MDTs). However, they gave examples indicating that they were more on the margins of these MDTs. For example, hospital pharmacists explain that doctors or nurses will not contact them if the start time of a ward round changes to ensure their attendance:

They do not sort of say where it is [name of pharmacist] or try to bleep me and find out where I am. They do not let me know when it is happening. Often I go up there at 8.30 and there is no sign of the doctors at all. So it is a bit, you know, hit and miss sometimes. (HP2)

Other examples include hospital pharmacists providing a patient with comprehensive information about a particular drug or drug regimen or reviewing patients' blood results without necessarily recording this or communicating this to the medical team particularly when no problems are found resulting in duplication of work. Hospital pharmacists themselves do not reflect on this aspect or how they can address this:

I notice that doctors will start medication without real consultation with the patient. So I take it upon myself to perhaps go and visit those patients after the ward round to explain to them what their new medication is and what side effects they might expect from it and how to use it. (HP1)

There seems to be a lot of overlap between our roles and doctors' roles in that respect, whereas we are all checking the bloods all the time for each and every patient. That is a grey area, which could be dealt with. (HP3)

Hospital pharmacists (the case of HPs) also describe different examples of overhearing doctors trying to find answers to a medication query but for whatever reason they do not approach the hospital pharmacist on the ward for advice:

I sometimes see them struggling over pharmaceutical questions when I am standing not that far away and I kind of think 'oh you could ask me. I know the answer to that question off the top of my head'. (HP1)

A hospital pharmacist reflects that if junior doctors have had good experiences of working with pharmacists on the ward then they will always value this. The outcome in the future is that pharmacists will be "seen as a more valuable asset to the team, actually just a standard part" (HP1), but questioned this potential development as, "I don't know if the NHS has the capacity to develop our roles because we will just get bogged down with dispensing and discharges and discharge medication" (HP1).

Mental health pharmacists (case of MHPs) report being integrated within the MDTs within the inpatient units partly because they have been working for many years within their NHS trusts and therefore had already established and earned the trust

of consultants. Mental health pharmacists prioritise attending MDT ward-rounds because they are able to influence prescribing decisions prospectively. They refer to the MDT ward rounds as:

The meat and bones of the service. Very many things are done at a multi-disciplinary level. (MHP5)

MDT you are all there, you [have] got that interaction there nobody has actual initiated anything but you are all working together in the MDTs. It is something you need. (MHP4)

Mental health pharmacists (case of MHPs) talk of not having the capacity to attend all the MDTs although they feel this is important:

People are saying can you come to this ward round. Sometimes there isn't the capacity to be able to do everything that people would like us to be able to do within the service. (MHP5)

Mental health pharmacists explain that consultants value their input and attendance at MDTs. There is a long history of MDT ward rounds within mental health. Mental health pharmacists feel their contributions are valued. They feel they are viewed as medicines experts due to having extensive knowledge of medicines use within mental health, but also because mental health patients have other physical long-term conditions where pharmacists' knowledge of non-mental health medicines is valued by doctors. This gives the impression that the pharmacist-doctor relationship is one of mutual respect for each other's professional knowledge and recognition of their complementary roles in collaborating together in delivering patient care:

I have got good working relationships with the consultants for instance so that they will come and ask you questions and check things with you and so on. Today I have had a consultant ringing me a couple of times about something that he is emailing me to check about something. (MHP5)

I think in mental health they tend to listen more because sometimes you get to a stage with some patients where you are thinking what on earth can we do next and I think all ideas are welcomed so I think they will listen, you know. Certainly the consultants will listen. (MHP4)

It was clear from the data analysis that it is pharmacists (in all the cases) who are the ones who have to instigate and actively work at building and establishing the pharmacist-doctor relationships. The pharmacist-doctor relationship is established

at the individual pharmacist and doctor level and is not transferable to other pharmacists.

There are different types or stages of pharmacist-doctor relationships which seem to consist of being non-existent, to a basic awareness of each other, to pharmacists having started to earn the trust of the doctor and finally to having earned this trust, allowing closer pharmacist-doctor collaboration.

There are substantial differences in how the pharmacist-doctor relationship and interactions have developed for community pharmacists (case of CPs) and for NHS pharmacists (cases of HPs, MHPs and CHSPs), which impacts on their pharmacy practice. The impression is that doctors are pharmacists' main clients.

5.3.2 Sub-theme: Helping patients

Pharmacists (in all of the cases) “*were passionate about making a difference to patient care*” (MHP1). They talk about the importance to them of having direct patient contact:

Knowing that I am helping making the patient better, that I am making a difference to the patient's life and patients' healthcare, it is the end user that motivates me. (HP1)

Pharmacists explain that if they feel they have helped a patient it made them feel good about themselves and the contributions they make:

With the patients you get a bit of an instant fix that you are helping somebody out on a daily basis. It is selfish to think that [it is a] personal reward for myself. (CHSP5)

Pharmacists provide information to patients about their medicines to help increase their understanding and to allow them to make informed decisions about their medicines. Pharmacists all describe talking to patients about their medication so they have a “*better understanding of their medicines and why they are taking them*” (HP2).

Pharmacists (in all the cases) see it as their role to look out for and act on behalf of patients, expressing the desire for pharmacists in the future to do the same for them when they themselves one day may be in a vulnerable situation. They mainly refer to the pharmacy interventions they are making, which patients may not be aware of:

I would like to think that there are pharmacists who would do the same when I am old. (CHSP2)

Hospital and community health services pharmacists (cases of HPs and CHSPs) talk very little about any direct interactions they have with inpatients. The implication is that they only have brief interactions with inpatients such as when they require information about a specific aspect of their medicines treatment.

In contrast, community pharmacists (case of CPs) explain the importance to them of building relationships with their regular customers, which takes time to establish. Community pharmacists gave this close contact with regular customers as the main reason for choosing to work in community pharmacy as opposed to hospital pharmacy:

After a few years you build a rapport and they feel they can tell you things. (CP5)

Community pharmacists (case of CPs) explain that patients sometimes view them as independent from GPs resulting in customers feeling more comfortable discussing their medicines and concerns informally with them:

They [customers] often feel freer to ask us than their GP once something has been prescribed. They often forget to ask questions when they are in the doctors and we are there as an opportunity for them to ask most questions we can answer. (CP1)

Community pharmacists gave examples of where their actions and interventions are based on a social concern for customers and where they went beyond what is expected of a pharmacist:

You can start seeing that the patient who has always been well groomed suddenly looking quite dishevelled and you can be quite concerned and you perhaps have a word [with the GP surgery] and say it might be time to get the patient in for a review. (CP1)

Community pharmacists paint a picture of their community pharmacy being centrally placed in the local community:

I think a small community pharmacy is where I prefer to be. I like to know the people that I am serving really. (CP1)

Mental health pharmacists (case of MHPs) explain that inpatients sometimes ask to speak to the pharmacist who they consider to be independent from the doctor. These inpatients knew the pharmacist because they have been admitted regularly

to hospital over the years and the pharmacist has worked on the wards for many years:

They [patients] will probably accept information from us rather than, they kind of see us as a maybe somebody that is a bit more independent than maybe the medical and nursing staff. You can also act as an advocate for them if things aren't shall we say going well or, you know, a lot of them have lost trust in the system anyway so sometimes we [pharmacists] can help. (MHP4)

Some pharmacists (in all of the cases) explain that they talk to patients' or carers' groups including how this is a rewarding experience. A pharmacist refers to this as "by far the best bit" mentioning that this is "what most of us went into the profession for is that we think we are going to make a difference to people. We do not think we are going to spend our lives writing policies" (CHSP 4). Pharmacists sometimes gave these talks in their own time:

I do some work with carer groups...interesting and rewarding...because people just don't get information about medicines and...you come across parents and carers who worry terribly about medicines we are putting into their loved ones. I do it for nothing. It is just something that I do as a pharmacist. (MHP5)

5.4 Theme three: Pharmaceutical surveillance

This theme is about what can be interpreted as the nature of the core function of pharmacy. There is no clear word or description for this in the literature. Instead the term 'pharmaceutical surveillance' was borrowed from the Foucauldian concept of 'surveillance' as a way of explaining this core function.

Pharmacists describe their practice of 'checking' and 'screening' prescriptions with the aim of finding discrepancies which prescribers are asked to correct. Pharmacists in NHS trusts (in the cases of HPs, MHPs, CHSPs) also extend this practice by influencing other healthcare professionals' practice by producing policies and procedures setting standards for medicines use that they are expected to follow. This has led to pharmacists being viewed by other healthcare professionals as the 'medicines police'.

Pharmacists appear to lack clear and consistent terminology for what it is they do as part of their pharmacy practice which makes it difficult for them to articulate this to themselves and others.

Pharmacists will also ‘counsel’ patients on their medicines to ensure they adhere to their medicines regimen by providing them with information about their medicines, thereby trying to influence their medicines-taking behaviour.

5.4.1 Sub-theme: Surveillance of other healthcare professionals

A recurring theme is that regardless of the healthcare setting in which pharmacists’ work they consider that the fundamental aspects of pharmacy practice are to prevent and protect patients from harm from medicines thereby improving patient care.

Pharmacists (in all of the cases) use the same metaphor, “*acting as a safety net*” (MHP1) to summarise what it is they do. Pharmacists (in all of the cases) find it difficult to articulate what they do and what their contributions to healthcare are, although all explain their contributions as improving patient care and patient outcomes by making medicines use safer:

It is all in the safety isn’t it? It all keeps coming down to the same thing. It is all about reducing risks; really the kind of improving patient care is definitely in there but a big part of that is trying to make them safe. (HP4)

A pharmacist explains that safe healthcare does not exist in an ideal world. In the real world medication errors happen and pharmacists have an important role in ensuring the number of medicines errors affecting patients is reduced:

In an ideal world doctors should prescribe, know everything about what they prescribe and what kind of interactions there are. They should review patients on a regular basis. Nursing staff should check everything and prevent errors getting to the patient in that ideal world. However, I do not think this is happening at all. If we [pharmacists] had not been there I think there would be more errors to patients potentially resulting in serious harm. (CHSP2)

A similar view is reiterated by a mental health pharmacist who felt that if there were no pharmacists on inpatient wards there would be “*a lot more unexplained deaths floating around*” (MHP4). Pharmacists (in all the cases) see themselves as healthcare professionals involved in reducing harm to patients which includes saving patients’ lives:

Screening prescriptions, if we come across any concerns of inappropriate prescribing or wrong doses and that kind of stuff, we pick up mistakes that could result in harm to patients. (HP5)

I make it sound like doctors are always making mistakes but there are things, you only need one or two that could be fatal. (CP5)

Pharmacists consider that they help to prevent doctors from having to answer to their regulatory body for mistakes they make:

A number of doctors out there have been really grateful for the contributions I have been able to make whether over what their line of enquiry was or when I spotted an error on a prescription that would otherwise have reflected badly on them. (CP2)

Pharmacists (in all of the cases) imply that doctors generally are appreciative of pharmacists identifying any prescribing problems or errors. Some pharmacists also indicate that some doctors and other healthcare professionals may not appreciate what they consider to be pharmacists' interference in their clinical practice:

Some doctors think we are a pain in the backside, that we ask too many questions. Some doctors are really appreciating that we are actually checking the prescription and alert them. Those are the ones that quite like discussing treatment options and plans with us. (CHSP2)

There is a difference between community pharmacists (case of CPs) and NHS pharmacists (cases of HPs, MHPs and CHSPs) in terms of the extent they are able to undertake 'checking' of prescriptions.

Community pharmacists (case of CPs), who have no access to patients' medical records or blood tests results, and who also do not work within the same organisation as GPs, talk of having to make educated guesses when 'checking' prescriptions or when counselling patients on their medicines:

You then have got the diagnostic side of it. What are they [doctors] actually treating them [patients] for? You actually have to make educated guesses quite a bit of the time. (CP4)

This is sometimes compounded by patients not being present in the community pharmacy. Instead community pharmacists have to relay information via a third party such as a carer or via a telephone call or by making small additional notes sent with the medicine:

We have not got the patient in the shop an awful lot of the time and so relaying information to carers and things can be quite difficult. (CP1)

In contrast NHS pharmacists (in the cases of HPs, MHPs and CHSPs) have access to medical and nursing staff, patients' medical notes, laboratory results and patients themselves when checking prescriptions. NHS pharmacists report that their pharmacy practice contributions mainly take place in a professional clinical environment such as on the inpatient wards as opposed to the hospital pharmacy dispensary:

I feel my contribution lies really on the wards. (HP1)

This allows NHS pharmacists to undertake what they refer to as 'clinical checking or screening' of patients' drug charts, which they consider forms part of their clinical pharmacy practice.

NHS pharmacists (in the cases of HPs, MHPs and CHSPs) feel they are often reactive in their approach but are working on being more proactive by interacting with medical doctors at the point a prescribing decision is made:

We are reactive but sometimes we are proactive as well. (HP5)

Pharmacists explain that being on the inpatient wards allows them to interact with prescribers on a daily basis to influence doctors' prescribing decisions.

I input into prescribing decisions on a daily basis. (HP4)

This includes pharmacists attending consultant-led ward rounds where they explain they were able to intervene and participate in prescribing decisions:

You would like pharmacists to be there at the point of prescribing so they can advise and screen the prescriptions and generally intervene at an early stage rather than wait until the patient has had the wrong drug. (MHP2)

I make my interventions and so on and recommendations at that point [during the consultant led ward round]. (MHP5)

NHS pharmacists (in the cases of HPs, MHPs and CHSPs) talk about undertaking reconciliation of patients' medicines on admission to hospital. NHS Pharmacists refer to the NICE and NPSA technology guidance (2007), *Technical patient safety solutions for medicines reconciliation on admission of adults to hospital*, which helped to endorse the pharmacist's role in leading on this within NHS trusts. This provides them with what pharmacists consider is a clear professional role and responsibility in ensuring patients' medicines are reconciled shortly after they are admitted to hospital by checking patients' drug histories and medicines on

admission. Medicines reconciliation is a technical process as opposed to a clinical process. This means pharmacy technicians also undertake medicines reconciliation:

NICE recognised that in terms of outcomes through medicines reconciliation and said that Pharmacy should be doing that role. (MHP1)

Pharmacists undertaking medicines reconciliation is a way of them 'checking' that in particular doctors have prescribed all the correct medicines for patients on admission:

Reconciling meds [medicines]. I think that things that have been left off the drug chart or have been overlooked then obviously then sometimes they can be quite significant. (HP1)

Pharmacists (in all of the cases) spoke of pharmacists having a different mind-set to other healthcare professionals that allows them to undertake 'pharmaceutical surveillance'. Pharmacists are systematic in their approach when looking for discrepancies or problems related to medicines, talking of having to be accurate when 'checking'. Pharmacists feel having to be accurate all the time is stressful particularly with an increasing workload:

You have to make sure you are extremely accurate, well accurate, well you cannot be extremely accurate. You have to be accurate. (HP5)

This means pharmacists have a tendency to concentrate on the details, because if they make a mistake when checking for example, a prescription, patients can be harmed (e.g., when preparing and checking toxic medicines such as chemotherapy drugs).

Pharmacists' (in all of the cases) mind-set involves finding things that are "not quite right and being able to fix it" (HP2) and to "pick up mistakes that could result in harm to patients" (HP5). They explain it is this mind-set that makes them different from other healthcare professionals when approaching a task such as 'checking' prescriptions:

When I look at a drug chart I am looking at it in a very different way to the way the doctors [are] looking at the drug chart. (HP1)

Pharmacists (in all of the cases) describe this 'mind-set' using metaphors relating to being 'detectives', wanting to find out why something with a patient's medicines

treatment does not seem quite right, explaining that, “for the pharmacist it is around assessing, ‘do I have the whole picture?’”(CP4):

I think that [a] mind-set of being slightly Sherlock Holmes with medicines, wanting to burrow down and find out ‘right what is going on here this doesn’t make sense’ that we [pharmacists] are the people who will have that eye on it. There is nobody else who really raises those questions. (CHSP1)

What I enjoy most is actually solving mysteries and solving problems and knowing that...my work has somehow helped the patient. (CHSP2)

Pharmacists (in all the cases) gave examples where ‘checking’ patients’ prescriptions or medicines treatment has identified issues that had not previously been identified by other healthcare professionals.

Pharmacists in NHS trusts (in the cases of HPs, MHPs and CHSPs) distinguish between pharmacy practice where they have direct patient contact and where they indirectly influence patient care within NHS trusts.

Pharmacists in NHS trusts refer to indirect pharmacy practice as that of establishing systems, processes and procedures for the safe use of medicines within their NHS trust:

The direct stuff, I go to the bedded units, I see the patients and I talk to the patients, I discuss stuff and treatments with doctors and with the nurses, and monitoring and that side of things and that is direct patient contact. What systems do we have in place to reduce risks to patients? It might not be direct patient contact but it is making sure people are using medicines safely, within the law which I forgot to say as well, it has to be legal as well. (CHSP 3)

NHS pharmacists are aware that there are not sufficient resources within the NHS for them to be present on wards at all times. Instead pharmacists have to find ways of working through other healthcare professionals to deliver the relevant pharmaceutical care directly to patients. Pharmacists consider this as a second best option. Pharmacists talk of training other healthcare professionals as a way of them being able “to impart their knowledge and skills to other staff groups” (MHP1):

There is more opportunity for appropriate training of the people who provide direct care and it all fits, it all slots into the safety agenda. (HP4)

There should be sufficient resources to get pharmacists, sort of pharmacy technicians into team levels, into counselling on a one-to-one basis. The alternative is to try to communicate your message to other people who do have that kind of face-to-face contact so they can sell that message too, but that always seems slightly second best. (MHP1)

NHS pharmacists (in the cases of HPs, MHPs and CHSPs) talk about how they directly or indirectly influence or modify the practice behaviour of other healthcare professionals by working with them to develop policies, procedures and prescribing guidelines and also by 'checking' or monitoring that other healthcare professionals follow correct practice through reviewing reported medication incidents, auditing medicines use and prescribing.

NHS pharmacists (in the cases of HPs, MHPs and CHSPs) monitor medicines-use and practice. This can involve reviewing medication errors to detect certain patterns or trends. Pharmacists identify any learning from medication errors, which sometimes involves changes to practice procedures. This change of practice will alter the practice of other healthcare professionals as a way of reducing the risks of a particular medication error happening again. A pharmacist explains that it is about:

Rectifying not just one mistake but trying to see a trend and actually, you know, to change protocols if necessary or change practice. (HP2)

NHS pharmacists talk of monitoring the prescribing of other healthcare professionals. An example is where community health services pharmacists monitor the prescribing of independent non-medical prescribers who will all have stated their scope of prescribing practice on an intent-to-prescribe form held by the NHS Trust's pharmacy team:

We monitor prescribing and if we think they [non-medical prescribers] are prescribing outside their scope of practice, we want them to do things that are safe and legal and within their scope of [their] practice. (CHSP4)

NHS pharmacists explain that if a non-medical prescriber prescribes medicines to patients that deviates from their stated scope of practice on the Intent-to-Prescribe form they will be contacted by a pharmacist who will request an explanation for this deviation in prescribing e.g., "the doctor was on holiday" but that is not a reason for prescribing it [the medicine]!". (CHSP4)

NHS pharmacists (in the cases of HPs, MHPs and CHSPs) also monitor the financial aspects of medicines as part of managing cost within NHS trusts:

Financial management of medicines so making sure we kind of get cost effective use of them. (MHP1)

Pharmacists achieve medicines cost reduction or containment by for example producing formularies or prescribing guidelines often in cooperation with or by influencing consultants:

Managed to get the consultant on board...alendronate is now first line. (HP4)

One of my roles is to save money on inhalers as part of the medicines saving schemes....me and the consultant sort of work together and are still working together. (HP2)

NHS pharmacists talk of restricting doctors' access to certain high risk or high cost medicines. If consultants wish to start a patient on a high risk or high cost medicine they will have to discuss and justify the reason for prescribing this with a clinical pharmacist before the pharmacy dispensary will supply it:

The consultant decided to initiate it [the high risk and high cost medicine] in the patient. He paged me and let me know about the patient. We had a discussion on the phone and I said I would go and review the patient as well, which I did, and checked the liver functions and renal functions to make sure it was appropriate for them to have this medication, as well as checking the drug chart to make sure there was no interaction. (HP3)

NHS pharmacists (in the cases of HPs, MHPs and CHSPs) talk about recording their clinical pharmacy interventions on a pharmacy database as a way of being able to demonstrate and justify to others the impact their ward-based clinical pharmacy practice has on reducing patient harm and improving patient care. Implicit in this is that interventions made by pharmacists are not recorded anywhere else and that these clinical pharmacy interventions are not particularly evident to other healthcare professionals in their interactions with pharmacists:

We improve patients' care and patient outcomes and we have to demonstrate that. That is one of the things about, you know, recording our interventions. We have to be seen to be doing that because somebody will turn around and say 'hang on what is this person actually doing, you know, there is no evidence that they are actually improving patient care'. (HP2)

This can indicate that there is some uncertainty regarding pharmacists' ward-based clinical pharmacy practice contributions as these are not fully embedded and understood by other healthcare professionals and senior NHS management. Pharmacists express concern that with increasing financial pressures being experienced by the NHS there could be the danger that pharmacists will be pushed back into the dispensary and that pharmacists "*will just get bogged down with dispensing and discharges*" (HP1):

My concerns are that if things are getting too tight [financially] we will be pushed back to the dispensary and less on the wards if they cannot see our clinical input. We need to make sure we sell ourselves more and more. (HP5)

NHS pharmacists are trying to link or convert their pharmacy interventions into direct or indirect financial savings to the health economy as a way of demonstrating that the interventions they make can pay for their salary. Pharmacists find it difficult to have to record interventions on top of an already busy job:

You have to keep your evidence to show what contributions you make. That is quite hard to keep that up and together really because you are trying to do your job. You have got so much to do in the hours that you are employed. You have to justify your job really, financial savings, saving your salary to justify it is worth having a specialist pharmacist. (CHSP5)

5.4.2 Sub-theme: The Medicines Police

Pharmacists (in all of the cases) describe being viewed as the "*police*" (CP1), "*policemen*" (CHSP 1) or the "*medicines police force*" (MHP1) by other healthcare professionals. This is related to pharmacists' 'pharmaceutical surveillance' role:

They [other healthcare professionals] consider us policemen because we are the people who tell them they cannot or shouldn't do this and that. I mean that has been my whole professional life and not just here. You are the person who comes in with the big stick preventing them from doing what they want to do. (CHSP4)

Pharmacists do not like to be viewed as the 'police', instead preferring other healthcare professionals to view them as allies by seeking advice from pharmacists earlier:

Your pharmacist isn't your policeman, it is your friend, use them prospectively, ask them first. (CHSP1)

Some of the pharmacists are pragmatic about being viewed as the “*medicines police*” because “*if the police are enforcing the standards*” (CHSP5) then this will help to improve medicines standards by making other healthcare professionals focus on medicines making it safer for patients:

I [have] always seen pharmacists as a bit like when you are driving on the motorway and police cars are there and suddenly everybody slows down and starts thinking about what they are doing. I think that is what that is part of our roles as well when we go to the wards and things. People start thinking about what they are doing and that is kind of human nature, isn't it? Because people get sloppy about things until they think 'Upps pharmacists!' I better do, and then the standards get raised again. (MHP1)

NHS pharmacists (in the cases of HPs, MHPs and CHSPs) have a broader scope of practice than community pharmacists (case of CPs), as they are also involved in developing, implementing and monitoring systems, processes and procedures in setting standards as to how medicines are used within their healthcare organisations including compliance with legal aspects around medicines and national best practice. This aspect of their practice can lead to challenging situations with other healthcare professionals.

NHS pharmacists (in the cases of HPs, MHPs and CHSPs) describe situations where other healthcare professionals view them as preventing them from performing their clinical practice in the way they want to. In this context pharmacists refer to feeling they are being viewed as “*nit-pickers*” (CHSP1) or “*spoilers*” (CHSP4) particularly in situations where pharmacists will challenge how these healthcare professionals have set up their practices or services without having fully considered legal or best practice guidelines or other medicines safety aspects:

I think we are pedantic people who stop things on nit-picking little reasons. No it is not nit-picking stuff, it is safety, is it legal, etcetera. (CHSP1)

This view of NHS pharmacists is difficult for them, because they feel they are working in the best interests of patients, healthcare professionals and their NHS trusts wanting to protect other healthcare professionals by preventing adverse situations occurring, although this view is not always shared by the healthcare professionals they are trying to protect:

When they [other healthcare professionals] involve us at a later stage we seem to be the stop for them because we want to make it safe for them, to cover them, to cover the Trust, to cover the patients and they often fail to see that. They often feel that we are difficult. (CHSP3)

NHS pharmacists (in the cases of HPs, MHPs and CHSPs) feel their work involves a lot of responsibility and accountability but that, unlike the police, they do not possess any real powers to make other healthcare professionals conform to their recommendations. This is frustrating and a demotivating factor for pharmacists. A pharmacist explains that pharmacist's practice "*is lots of accountability and responsibility and no power*" (CHSP4).

5.4.3 Sub-theme: Influencing patients' medicines-taking behaviour

Pharmacists (in all the cases) talk of 'counselling' or providing patients with information about their medicines. Pharmacists believe that if patients understood the reason for taking their medicines they would modify their medicines-taking behaviour and take them as intended. Pharmacists explain that they will 'counsel' patients on their medicines to ensure that:

They have a better understanding of their medicines and why they are taking them so that they are more likely to take them and then that means they hopefully are appropriate medicines so they are going to stay out of hospital and not come in again because of medicines related problems. (HP2)

Medicine counselling of patients includes the pharmacist 'checking' the patient's knowledge and understanding of their medicines such as what they are taking and what their medicines are for. This allows pharmacists to identify any gaps or problems in the patient's knowledge and understanding and to rectify this by providing the required information.

Community pharmacists (case of CPs) have a more formal role in providing medicines information to patients. All community pharmacists participating in this study provide Medicines Use Reviews (MURs) and New Medicines Services (NMS), which community pharmacies are paid by the NHS to deliver. This makes these services more formal, including having to obtain patients' consent and completing paperwork.

Patients generally do not ask for a MUR or to participate in the NMS. Community pharmacists talk of “recruiting” (CP1) patients by approaching them to sign up to receive this service:

I have come out with my clip-board and you can see them [patients] looking and thinking ‘Oh my God what are they going to ask me now’.
(CP1)

Community pharmacists think that this formal approach to MURs and NMS acts as a deterrent for patients:

They have to sign a consent form and because of that a lot will just, you know, dismiss that straight away. (CP1)

A community pharmacist explains that to try to make patients agree to have a MUR is difficult and that it is important to make the MUR feel less formal by appearing to be almost as a normal conversation between two people:

I try to make it more of a conversation with people [rather] than a very formalised process because they tend to immediately run off.
(CP1)

This community pharmacist reflects that generally patients agreeing to participate in the NMS are already compliant with their new medicine. The implication is that the NMS may not target patients who may have problems with their newly prescribed medicines as these patients may be less likely to agree to receive the NMS:

The New Medicines Service I think is kind of preaching to the converted because if you can recruit the patients to take part they are usually the people who are taking their tablets anyway. (CP1)

Community pharmacists report that MURs are generally of benefit to patients:

For patients giving them an explanation of how their medicines work and talking to them about their concerns around medicines. We just need to make it clear that they understand what they are taking and what their (medicines) effect should be. (CP4)

Community pharmacists report that patients often leave the MUR session with more information and knowledge about their medicines:

We often pick up things where people are not taking the right number of doses or they have got the blue and brown inhalers completely mixed up. (CP1)

I would say 90% of the MURs that I do there is something for the patient to take away...something that will give them a bit more knowledge and can be beneficial. (CP2)

In addition to this, community pharmacists are also expected to provide patients with healthy living advice, with the aim of modifying patients' life style:

You are also meant to give healthy living advice and that at the same time. (CP1)

5.5 Theme four: Re-professionalisation strategies

This section is about how pharmacists (in all the cases) try to improve their professional recognition and status. Pharmacists link their professionalism to their work identity as 'drug experts', but generally do not engage with the concept of professionalism and what this means to them or the pharmacy profession. The study data shows that experienced pharmacists are ambivalent about being considered a professional. Pharmacists link this to having to be registered with a regulatory body and complying with standards with the possibility of being removed from the pharmacy register.

Pharmacists aim to enhance their professional status, by pursuing re-professionalisation efforts to extend their scope of practice. These efforts are, (i) delegating routine or mundane tasks such as dispensing to less qualified pharmacy technicians, (ii) increasing their knowledge and skills through education and training and wanting to move from being generalists to specialists to gain recognition or to find ways to maintain their knowledge and skills, (iii) aiming to support or free-up other healthcare professionals' time through delegation to allow them to focus on more complex patients and (iv) identifying gaps in practice that is causing a problem and then closing these gaps. NHS pharmacists (in the cases of HPs, MHPs and CHSPs) and community pharmacists follow different re-professionalisation strategies and to different degrees.

5.5.1 Sub-theme: Professionalism

Pharmacists (in all the cases) consider they are the drug experts and expect other healthcare professionals to recognise them as such:

We are the drug experts. We are the 'drug chart tweakers' and it is really important that patients have the optimal medication. We are people with the expert knowledge so I definitely think we are the experts. (HP2)

You have a set of skills nobody else possesses. The vast majority of treatment options are often, you know, after any form of surgery, the main treatment is medication and that [is] what we are experts in. (CP4)

Pharmacists express their frustration when other healthcare professionals consider themselves knowledgeable on medicines or claim an area of practice that pharmacists consider is their area of expertise. This makes pharmacists want to work with these healthcare professionals as a way of showing them in a non-confrontational way that they may not have the required knowledge:

I have worked quite a bit with OTs [Occupational therapists]. I think we should work a little more closely in particular around the blister pack stuff. That was a big eye opener for me was how much they saw that as their role and we see it in pharmacy as our role. (HP4)

Everybody seems to think they are experts in medicines when they are not because, like I said earlier, they do not know what they don't know. Everybody knows a little bit and they are all an expert. (CHSP4)

Pharmacists (in all of the cases) articulate the importance to them of other healthcare professionals and patients recognising and respecting their expert knowledge and skills, including as pharmacists, “*being proud of what you do and who you are*” (HP4). Pharmacists link this to their own professional standing and therefore status in society, “*that means you should be able to be a bit more of a pillar of society*” (HP4):

It was about my professional recognition and standing. (CHSP3)

Pharmacists associate professionalism with their work identity as “*drug experts*” (HP2) and being “*valued for our expertise around medicines*” (MHP1). They feel frustrated and undervalued if their advice is not considered by others as this questions their integrity as professionals and therefore their professionalism. A pharmacist explains that:

I am respected for that particular knowledge and skill set. I am easy going until somebody questions what I say. It is my professionalism. (CHSP4)

Two pharmacists reflect that professionalism is not something newly qualified pharmacists fully possess as this is learnt through pharmacy practice by observing and working alongside senior pharmacists and other healthcare professionals:

When I was a new pharmacist the people who were my seniors and now retired, it [professionalism] was drip fed through my veins for all those years. (CHSP3)

Growing up in a professional sense...growing up in your job so as you understand that you are responsible for what you do and you are responsible for the consequences of what you do. (HP4)

Conversely, when pharmacists were asked directly about professionalism in relation to pharmacy practice they repudiated that professionalism is an important aspect of their professional life or practice. The reason is that it is not something they have previously thought or reflected on or a concept they have actively engaged with.

Pharmacists' initial responses to the study questions on what it meant to them to be a professional were: *"It is a difficult question"* (HP1), *"I have never thought about it"* (HP3), *"I don't think I can really answer that"* (HP4), *"I don't think about being a professional"* (MHP 1), *"You don't actually give it a lot of thought, you take it for granted"* (MHP2), *"I don't know. Nobody has ever asked me this question before"* (MHP3), *"I found that one [the question] difficult to answer"* (CHSP1), *"It is a tricky one"* (CHSP 5), *"It isn't a huge thing for me"* (CP1), *"In truth it does not mean a lot to be considered a professional"* (CP2), *"To me personally? Not a lot"* (CP5). A few said that they were *"proud to be considered a professional"* (CP3) or *"it does mean a lot to be considered a professional"* (CP4), although they did not elaborate further on this.

Pharmacists (in all the cases) associate being a professional with having to be registered with the General Pharmaceutical Council (GPhC), their regulatory body, including complying with professional standards and regulations as set by the GPhC. During the study interviews, some pharmacists attempted to recollect a verbatim definition of 'a professional', including making reference to sections within the GPhC's *Standards of conduct, ethics and performance* as if this was about a set of predefined rules to be followed. They partly rephrased the open study interview questions into test questions as a way of compensating for being unable to express their own thoughts or views on professionalism in the context of their pharmacy practice and what it meant to them:

What is the definition of being a professional? Being a professional means... (CHSP3)

A pharmacist notes that when it became a statutory requirement for pharmacy technicians to be registered with the GPhC that “*it has not changed their behaviour at all now being a professional*” (CHSP3), implying that pharmacists consider that there is more to being a professional than just being registered with a regulatory body:

I do not feel that being a professional is having a piece of paper that says I am a professional. (CP1)

Pharmacists feel that being a professional is about being held accountable for their behaviour and conduct at all times; “*It is everything that you do whether in work or outside work*” (CP3). For some pharmacists being a registered professional had negative connotations as it was associated with a fear of being held publically accountable for their conduct by the GPhC, including having sanctions imposed on their registration or being removed from the pharmacists’ register:

The prospect of being struck off and I think the humiliation because it would have been put out there wouldn’t it? (CHSP1)

Pharmacists are uncertain if others perceive them as professionals or not. Some pharmacists feel that the general public may not perceive them as professionals because they are mainly familiar with community pharmacists working in retail shops, so not realising or associating them with being registered healthcare professionals:

I do not know that pharmacy itself is particularly perceived as a profession by the general public. (CP1)

Some pharmacists feel that others including other healthcare professionals may not necessarily be aware that pharmacists are registered healthcare professionals:

I am not sure that everybody realises that pharmacists are professionals. (CHSP1)

Other pharmacists, almost as a way of corroborating that others perceive them as professionals, refer to the number of people who ask them to sign their passport photos:

I think pharmacists are considered professionals. You just need to see the number of people who ask me to sign their passport photo. (CP2)

Pharmacists generally perceive that others may not consider them as professionals. This can result in them unintentionally reinforcing others’ views of

them, and makes them think that being a professional is unimportant. Pharmacists perceive that professionals expect to be treated differently to others because they think “*they are better than everybody else*” (CP5), which may create an undesirable social barrier reinforcing their view that pharmacists are no better than anyone else:

We are no more or less than a house-keeper [on the ward]. (CHSP2)

'I am a professional, treat me in a certain way'; it isn't a huge thing for me. (CP1)

Pharmacists' views are based on them trying to establish working relationships with doctors and other healthcare professionals and finding that these healthcare professionals expect to be treated in a certain way. This leaves a social distance between them and the pharmacist with them feeling that other healthcare professionals do not always treat them as professionals. As one pharmacist put it:

Other professional colleagues, it is nice if they do recognise we are working to exactly the same sort of standards and regulations as they are. (CP1)

Community pharmacists gave examples of where they feel their professionalism was compromised but felt unable to challenge this. An example was their employer setting performance targets including having to complete a certain number of MURs. Another one is where prescription-only medicines (POM), which are often used for long-term conditions are made available as 'pharmacy-only medicines' (P-medicines) where the community pharmacists feel they have to comply with their customers' wishes to purchase these even if they professionally considered this inappropriate. They justify this arguing that patients will go to another community pharmacy where they can obtain this product. Pharmacists feel it is regulations that impact negatively on their professional judgement and autonomy:

Anything that somebody potentially is going to take for life is not a good POM to P choice. (CP1)

The experienced pharmacists in this study want to be recognised for their expertise by others linking this to their professionalism. Based on the study interviews the pharmacy profession has not actively engaged with the concept of professionalism in relation to pharmacy practice and what it means to them. Pharmacists are unsure if the public, patients or other healthcare professionals are

aware that they are registered healthcare professionals, which appears to make them uncertain about viewing themselves as professionals. They link being a professional with being registered with a regulatory body and having to comply with certain standards with the fear of being removed from the pharmacists' register, whilst creating a social barrier between themselves and others. The experienced pharmacists in this study, many of whom are involved with training pre-registration pharmacists and more junior pharmacists, are practice role models in terms of professionalism for newly qualified pharmacists, who will be the pharmacy workforce that will be helping to shape and re-professionalise the pharmacy profession of tomorrow. Pharmacists do not use their professionalism as a strategy of informing and re-iterating to others, including the public, of pharmacy's values and obligations in relation to healthcare as part of their re-professionalisation strategies.

5.5.2 Sub-theme: Delegation, education and supporting

Pharmacists (in all of the cases) are following re-professionalisation efforts of delegating their routine work of dispensing medicines to pharmacy technicians and extending their scope of practice. The enthusiasm with which pharmacists are pursue the delegation of the dispensing function is different between NHS pharmacists (in the cases of HPs, MHPs and CHSPs) and community pharmacists (case of CPs), with the latter almost only being at a stage of thinking about the possibility of delegating some aspects of the dispensing process. The re-professionalisation efforts for extending scope of practice are notably different between NHS pharmacists and community pharmacists.

Pharmacists (in all of the cases) support extending their scope of practice further with all reporting feeling underutilised. The barrier to extending their practice is an increasing workload which is their main concern and immediate priority and lack of resources. A pharmacist explains that:

There is a high workload and you have to prioritise your work. (HP5)

Pharmacists find it difficult to rise above their current work-pressures to find the energy and time to think about how to develop their practice further, instead reporting having to constantly “*firefight*” (HP4) and that “*it gets very stressful*” (CP5).

Hospital pharmacists consider that on the wards their clinical pharmacy practice adds to doctors' roles rather than taking some of their work and responsibilities away. A hospital pharmacist speculates that once other healthcare professionals have worked closely with pharmacists they will begin to understand what pharmacists can do. This will result in increased expectations and demands being placed on pharmacists, which they are unable to meet because of a lack of resources:

I think with understanding comes demands and we cannot fulfil those demands. (HP4)

Two pharmacists became visibly upset during the study interviews as it made them reflect on what they described as daily struggles, barriers and work-pressures they have to deal with:

I suppose actually talking about things and facing up to how frustrating everything is. I suppose you just carry on and you don't stop to think about it. (CP5)

Pharmacists (in all of the cases) follow a strategy of delegating work that traditionally was undertaken by them to pharmacy technicians as a way of freeing up their time to undertake more clinical pharmacy activities. This strategy is pursued actively within NHS trusts (in the cases of HPs, MNPs and CHSPs) and to a much lesser degree within community pharmacy.

NHS pharmacists (in cases of HPs, MHPs and CHSPs) explain that on the hospital wards pharmacy technicians work alongside them taking patients' drug histories, reconciling patients' medicines on admission and counselling patients on their medication. These are activities pharmacists also undertake if there is no pharmacy technician to support them. Pharmacists feel that pharmacy technicians improve their "*professional life because they can deal with a lot of the day to day stuff. I do not have to deal with all the necessary mundane things*" (MHP5). Pharmacists are concerned that other healthcare professionals do not distinguish between or understand the differences between pharmacists and pharmacy technicians, "*I am sure they think she is a pharmacist*" (MHP5). Some pharmacists are concerned that this can result in pharmacists gaining less acceptance and recognition particularly as pharmacy technicians will also approach doctors on hospital wards regarding issues related to patients' medicines. A hospital pharmacist is explicit about this concern in a diary entry:

It was decided that after taking drug histories and reconciling medicines, technicians would be able to make interventions directly to the doctor/prescriber. I thought this was inappropriate as there was the possibility of inappropriate referrals and the fact that other healthcare professionals seem to view everybody from the pharmacy as pharmacists and there is no differentiation of status. (Hospital pharmacist, diary)

Hospital pharmacists (case of HPs) talk of having relinquished control over the hospital pharmacy dispensary to pharmacy technicians:

Us clinical pharmacists have no power over the pharmacy dispensary. (HP2)

This meant hospital pharmacists have to spend less time working in the hospital pharmacy dispensary and can spend more of their time on the wards:

We have a [pharmacy] technician-led dispensary to do all the dispensing and checking so actually I can use my expertise differently. (HP1)

Hospital pharmacists explain that having a pharmacy technician-led hospital pharmacy dispensary can result in inter-professional friction. A hospital pharmacist describes it as “*very black and white in the dispensary*” (HP1), giving the impression that pharmacy technicians in the hospital pharmacy dispensary are rigidly applying their internal technical processes, not always understanding the clinical aspects relating to patient care and not prioritising processing medicines in response to individual patients’ clinical needs. A hospital pharmacist explains that, “*sometimes I almost have to give sob-stories to the [hospital pharmacy] dispensary in order to get something done quickly*” (HP1). This delegation of work to pharmacy technicians is still considered a positive development by hospital pharmacists as it frees them up “*with pharmacists actually having more of a clinical role. That is the way to go*” (HP5).

Community pharmacists (case of CPs) express concern regarding pharmacy technicians taking over part of their role feeling that “*our pharmacists’ role has been kind of diluted a little bit*” (CP2). The overall impression is that community pharmacists have not delegated work to pharmacy technicians to the extent this is happening in NHS trusts, with community pharmacists still being physically present in the pharmacy dispensary undertaking the majority of the dispensing activities unlike hospital pharmacists who spend their time on the wards instead.

Pharmacists appear to be ambivalent about delegating work to pharmacy technicians. On one level delegation has enhanced their professional life by freeing them up to concentrate on the more clinical aspects of their practice and at another level pharmacists express scepticism that this can adversely impact on how they are perceived by other healthcare professionals who do not differentiate between pharmacists and pharmacy technicians. This can reflect less favourably on pharmacists, affecting their professional status. Although pharmacy technicians now share some pharmacists' tasks, this has not freed pharmacists up to develop their clinical roles further but has instead allowed them to do more of what they are already doing due to the increasing workload with the only difference being they are working less in the hospital pharmacy dispensary:

I would love to develop my role into a bit more of a specialist role but at the end of the day the service calls and we have got to provide a core service with providing medication. So how are we supposed to push ourselves forward as a respected profession when we are stored away in the dispensary all the time? I think that will be a challenge but I think the attitudes are there...but perhaps not the resources. (HP1)

NHS pharmacists (the cases of HPs, CHSPs and MHPs) pursue re-professionalisation by being recognised as clinical specialist pharmacists in a particular area. This is reflected in those pharmacists completing formal post-graduate courses. In addition they can also belong to external specialist interest groups, for example being members of the UK Clinical Pharmacy Associations which have several clinical specialist interest sub-groups. Specialist interest groups allow pharmacists to be part of a network working in similar clinical specialist areas as a way of sharing problems and resources and updating each other's clinical practice.

NHS pharmacists (in the cases of HPs, MHPs and CHSPs) talk of having strategies of not only refreshing knowledge, but describing a process of adding new knowledge by specialising in a particular clinical area, the motivation being to increase their professional recognition, autonomy and status:

It is really important to me to be up-to-date and to be up-to-date with the latest kind of news, what is actually happening now rather than relying on things that I think I used to know...I like having knowledge that no one else has really. I can say I like to be at the front of knowledge. (HP4)

Pharmacists (in the cases of HPs, MHPs and CHSPs) are disappointed that the introduction of consultant pharmacist roles has not taken off as expected or been built into pharmacy career structures or appropriately funded within the NHS. Instead clinical pharmacists wishing to progress up the pay-scale explained they would have to “go into a bit of a management role” (MHP1):

A clinical kind of consultant role really hasn't happened in a way that I would have liked, you know, a clinical consultant post. (MHP 1)

NHS pharmacists associate being a consultant pharmacist with increased clinical autonomy and professional recognition, implicitly including increased professional status. A hospital pharmacist has aspirations about being a consultant pharmacist:

I want to be the master of my universe basically...my ambition is to eventually achieve a consultant pharmacist level in my specialism and my motivation is to gain enough...practice-based knowledge as well as clinical knowledge to be able to achieve that level of practice. (HP3)

Another pharmacist is working towards being formally recognised as a pharmacist with special interests:

I am currently battling to get accredited as a pharmacist with special interests. I am having problems with getting the accreditation panel together and the validation documents. (CHSP5)

NHS pharmacists (in the cases of HPs, MHPs and CHSPs) think that in the future there will be a greater need for their medicines expertise in a supporting role to doctors. This is due to more medicines being available and an increasing number of patients with complex medical conditions. Pharmacists feel that doctors will not be able to retain all the relevant knowledge and information about medicines and will therefore rely to a greater extent on pharmacists to support them with their prescribing decisions once a diagnosis is made:

Medicines are becoming ever more complex. The range of medicines that people take are becoming ever more complex and doctors at all levels need to have a sounding board to give them advice on safe prescribing. (MHP3)

An example of pharmacists' clinical pharmacy skills being utilised to support doctors with more complex medicines regimens is where a clinical medication review pharmacist is employed by a clinical specialist department. This clinical medication review pharmacist is based with and is part of a multi-disciplinary team led by a consultant.

This pharmacist has access to patients' medical notes and is undertaking regular clinical medication review clinics which patients will attend. This pharmacist works closely with the consultant to review and discuss patients' treatments and medicines regimens utilising the pharmacist's expertise:

I have direct patient involvement...medication review clinics with patients that are prescribed [specialist] medicines...meeting patients that are newly diagnosed and on to treatment, pregnant women that need to go on to treatment, and all those that are having problems with their medication. (CHSP5)

This clinical medication review pharmacist explains being viewed by the multi-disciplinary team as, "I am seen as an entity on its own" (CHSP5), but that, "I am certainly not pushed to do anything that isn't pharmacy related" (CHSP5). This pharmacist talks of supporting the consultant with decision-making around complex medicines regimens for patients:

I have had an email from the consultant asking me about interactions...given me a list of all the GP medication they are on, the proposed medicines regimen they want to put them on, what problems can I see with those. (CHSP5)

Community pharmacists (case of CPs) do not pursue the same re-professionalisation efforts as the pharmacists in NHS trusts (the cases of HPs, MHPs and CHSPs) of increasing and improving their clinical pharmacy knowledge and skills. Community pharmacists' employers did not appear to fund external professional development opportunities for their employees. Community pharmacists were finding it difficult to maintain their required continuing professional development (CPD) as this has to be carried out in their own time. In terms of attending an evening education event a community pharmacist explains:

When you have had a long day it is quite hard to get motivated...even if you have got the motivation it is also how awake you are when you are there. (CP1)

Community pharmacists use other strategies to maintain their knowledge such as, "try to embrace any of the new services" (CP1) or be pre-registration pharmacy student tutors as a way of "pushing myself further" (CP4).

In addition, community pharmacists talk of supporting GPs further by being able to increase their ability to diagnose and treat self-limiting minor ailments by being

available to patients without an appointment, explaining that “*people do not have to wait for it and I think that is really important*” (CP2):

We do kind of minor diagnosis for certain things because otherwise we would be sending people to the doctor for everything, which would be a nightmare. (CP2)

Community pharmacists talk of patients presenting in the pharmacy where they are able to make the diagnosis but have to refer the patient to the GP for a prescription because it is not legally possible for them to initiate treatment for the patient without a prescription. A community pharmacist gives an example of this:

I firmly believe that trimethoprim 3 days' supply should be available for ladies with uncomplicated cystitis. I don't think that would be the end of the world because all the people standing in there referring [to the GP] every single one will come back with a script in their hand. (CP1)

Community pharmacists explain that if the legal category for more prescription-only (POM) medicines used to treat self-limiting conditions is changed to P (pharmacy only) medicines, this would allow them to undertake minor diagnoses and provide treatment without referring patients to the GP:

Chloramphenicol was a good one...it means people can start treatment straight away. (CP1)

Community pharmacists' motivation appears to be about helping patients by providing a good service, utilising their qualifications and helping GPs by freeing up their time to focus on more complex cases. However, community pharmacists also talk of there being competition or “*a certain rivalry in terms of what services are provided from pharmacies and which ones GPs are going to do*” (CP1). GPs view community pharmacy as taking services and income away, as opposed to helping them:

I do not know if we are seen to be backing them up so much as taking away some of their jobs. (CP1)

Community pharmacists feel that they are healthcare professionals who have more contact with patients than any other healthcare professionals. This provides them with opportunities to take on some of GPs' work in managing chronic, long-term conditions. It is unclear if this is a view that is shared by GPs considering the rivalry between the two professions and the isolation of community pharmacists from the rest of the primary care team:

The stuff that GPs are dealing with at the moment, they can become more specialist and actually the bottom line of a large chunk of that can be taken over by community pharmacy and nursing. (CP4)

A community pharmacist implies that GPs generally have stopped pharmacists extending their roles, by not supporting various proposals for them to take on more formal services.

5.5.3 Sub-theme: Competing with nurses for new jurisdictions

Some pharmacists (in all of the cases) aspire to become independent prescribers or they are already qualified prescribers (in the cases of HPs, MHPs and CHSPs only). Pharmacists see this as a way of expanding their professional role and saving doctors' time.

Although pharmacists do not express this explicitly, there is implicitly a view expressed that GP practice nurses or specialist nurses in hospitals have started to take on roles where pharmacists feel their knowledge and skills around medicines could have been utilised instead. Pharmacists are finding themselves in competition with nurses over extending their roles into prescribing. Pharmacists have little respect for nurses' knowledge around medicines:

Nurses do not have a lot of education on medicines. (CHSP4)

Specialist nurses see patients and provide recommendations about their medical treatment, which doctors may follow by prescribing the recommended treatment. Pharmacists are in a position where they may question a doctor about a prescribed treatment and the doctor may say they just followed the specialist nurse's recommendation, not taking responsibility for their own prescribing. A pharmacist gave an example of a specialist nurse attending a ward, who recommended that the doctor should prescribe an additional medicine not realising or recognising that the patient had already been prescribed this medicine:

The specialist nurse was there [on the ward] being a bit snooty and ignoring me. She asked the doctor to cover [the treatment] with a PPI [proton pump inhibitor] which was fine but the patient was already on a PPI so it was therapeutic duplication. (CHSP4)

Pharmacists do not consider that nurses have sufficient knowledge about medicines, and yet they are increasingly finding themselves in positions where they need to discuss nurses' treatment decisions or recommendations with them or with doctors who prescribe what specialist nurses have recommended. They

also find themselves having to compete with nurses who extend their practice into prescribing. For example a hospital pharmacist, qualified as a supplementary prescriber, had been unable to work as a prescriber in a specialist clinical area partly because of being required to work in the pharmacy dispensary and partly because a specialist nurse was already employed to work in this specialist clinic prescribing for patients. The consultant preferred the nurse to run the clinic instead of the pharmacist because the pharmacist would not be fully integrated within the clinical department in the same way the nurse prescriber was. This pharmacist continued to explore ways of being able to be part of the specialist clinics to see patients and prescribe their treatment. Instead of the pharmacist viewing the extension of practice as freeing up the doctor's time, this pharmacist was now relating this as freeing up the nurse's time by the nurse delegating a clinic to the pharmacist so she could focus on seeing patients with more complex needs:

The nurse may want to just give up the [name of specialist treatment] clinics [to me] so this may free her up to do other work. [Name of specialist treatment] clinics tend to be quite routine so the pharmacist could take that. (HP5)

NHS pharmacists (in the cases of HPs, MHPs and CHSPs) feel that being independent prescribers would be a natural progression for them when checking or screening prescriptions on the inpatient wards. It would allow them, when checking prescriptions, to correct any prescribing errors or discrepancies themselves without having to contact the doctor. Pharmacists believe that this will ensure patients' prescribed medicines are correct, utilising their clinical knowledge and skills, including providing them with more clinical autonomy as they will not need to spend their time contacting the doctor to amend prescriptions. Pharmacists do not view this development as taking anything away from doctors but more as a way of freeing up their time and supporting to their roles:

I am writing things on drug charts and then shoving them under the doctors' noses, so I am in effect prescribing without being a prescriber. I need to be able to prescribe. (HP4)

Sometimes all you need to do is to cross out one thing [on the drug chart] and write it correctly. (MHP5)

Pharmacists (in the cases of HPs and MHPs) explain that they are often dealing with junior doctors who have limited knowledge around medicines. When pharmacists check medicines prescribed on the inpatient prescription charts and

identify that a medicine either needs to be prescribed, amended or stopped they often have to approach junior doctors for these changes to be made. They are in the perverse situation where they themselves are more competent in making these prescribing decisions:

We are looking at the prescribing of junior doctors who have not got the expertise that we should have as senior pharmacists...we are helping them to prescribe. (HP2)

NHS pharmacists (in the cases of HPs, MHPs and CHSPs) explain that doctors remain in control of their prescribing rights. This was illustrated by a trust where consultants decided that independent prescribers such as nurses and pharmacists could only work as supplementary prescribers. They can therefore only work according to approved clinical management plans signed off by doctors. Doctors within this trust limited the scope of non-medical independent prescribers' practice by removing any need for them to make any diagnoses:

They [doctors] do not support independent prescribing, only supplementary. (MHP5)

5.6 Theme five: Two different professions

This theme is about a potential split within the pharmacy profession between community pharmacists and pharmacists working in NHS trusts.

The study interview questions did not directly ask pharmacists about their perceptions of pharmacists working in other healthcare settings. NHS pharmacists (in the cases of HPs, MHPs and CHSPs) offered their opinion on community pharmacists basing this on their experience of working or having worked as locums in community pharmacy or of their general perception of community pharmacy. They are dismissive of their community pharmacist colleagues' knowledge and skills.

The data analysis shows that the recurrent discussion of pharmacists' practice of dispensing medicines is also the part of pharmacy practice that is considered uninteresting and a poor use of pharmacists' knowledge and skills. NHS pharmacists (in the cases of HPs, MHPs and CHSPs) are in the process of moving away from dispensing, which they consider to be a technical function by transferring their jurisdiction of this function to less qualified pharmacy technicians,

allowing them to concentrate on utilising and developing their clinical pharmacy practice. In contrast community pharmacists are perceived to spend the majority of their time dispensing medicines and not having developed their practice much beyond that. This gap in pharmacy practice between community pharmacists concentrating on dispensing, as distinct from clinical pharmacists in NHS trusts, appears to be creating a split within the pharmacy profession as these pharmacists have little in common in terms of their practice. This is producing almost two different professions. Community pharmacists and hospital pharmacists do not work across the interface for the benefit of patients.

These differences in pharmacy practice have reduced the mobility of pharmacists between healthcare settings, with community pharmacists lacking clinical pharmacy knowledge and skills to easily transfer into working in NHS trusts, unless they start at a junior pharmacist level accepting a pay cut.

5.6.1 Sub-theme: Community pharmacists as dispensers

NHS pharmacists feel that community pharmacists do not utilise their qualifications beyond dispensing of medicines, which they view as a technical function as opposed to a clinical pharmacy function. Pharmacists in NHS trusts are disappointed that community pharmacists have not developed their pharmacy practice into more clinical pharmacy services. They feel this reflects badly on the pharmacy profession as a whole. For example two NHS pharmacists expressed the view:

They [community pharmacists] could have been so much more but I think they are not. (HP1)

Pharmacists in NHS trusts are disappointed that community pharmacists continue to spend the majority of their time dispensing medicines:

An awful lot of very highly qualified [pharmacists] working in community pharmacies perhaps are not using their skills to the best of their abilities and I think is an enormous shame. They don't seem to be seeing further than their dispensing role. (MHP5)

NHS pharmacists (in the cases of HPs, MHPs and CHSPs) think it is a positive development that community pharmacists have started to deliver more services such as Medicines Use Reviews (MURs) and New Medicines Services (NMS), although many of them are unclear what these enhanced community pharmacy

services entail. This did not detract from their view of community pharmacists spending most of their time dispensing medicines.

NHS pharmacists feel that professionally there is a big difference between themselves as clinical pharmacists where most of them have a post-graduate clinical qualification compared to community pharmacists who they do not think of as clinical pharmacists. NHS pharmacists do not feel that community pharmacists have the clinical knowledge and skills they themselves possess and they do not work in a clinical environment, instead working in a retail shop. A pharmacist explains that:

It is rare that you come across community pharmacists who have already got a clinical qualification or diploma or something. (MHP5)

None of the community pharmacists in this study had any post-graduate qualifications.

NHS pharmacists (in the cases of HPs, MHPs and CHSPs) base their views of community pharmacists by having come across examples of what they refer to as poor pharmacy practice. This includes community pharmacists not having undertaken basic checks of prescriptions resulting in patients receiving a medicine dose that was either ineffective or too large over an extended period of time. They feel this is letting patients and the pharmacy profession down. Speaking about coming across examples where community pharmacists have not checked the prescription properly, this pharmacist explains that:

My second thought might be blimey what is the doctor doing or my initial thought would be where is the pharmacist? (CHSP2)

NHS pharmacists do not expect community pharmacists to have clinical pharmacy knowledge. They do expect them to be able to undertake some basic checks of prescriptions. They suggest that community pharmacists as part of their check of prescriptions as a minimum should look the medicines up in the British National Formulary if they are unsure about a medicine dosage so patients receive the correct dose.

These examples of poor pharmacy practice by community pharmacists led NHS pharmacists to question the value of community pharmacists:

I do not expect them [community pharmacists] to have clinical knowledge and skills but if you are not doing the basic of basic then what is the point of being a pharmacist? (CHSP 2)

NHS pharmacists (in the cases of HPs, MHPs and CHSPs) express the view that they do not consider community pharmacy to be a valuable profession. The implication is that community pharmacists are not fully accepted by them as being part of the pharmacy profession:

Pharmacy is a valuable profession...I do not think in community [pharmacy] it is. (HP1)

There is a feeling that community pharmacists reflect badly on the pharmacy profession as a whole:

I get really furious with that because that is my profession. (CHP2)

A hospital pharmacist who also works as a locum in community pharmacy feels that community pharmacy does not deliver value for money for the NHS due to undertaking MURs on patients which are not required in order to claim the NHS fee. This hospital pharmacist explains experiencing being pressurised to undertake a MUR when working as a locum in a community pharmacy:

If you have a store manager in there going, put so and so in the consultation room so you can do an MUR. They want me to do an MUR on a 23 year old who just had two drugs. I don't think that provides the NHS with value for money. It devalues those services. (HP1)

There appears to be a deep divide in the pharmacy profession, with community pharmacists being considered to be almost a completely different profession although there is still an acknowledgement that community pharmacists are part of the pharmacy profession. A NHS trust pharmacist concludes that:

I think that they are almost distinct professions. Community pharmacy is completely different to hospital pharmacy. (MHP3)

The data analyses show that there is an intra-professional split within the pharmacy profession. NHS pharmacists (cases of HPs, MHPs and CHSPs) consider that community pharmacists belong to a separate profession compared to the rest of the pharmacy profession. This is due to the differences in pharmacy practice between pharmacists in NHS trusts and community pharmacists. They have not managed to develop their clinical pharmacy practice, they are working in a retail shop which is a non-healthcare environment, they are not part of any multi-

disciplinary teams and there are times when community pharmacists do not get the simple dispensing of medicines right by undertaking basic checks to ensure patients are safe. A pharmacist summarised that:

The core of community pharmacy is still dispensing and some pharmacists have chosen to concentrate on that. (HP3)

5.6.2 Sub-theme: Reduced mobility between healthcare settings

Pharmacists (in all of the cases) initially express the long-held historic belief that because all pharmacists possess similar basic knowledge and skills that this allows a certain degree of mobility of pharmacists between the different healthcare settings. On reflection pharmacists realised that it is not easy to move between healthcare settings particularly for more experienced pharmacists who have worked within a particular healthcare setting for some time:

I think it is possible but I do not think it is easy. (MHP5)

To me that would be a major decision to swap, as you get older you have so much experience in one particular field, maybe mental health would not be such a big difference. (CP1)

NHS pharmacists (in the cases of HPs, MHPs and CHSPs) talk of different grades of pharmacists from junior training grades to more experienced clinical pharmacists to chief pharmacists leading a pharmacy team. There is an expectation that senior NHS pharmacists will have obtained a post graduate diploma in clinical pharmacy or similar qualification which is considered “a good foundation” (HP5) for clinical pharmacy practice.

In sharp contrast community pharmacists (case of CPs) explain that there generally is no career grade of pharmacists or any expectation, or investment by their employer, for them to undertake further formal study such as a post-graduate diploma in clinical pharmacy. Instead community pharmacists are able to start as a pharmacy manager on the day they registered as a pharmacist. A community pharmacist explains that:

I graduated on a Friday and started my first manager job on the Monday. (CP1)

Community pharmacists (case of CPs) are aware that if they are to transfer to working within a NHS trust they will need to start at a junior pharmacist level:

Transferring from a store [community pharmacy] to come in to do ward rounds is a huge change besides hospital pharmacists are not paid as well as community pharmacists. (CP3).

An example was given of community pharmacists transferring into mental health having taken a pay-cut as they were unable to work at any higher pharmacist pay-grade due to not possessing the relevant contextual theoretical and practical clinical pharmacy experience, knowledge and skills to do so:

We have taken two community pharmacists. They both took a £10,000 pay cut to come and join us. (MHP3)

These community pharmacists lacked formal clinical pharmacy post-graduate training and previous experience of working in a particular healthcare setting. A pharmacist explains that community pharmacists will require further training before they are able to practise at a more senior clinical pharmacy level:

If I do take somebody who comes to me without the full knowledge and skill I need, then obviously there is a lot of work to bring these people to the point where we think 'yes they are practising at a level we are happy with'. (MHP5)

Pharmacists (in the cases of MHPs and CHSPs) explain that they have worked within another healthcare setting such as an acute hospital trust before transferring into working in mental health or community health services. The reasons are that these healthcare settings only employ a limited number of pharmacists, therefore they do not have the pharmacy infra-structure to support the early training of pharmacists such as pre-registration pharmacists for the first years after registration with the GPhC:

We don't have pre-registration pharmacists. They are either in community pharmacy or acute hospitals. They spend one week with us a year. We are unable to take band 6 pharmacists [newly qualified pharmacists] so we have to wait until they want to specialise and it is at that point we can attract and recruit them. (MHP3)

The investment in the early training and careers of pharmacists, who then transfer into mental health or community health services, comes mainly from acute hospitals. These pharmacists will often have completed a postgraduate certificate or diploma in clinical pharmacy before transferring into mental health or community health services:

We have to wait until somebody effectively has got a certificate in clinical pharmacy. (MHP3)

Pharmacists (in the cases of MHPs and CHSPs) explain that in addition to the knowledge and skills required to be considered a clinical pharmacist, they are also required to have contextual knowledge and skills pertaining specifically to the healthcare setting in which they work. A pharmacist explains that:

The knowledge and skills that you have to have to work in mental health compared to even working in the acute trust can be different. (MHP5)

These contextual knowledge and skills are described (in the cases of MHPs and CHSPs) as pharmacists having to adopt a different mind-set. Pharmacists (in the cases of MHP and CHSPs) had themselves experienced this initial lack of contextual knowledge when they moved from working in an acute hospital into either mental health or community health services, respectively:

There is a mindset of acute which is, you are trying to get people out of hospital quickly, whereas we [mental health] are much more long-term, therefore a longer journey. So that is a bit of a challenge that people have to kind of think about that kind of mind-set, but a lot of the skills are transferable and certainly around patient safety and so on. (MHP1)

In terms of moving into community health service, I was a bit cocky about 'oh yes this is exactly the same' and very quickly found myself [like] a rabbit in the headlights. It is very different. It is a different mind-set, you have to think differently. (CHSP1)

This indicates that in addition to pharmacy knowledge and skills, there are different types of 'mind-sets' pharmacists need to adopt reflecting the healthcare setting. These contextual knowledge and skills reflect the types of patients, clinical services delivered and how the different staff groups of pharmacists interact within a healthcare setting. It can take some time for a pharmacist to adopt to this required 'mind-set' when transferring into a healthcare setting they are unfamiliar with.

Due to differences in the clinical knowledge and skills and contextual knowledge and skills related to specific healthcare settings, including the different medicines and medicines management issues related to a specific healthcare setting, pharmacists developed and joined specialist pharmacists' interest groups allowing them to link-in and network with pharmacists who work in similar healthcare settings to themselves. This was to help address these particular issues but also

as a way of seeking recognition for their acquired contextual or clinical specialist knowledge and skills.

For example, mental health pharmacists (case of MHPs) are members or associate members of the College of Mental Health Pharmacy, “*because it is a really useful network in terms of sharing, a lot of value in terms of collective working, an opportunity to share and learn*” (MHP1).

These special interest groups act to further differentiate between pharmacists working within different healthcare settings or clinical specialities, increasing the requirements for formally demonstrating their contextual and specialist knowledge and skills that implicitly are designed to recognise these pharmacists as specialists. This is implicitly a barrier that makes it more difficult for pharmacists to transfer between the different healthcare settings unless they are prepared to start at a more junior pharmacist level:

The College model is around giving accreditation to pharmacists who work in mental health, it is kind of a badge. It is badge that says it is a quality standard, saying if you have achieved this people recognise that. (MHP 1)

For NHS pharmacists (in the cases of HPs, MHPs and CHSPs) there is an underlying assumption that they can always work in community pharmacy as a fall-back position or as part of planning retirement by undertaking locums in community pharmacy. These pharmacists thought they would only require limited training mainly related to technical processes to be able to work in community pharmacy:

I have always got that [community pharmacy] to fall back on. (CHSP 5)

If I were to go into the retail sector, community pharmacy, I would probably need a bit of training before I was fully competent. (HP3)

5.6.3 Sub-theme: No collaboration across healthcare settings

Pharmacists (in all of the cases) in this study came across as dedicated professionals, motivated by improving patient safety and care:

Knowing that I am helping making the patients better, that I am making a difference to the patient's life and patient's healthcare...it is the end user that motivates me. (HP1)

The impression is that the majority of pharmacists (in all of the cases) as professionals are inward-looking in the sense that they are mainly concerned with their own every-day problems and issues within their own working sphere. Pharmacists (in all of the cases) do not come across as reflecting on their role or place within this working sphere or within the wider healthcare context.

The data analysis shows that pharmacists (in all of the cases) are busy and over-worked professionals. This can partly explain why pharmacists' views of the profession is mainly based on or limited to their own working sphere as there is no time for them to reflect on this during their daily work.

Pharmacists (in all of cases) do not appear to consider the future direction of the pharmacy profession including what the potential future options or threats could be. Pharmacists feel secure in their belief that there will always be a need for pharmacists and that they will always be able to get a job:

I am never worried about being out of a job, never given it any kind of thought. I think pharmacists are going to be fine at least in my lifetime. (HP2)

I do not think we will ever be replaced by robots because I do not think they will be able to do the same job. (CP2)

The main external concern expressed by pharmacists (in all of the cases) is the increasing number of pharmacy students being accepted by universities and the impact this may have on future pharmacist jobs:

The increase in the number of [pharmacy] students coming out of university has had a huge impact on the sort of job numbers that are available, [they are] actually going to struggle to find a job. (CP1)

It concerns me that we have 67 applications for three band 6 [junior pharmacists] posts. (HP1)

Pharmacists (in all of the cases) imply that they are working with pharmacists from other healthcare settings although on exploring this further it was apparent that this is not generally the case but appeared to be a matter of wishful thinking.

Based on the study data, the overall impression is that pharmacists (in all of the cases) do not collaborate or communicate with other pharmacists across organisational boundaries in any systematic or consistent manner related to

patient care, for example regarding the transfer of patient care from one healthcare setting to another. A hospital pharmacist reflects that:

We should be thinking we are all pharmacists and we are there to communicate and to work with other pharmacists in the other sectors. It should be possible. I think there is not enough joined up businesses, sort of communication and joined up care. (HP2)

Although pharmacists (in all of the cases) are motivated by improving patient safety and care this view seemed to be limited to the healthcare setting in which they themselves work. Pharmacists have limited understanding of other healthcare settings than the one they work in.

Pharmacists are busy professionals that have limited time to reflect on their pharmacy practice and their place within the healthcare setting in which they work. This leaves the impression that pharmacists working within a particular healthcare setting are focused on their own limited working sphere making them seem insular professionals who are inwardly-looking and lacking a wider perspective of healthcare.

5.6.4 Sub-theme: Clinical versus dispensing pharmacists

NHS pharmacists (in the cases of HPs, MHPs and CHSPs) differentiated between two different types of pharmacists: clinical pharmacists and pharmacists mainly involved in dispensing medicines. They consider the latter a technical function that can be taken over by less skilled staff such as pharmacy technicians, “*generally techs [pharmacy technicians] can do that*” (HP4).

NHS pharmacists wish to move away from working in the pharmacy dispensary as this takes them away from their clinical pharmacy practice.

NHS pharmacists explain that they are in the process of relinquishing control over the pharmacy dispensary giving this control to pharmacy technicians:

We have a [pharmacy] technician-led dispensary to do all the dispensing and checking so actually I can use my expertise differently. (HP1)

Pharmacists (in cases of MHPs and CHSPs) gave examples of already having formally separated the clinical pharmacy and medicines supply functions by contracting out the dispensing and supply of medicines to external providers (e.g., community pharmacies or acute hospital trusts). These NHS trusts have chosen to

directly employ pharmacists and pharmacy technicians to provide the clinical pharmacy functions:

...the set-up we have got in our trust with all of the clinical roles of pharmacists and pharmacy technicians is carried out in-house. Everything else has been contracted to somebody else. (MHP3)

This separation of the clinical pharmacy and medicines supply functions allows pharmacists (in the cases of MHPs and CHSPs) to focus on the clinical pharmacy aspects of their pharmacy practice, although they report that they “*sometimes act as a kind of go between, sometimes, between nursing staff and the [name of community pharmacy]*” (MHP3). Pharmacists (in the cases of MHPs and CHSPs) explain that other healthcare professionals, in particular nursing staff, do not fully understand this set-up and will still contact the pharmacy staff regarding medicines supply. A mental health pharmacist explains that being contacted about medicines supply was almost pointless as this pharmacist had nothing to do with the medicines supply function:

I sometimes think they [nursing staff] do not understand for instance the way we work. That they ring me up to tell me they haven't got the [medicine] order through from the dispensary isn't going to help them one bit. I haven't got any access to the pharmacy dispensary so to speak. (MHP5)

Pharmacists (in the cases of MHP and CHPS) explain that hospital pharmacists cannot comprehend this complete separation of the clinical pharmacy and medicines supply functions:

The pharmacy team in the acute [hospital] trust that we have integrated with cannot understand that we do not have a [pharmacy] dispensary. (CHSP1)

Pharmacists (in the cases of MHP and CHSPs) speculate, as some acute hospitals have already contracted out their out-patient dispensing to community pharmacies, that it may not be long before acute hospital trusts also will contract out their inpatient medicines supply and dispensing functions to be managed by external providers. They consider that this set-up will allow pharmacists and pharmacy technicians employed by NHS trusts to focus on their clinical roles on the wards, spending more time on patient activities instead of spending or wasting their time on being involved in medicines supply and dispensing activities:

The actual dispensing process is a fairly simple straightforward process. I think that acute hospitals will hive off the [medicines] supply operations to commercial operations. (MHP3)

A hospital pharmacist predicts that in the future a new pharmacy role will evolve with the remit of focusing on the medicines dispensing and supply function with other pharmacists developing their clinical pharmacy practice by completely moving away from medicines supply. The result will be two separate professions:

We might end up with kind of more prescriptionist-type people. That side of the pharmacy role I just do not do any more. I am firmly into the clinical side. (HP4)

5.7 Summary

This chapter addresses the findings from the collective case study by drawing on the theories of the sociology of the professions. The overarching themes presented in this chapter were unexpected and not anticipated from the outset.

There are differences in pharmacy practice between pharmacists employed by the National Health Service (NHS) trusts (i.e., the cases of HPs, MHPs and CHSPs) and pharmacists employed by community pharmacies (the case of CPs).

There are more subtle differences between the three cases of HPs, MHPs and CHSPs as they all work for NHS trusts. Most NHS pharmacists gained the foundation of their clinical pharmacy experience in hospitals before moving into mental health or community health services. When referring to these three cases 'NHS pharmacists' is used.

The hidden healthcare profession: NHS pharmacists (i.e., the cases of HPs, MHPs and CHSPs) are aware that the public and patients view them as community pharmacists. The public associates community pharmacists with 'retail' shops linked with the images of shopkeepers and sticking labels on boxes. Patients are often surprised to meet pharmacists on inpatient wards, and when they do often consider they are there to supply them with medicines. Patients are unaware of NHS pharmacists' involvement in their care. The only minor exception to this is some long term mental health patients with frequent admissions to inpatient mental health wards who after a while get to know the mental health pharmacists.

Community pharmacists spend the majority of their time dispensing. Hospital pharmacists undertake activities on wards previously undertaken in the pharmacy dispensary. In all the cases pharmacists are associated with the dispensing and supply of medicines, being aware that this is the most important aspect of their practice for patients to receive their medicines on time. It is this act of their practice that is known and visible to others. Community pharmacists feel that the physical space of a community pharmacy is not a place to deliver certain healthcare services, viewing patients as customers. Community pharmacists experience dissonance between them managing a commercial retail shop and their role as pharmacists.

Pharmacists in all the cases complain of a lack of visibility in the media. The act of dispensing is not considered to form part of patients' healthcare. Pharmacists' contributions to patient care remains invisible to the public. This makes pharmacists the hidden healthcare profession.

Important relationships: In all the cases the most important relationship for pharmacists is with doctors. Hospital pharmacists (case of HPs) feel a certain freedom when working on wards away from the dispensary. They opt in and out of attending consult-led ward rounds instead of prioritising these. They prioritise checking discharge prescriptions on the wards. Mental health pharmacists (case of MHPs) prioritise attending multi-disciplinary ward rounds thereby contributing to patients' treatment at the point of prescribing.

In the case of community pharmacists (case of CPs) General Practitioners (GPs) do not always respond to their requests. Community pharmacists mainly communicate with GPs through telephone calls via intermediaries such as the GP receptionist or practice nurse.

Although patients are important to all pharmacists, for NHS pharmacists these encounters are often transient and brief. Community pharmacists all want to establish and build relationships with their customers as a way of getting to know them so they will continue to use their community pharmacy.

Community pharmacists deliver formal medicines review services to patients, although there is no demand from patients for these services and GPs tend to ignore the reports sent to them by community pharmacists. Community

pharmacists all have consultation rooms although they prefer to consult with patients at the dispensing counter to retain oversight over the dispensary.

Pharmaceutical surveillance: In all the cases pharmacists talk of checking and screening of prescriptions. NHS pharmacists talk of producing policies, procedures and prescribing guidelines for other healthcare professionals within their NHS trust to follow as well as monitoring and auditing other healthcare professionals' medicines use. This includes providing training to ensure they understand the standards to follow. In all the cases pharmacists feel they are viewed as the 'medicines police' by other healthcare professionals.

In all the cases pharmacists try to influence patients' medicines taking behaviour by providing them with information about their medicines. In the case of CPs they also check how patients are taking their medicines through undertaking formal Medicines Use Reviews (MURs) and New Medicines Service (NMS).

Pharmacists appear to not have a term or word to describe this aspect of their practice, therefore the term 'pharmaceutical surveillance' was borrowed from the Foucauldian concept of 'surveillance' (See *Chapter 4, Section 4.10.3 Moving from data to theme*).

Re-professionalisation strategies: In all the cases pharmacists have not engaged with the concept of professionalism, instead viewing this as standards imposed on them by their regulatory body with the fear of being removed from the pharmacy register. They learn professionalism by undertaking pharmacy practice. Pharmacists are ambivalent about considering themselves as professionals, seeing this as creating a social distance between themselves and others (e.g., patients).

There are differences between community (case of CPs) and NHS pharmacists' (cases of HPs, MHPs and CHSPs) re-professionalisation strategies. NHS pharmacists actively gain additional clinical pharmacy knowledge through formal post-graduate education or by belonging to special interest groups to be at the forefront of knowledge. Their ambitions are to be recognised as clinical specialist pharmacists or to become consultant pharmacists, thereby increasing their own status and hence that of the profession. Community pharmacists struggle to attend any external training which often has to be in their own time or after work. Instead

they follow a strategy of taking on new services and training pharmacy students in an effort to keep themselves up-to date and break with their professional isolation.

NHS pharmacists view their clinical pharmacy contribution as not taking anything away from others. Instead they add to the work others do for example enabling and supporting doctors and other healthcare professionals to make the right prescribing choices. Community pharmacists want GPs to delegate some of their routine tasks to them. They are aware that in reality GPs do not want to delegate work to them due to being in competition and there being no shared access to GPs' patient records and due to pharmacists' shopkeeper image.

NHS pharmacists have in some of the cases (i.e., case of MHPs and CHSP) already given up the control of the pharmacy dispensary and in the case of HPs pharmacy technicians have started to take control of the dispensary. This is unlike community pharmacy (case of CPs) where they are unable to contemplate giving up this aspect of their practice and not having anything to replace it with.

NHS pharmacists are prepared to give up their control over the dispensary to pharmacy technicians to allow them to spend time on clinical pharmacy activities. Pharmacy technicians will discuss patients' medicines with doctors, nurses and patients on the wards. However, other healthcare professionals are unaware that there is a difference between pharmacy technicians and pharmacists viewing them all as pharmacists. NHS pharmacists are concerned that this reflects badly on the pharmacy profession.

Two different professions: NHS pharmacists want to give up their control of the pharmacy dispensary to focus on the clinical aspects of their practice. They feel that community pharmacists have failed to develop their practice beyond dispensing and that they belong to a different profession than themselves.

The next chapter discusses these findings by engaging in a dialogue between the findings and the literature using the working theories on the sociology of the professions (See *Chapter 2, Section 2.3 Theories from the sociology of the professions*) and building on what is already known about the pharmacy profession (See *Chapter 2, Section 2.4 Sociological examination of pharmacy and Chapter 3, The case of the pharmacy profession*) to help contextualise and interpret these findings further in answering the research question.

CHAPTER SIX: Discussion

6.1 Introduction

This study set out to address the research question: *How do pharmacists working in different healthcare settings perceive their status in society today?*, through exploring experienced pharmacists' perceptions of the nature of their pharmacy practice in relation to the healthcare setting in which they work linking this to their professional status in society (Abbott, 1981).

To answer the research question a qualitative collective case study methodology was used consisting of four cases. Each case study included five experienced pharmacists from community pharmacy, acute hospital, mental health and community health services, respectively. A total of twenty pharmacists were included. The main data were derived from one in-depth individual semi-structured interview. The data from each case were analysed using inductive thematic analysis followed by a cross-case analysis. It is the findings from the collective case study that is discussed in this chapter.

The research question supported by four study aims informed this study and guided the cross-case analysis. These research aims were:

- To identify the core function that defines the pharmacy profession.
- To explore pharmacists' views about how others' perceptions of them affects the nature of their pharmacy practice.
- To explore how pharmacists perceive they maintain or extend the nature of their pharmacy practice.
- To make comparisons between pharmacists' perceptions of the nature of pharmacy practice in relation to the healthcare setting in which they work.

Five themes for this qualitative collective case study were:

- The hidden healthcare profession.
- Important relationships.
- Pharmaceutical surveillance.
- Re-professionalisation strategies.
- Two different professions.

This chapter places the findings in a wider context by engaging in a dialogue between the findings and the literature using the working theories on the sociology of the professions (See *Chapter 2, Section 2.3 Theories from the sociology of the professions*) and building on what is already known about the pharmacy profession (See *Chapter 2, Section 2.4 Sociological examination of the pharmacy profession* and *Chapter 3, The case of the pharmacy profession in England*) to help contextualise and interpret these findings. These findings were unexpected as they were not anticipated by the interview schedule. This took the findings into unanticipated territory necessitating engagement with additional literature and theories to explore these further.

The structure of this chapter is outlined below, with the five themes highlighted in bold. This discussion chapter is not divided into sections according to each theme except for the themes: **Pharmaceutical surveillance** (See *Section 6.2 The core function that defines pharmacy*) and **Two different professions** (See *Section 6.7 Intra-professional tensions*). The remaining themes are contained in the discussions within the different sections.

In this chapter 'NHS pharmacists' (clinical pharmacists) refers to hospital, mental health and community health services pharmacists (i.e., the cases of HPs, MHPs and CHSPs). Instead of referring to the case of community pharmacists (the case of CPs) or the case of hospital pharmacists (the case of HPs), the terms 'community pharmacists' or 'hospital pharmacists' are used. When the more generic terms 'pharmacists' or 'all pharmacists' or 'pharmacy profession' are used these refer to all the cases (i.e., the cases of CPs, HPs, MHPs and CHSPs). This is to make this chapter more readable and easier to follow.

The nature of pharmacy practice was explored using a Foucauldian perspective to determine the core function that defines the pharmacy profession as **pharmaceutical surveillance**, consisting of surveilling others' medicines-use including influencing other healthcare professionals' practice and patients' medicines-taking behaviours (See *Section 6.2 The core function that defines pharmacy*). Pharmacists are the **hidden healthcare profession**. They are reliant on doctors to undertake and develop their pharmaceutical surveillance. This involves identifying doctors' prescribing errors, which is a difficult message to convey in the public arena. The images the public has of pharmacists as

shopkeepers and putting labels on boxes ties them to the physical space of the pharmacy dispensary, further reinforcing them as the hidden healthcare profession (See *Section 6.3 Images of pharmacists*). In addition, pharmacists' collective professional identity as medicines experts is weak (See *Section 6.4 Pharmacists – who are they?*). Pharmacists are not viewed by others as healthcare professionals and the public is unaware that they are registered with a regulatory body (See *Section 6.5 Professionalism and pharmacists*).

Professions use their understanding of professionalism as a **re-professionalisation strategy** to increase their status. The pharmacy profession has not developed a mature understanding of professionalism and is not using this as a re-professionalisation strategy. Instead professionalism is a discourse whereby the State, via its regulatory body, influences pharmacists' behaviour in practice. Community pharmacists' commercial employers utilise organisational professionalism as a performance management tool leading to community pharmacists being in conflict between their own and that of their employer's organisational professionalism, reducing their control and autonomy over their pharmacy practice (See *Section 6.5 Professionalism and pharmacists*).

One of the most **important relationships** for pharmacists is with doctors. NHS pharmacists follow **re-professionalisation strategies** aimed at closer working with doctors which enables them to develop their clinical pharmacy knowledge and skills, increasing the level of pharmaceutical surveillance they can undertake. NHS pharmacists aim to specialise in a specific clinical area so they can undertake more complex and specialised pharmaceutical surveillance. Community pharmacists have not similarly developed relationships with doctors (GPs). They instead hope that GPs may delegate some of their routine work to them. Pharmacy technicians pose the biggest threat to pharmacists' practice and status, although pharmacists are dependent on them to undertake routine work (See *Sections 6.2.4 Encroachment, delegation or a new jurisdiction* and *6.6 Inter-professional relationships*).

NHS pharmacists have little in common with community pharmacists in terms of their pharmacy practice, collective professional identity, inter-professional relationships, work environment, career patterns and re-professionalisation strategies. Community pharmacists have failed to re-professionalise their

pharmacy practice, continuing to focus on the act of dispensing, resulting in stagnation which has a de-professionalising effect on the whole pharmacy profession. The result is that the pharmacy profession essentially consists of **two different professions** (See *Section 6.7 Intra-professional tensions*).

6.2 The core function that defines pharmacy

A Foucauldian perspective was utilised to look beneath the surface of the nature of pharmacy practice to identify the core function that defines the pharmacy profession (See *Chapter 4, Section 4.10.3 Moving from data to theme* and *Chapter 7, Section 7.2.5 Analysing and making sense of the data*). This includes exploring whose purpose the pharmacy profession serves, providing a different perspective and interpretation of its power in society today (Ryan, Bissell and Traulsen, 2004).

6.2.1 Medicines and medicines-use as social objects

Social objects are conceptualised as a human construct as people are living and working within different social contexts where objects have certain meanings to them. Social objects are formed, sustained and transformed by the processes that takes place in social interactions and are defined by the meanings derived from the ways in which a group of people or in this case pharmacists acts towards them, rather than from the inherent nature or quality of these objects (Blumer,1986). Therefore:

“Objects are social products in that they are formed and transformed by the defining process that takes place in social interaction”.
(Blumer, 1986, p.69)

Dingwall and Wilson (1995) explain that all professions are “constituted around a social object” (p.125). According to Denzin and Mettlin (1968) doctors have agreed that illness and diseases are the social objects which their services are directed towards to cure, prevent, control and eliminate diseases, whereas they argue that the pharmacy profession has not agreed what its social objects are. Dingwall and Wilson (1995) disagree with Denzin and Mettlin (1968), determining that the ‘social object’ of pharmacy is for pharmacists to utilise their expertise and core function of ‘information giving’ to symbolically transform natural chemicals into pharmacologically active medicines (See *Chapter 2, Section 2.4.4 Dispensing and information-giving*).

The social objects for pharmacy in healthcare go beyond transforming social objects from a chemical into a pharmacologically active medicine through 'information-giving' as suggested by Dingwall and Wilson (1995). This study found that pharmacists are transforming not only medicines but also how they are used by others by utilising 'pharmaceutical surveillance' which is much broader and yet more specific than 'information-giving'. Pharmacists transform 'medicines' and 'medicines-use' into social objects that are used in different social contexts by different actors (e.g., doctors, nurses or patients) in different ways. They do this by applying their special knowledge and skills as 'medicines experts' to identify and reduce risks related to medicines and how they are used within these social contexts with the aim of improving patient safety. Pharmaceutical surveillance includes pharmacists surveilling other healthcare professionals' practices related to medicines-use (e.g., prescribing, administration or monitoring) and patients' medicines-taking behaviour. Pharmacists believe they are the only healthcare professionals who possess the special knowledge, skills and approach to undertake pharmaceutical surveillance, whereas other healthcare professionals can also undertake the 'transformational work' of 'information-giving' (Hibbert, Bissell and Ward, 2002). The transformation of 'medicines' and 'medicines-use' dictates how pharmacists construct and organise their pharmacy practice of 'pharmaceutical surveillance'.

Pharmacists want to bring social order to influence how medicines are used in different social contexts. They do this through their core function, 'pharmaceutical surveillance' regardless of the healthcare setting in which they work or whether socially interacting with policy-makers, other healthcare professionals or patients. Pharmaceutical surveillance goes beyond 'information-giving' (Dingwall and Wilson, 1995) and that of 'dispensing' as determined by Harding and Taylor (1997). Dingwall and Wilson's (1995) study is still referred to in the sociological literature without being contested in its examination of distinct aspects of community pharmacists' practice (e.g., Medicines Use Reviews (MURs) and New Medicine Service (NMS)) and linking this to their status (McDonald et al, 2010; Waring et al, 2016; Waring and Latif, 2017). Harding and Taylor (1997) argue that if new services or jurisdictional claims made by pharmacists are not aligned with their core function then these will be counter-productive resulting in de-professionalisation. This demonstrates the importance of determining the core function that defines the pharmacy profession in healthcare today.

6.2.2 Pharmaceutical surveillance

Different aspects of pharmacy practice have previously been either discussed or analysed by drawing on Foucault's ideas and concepts mainly relating to community pharmacists and their interactions with patients (Hibbert, Bissell and Ward, 2002; Jamie, 2014; Waring et al, 2016; Waring and Latif, 2017). (See *Chapter 2, Section 2.4.5 Surveillance, discipline and 'pastoral power'*).

The Panopticon prison and its disciplinary techniques can be applied to pharmacists' practice of pharmaceutical surveillance to explain their power in healthcare (Foucault, 1977; Ryan, Bissell and Traulsen, 2005) (See *Chapter 2, Section 2.3.2.1 Power and knowledge*).

According to Foucault power is everywhere and where there is power there is resistance (Foucault, 1977; Bissell and Traulsen, 2005). In a Foucauldian sense disciplinary power is not necessarily exercised against the interests of others, nor does it mean that influencing the conduct and behaviour of others is undesirable (Foucault, 1977; Lemke, 2002). The disciplinary power that pharmacists exert as part of their pharmaceutical surveillance is ultimately aimed at ensuring risks related to medicines and medicines-use are managed with patient safety being paramount. Lemke (2002) explains that disciplinary power can result in empowerment by for example pharmacists providing patients with more knowledge about their medicines allowing them to self-manage their medicines more effectively (Foucault, 1977).

The disciplinary power that pharmacists possess should not be confused with domination which is a type of power that is stable and hierarchical, fixed and is difficult to reverse as this is embedded in society, such as doctors' domination or hegemony over pharmacists (O'Neill, 1986; Lemke, 2002). Domination is linked to the neo-Weberian social closure perspective (Macdonald, 1995; Saks, 2016) (See *Chapter 2, Sections 2.3.2 The 'power approach' and 2.4.2 Medical hegemony and jurisdictional uncertainties*)

Pharmacists look for or find problems, discrepancies and deficiencies related to medicines and their use with the aim of solving or rectifying these. This is independent of the healthcare setting in which they work. They apply techniques of surveillance using terms to describe this such as 'checking' or 'screening',

'monitoring' and 'auditing' the work of other healthcare professionals, 'counselling' patients on their medicines, 'training' other healthcare professionals and patients, producing policies and prescribing guidelines to change or correct others' attitudes and behaviour in relation to medicines-use. The nature of pharmacy practice mainly consists of surveilling the work and behaviours of others and correcting these with Dingwall and Wilson (1995) referring to pharmacists as contributing to "the maintenance of order or discipline in the social world" (p.125).

Pharmacists aim to make it safer for patients. They do this through mitigating or reducing harm from medicines to patients, but also in terms of supporting other healthcare professionals to maintain their professional registration (i.e., by preventing them making medicine errors) and, in the case of NHS pharmacists, their NHS trusts by preventing litigation claims relating to medication. Pharmacists have a self-image of acting as a safety net. They combine others' social medicines-use behaviours (e.g., doctors' prescribing, nurses' administering and patients' medicines-taking behaviour) with risk factors by identifying and addressing 'risky' or 'deviant' medicines-use behaviour. Their pharmaceutical surveillance is linked to the notion of risks and risk factors that may or may not result in harm due to there often being possibilities for future harm (Armstrong, 1995).

Pharmacists' surveillance activities are exercised through "a meticulous observation of detail" (Foucault, 1977, p.141) generating a body of "methods and knowledge, descriptions, plans and data" (Foucault, 1977, p.141). It is through this surveillance that pharmacists find a "whole domain of knowledge" (Foucault, 1977, p. 185) which provides them with more power as the "formation of knowledge and increase of power regularly reinforce one another in a circular process" (Foucault, 1977, p. 224). Pharmaceutical surveillance undertaken on the wards by NHS pharmacists has enabled them to generate more clinically specialised knowledge allowing them to undertake more advanced surveillance of doctors and nurses. They do this by making sure doctors and nurses conform to prescribing guidelines and internal policies for medicines-use and also by checking that patients' medication is monitored by doctors in accordance with clinical guidelines (e.g., having regular blood tests) or questioning their clinical decision-making when prescribing medicines. NHS pharmacists have more power and therefore relative

status compared to community pharmacists. It follows that pharmacists' power is embedded in their daily activities.

This Foucauldian perspective can view pharmacists as working as an agent of the State, helping to ensure safe and economical use of medicines. NHS pharmacists' pharmaceutical surveillance has developed in the direction of undertaking advanced clinical pharmaceutical surveillance of doctors' prescribing, whereas for community pharmacists it has developed towards surveilling patients' adherence to their prescribed medicines (Latif, Pollock and Boardman, 2011, 2013) (See *Section 6.2.3 Cognitive pharmaceutical services*).

During the introduction of the welfare state the government split the prescribing and dispensing activities for economic reasons as a way of managing the drug cost, with doctors prescribing and pharmacists dispensing (See *Chapter 3, Section 3.2.3 The introduction of the welfare state and the National Health Service*). Once pharmacists started to work within hospitals it became clear that their input on the wards in monitoring doctors' prescribing choices helped to contain drug costs. This had an economical advantage for the NHS and therefore the State. Consecutive governments have supported the notion and development of clinical pharmacy (DH, 2008) (See *Chapter 3, Section 3.2.4 Hospital pharmacy*).

It is in the techniques of the 'examination' where pharmacists can gain power. The importance of the 'examination', through which power is gained, involves documentation and recording the examination as a way of undertaking surveillance (Nettleton, 1992). NHS pharmacists' pharmaceutical surveillance is a source of power and has helped them earn acceptance as a member of the multi-disciplinary team on wards. NHS pharmacists are using the number of doctors' prescribing errors as leverage to expand their practice. There is anecdotal evidence to suggest that pharmacists are reluctant to report these errors via formal incident reporting systems (Williams, Phipps and Ashcroft, 2013). Pharmacists aim to gain or maintain close working relationships with doctors by avoiding conflict and confrontation by seeking ways of reducing tension created when pointing out doctors' prescribing errors (Mesler, 1991; Edmunds and Calnan, 2001; Williams, Phipps and Ashcroft, 2013).

Pharmacists may correct doctors' prescribing discrepancies or omissions immediately so it is not relevant to record these. NHS pharmacists avoid writing

anything adverse in patients' medical records as this will reflect badly on the doctor and will negatively affect their relationship, which they depend on to utilise their clinical pharmacy knowledge and skills (Mesler, 1991; Williams, Phipps and Ashcroft, 2013) (See *Section 6.6.1, Dependency on doctors*). NHS pharmacists sometimes document the outcome of their 'examination', referred to as pharmacy interventions, in a separate pharmacy database that only the pharmacy department can access. This allows them to produce anonymised reports of their contributions to patient care should the need arise.

According to a Foucauldian perspective, pharmacists' power is reduced due to not recording the outcome of their 'examination' (i.e., pharmacy interventions) in contemporaneous patient medical records making the pharmaceutical surveillance aspect of their practice less visible to others. Therefore, the interventions NHS pharmacists make are not scrutinised or surveilled by others: "the examination that places individuals in a field of surveillance also situates them in a network of writing" (Foucault, 1977, p. 189). The power of writing (i.e., recording) is an essential part of the mechanism of discipline. Pharmacists' disciplinary power is invisible to others except to those who are subject to their pharmaceutical surveillance (Foucault, 1977).

Pharmacists' pharmaceutical surveillance takes place at the micro-level (workplace) but appears to be largely missing at the macro-level (political, economic and public) because their pharmaceutical surveillance is not in the public domain, so the public and society remains unclear about their contributions to healthcare.

Theories on the sociology of the professions suggest that pharmacists' practice is ultimately controlled or limited by the dominance of the medical profession regardless of the healthcare setting in which they work (Johnson, 1972; Bissell and Trauslen, 2005). Using a Foucauldian perspective to examine pharmacists' practice across four healthcare settings shows that pharmacists have subtle power over doctors. This power is more marked for NHS pharmacists particularly in terms of ensuring the economical and safe use of medicines.

The nature of pharmacy practice in healthcare is both complex and diverse, being influenced by multiple factors making it difficult to fully appreciate what pharmacists' core function is. This study found that the core function that defines the pharmacy profession is pharmaceutical surveillance.

6.2.3 Cognitive pharmaceutical services

As healthcare has evolved, there is not only a focus on treating illness but also on prevention by treating healthy people due to the potential risk of future illness by assessing their risk factors for certain conditions, incorporating physical as well as social factors such as behaviour and life-style choices (Armstrong, 1995; Bissell and Traulsen, 2005). The result is that patients are prescribed medication to treat illness, but also to prevent conditions they could potentially develop in the future. There are a rising number of patients with chronic illnesses with poor adherence to their treatment with between 30 to 50 percent not taking their medicines as intended (Pound et al, 2005; Nieuwlaat et al, 2014). This leads to poor health outcomes resulting in increasing medicines waste and use of health care resources. The consequence is rising healthcare costs (WHO, 2003; Wiedenmayer et al, 2006) (See *Chapter 1, Section 1.2 Societal purpose and responsibilities of the pharmacy profession*). Patients' behaviour around their adherence to medicines consists of unintentional and intentional factors (Vermeire et al, 2001; NICE, 2009). Pharmacists are pre-occupied with checking patients' compliance with their medication (Ryan, Bissell and Traulsen, 2004). The term compliance is no longer used as it implies patients have to follow the prescriber's order. To humanise the term 'compliance' it was replaced with 'concordance' or 'adherence' suggesting that there is a jointly negotiated agreement between the prescriber and the patient regarding their medication-taking (Bissell and Traulsen, 2005; NICE, 2009).

Community and NHS pharmacists are "symbolically and physically" (Jamie, 2014, p.1144) moving their pharmacy practice away from the dispensary to the consultation room in community pharmacies and to the wards at the patient's bedside, respectively (Anderson, 2001). Pharmacists' practice involves 'counselling' or 'examining' patients' understanding of their medicines with the aim of influencing their medicines-taking behaviour to increase their adherence (Roberts et al, 2006; Latif, Pollock and Boardman, 2011, 2013; Twigg et al, 2013).

NHS pharmacists have brief encounters with patients at their bedside on the wards which is a 'public space' providing limited privacy. They do not formally record this counselling or 'examination' of patients' medicines-taking behaviour besides sometimes providing a list of the patient's medicines and reasons for

these being prescribed as part of their medicines information-giving. NHS pharmacists in this study, besides mental health pharmacists, came across as disconnected from the social and cognitive context of patients' medicines use due to having limited direct contact with patients and these interactions being brief and limited.

It is important to community pharmacists to develop long-term relationships with their regular patients as a way of getting to know them, which includes their diseases, medication and social situations. Unlike NHS pharmacists, formal cognitive pharmaceutical services, such as MURs and NMS are delivered by community pharmacists. These are directly funded by the NHS as the State requires value for the money it spends on medicines by ensuring patients adhere to their treatment (Elliott et al, 2014). Community pharmacists are moving their informal patient counselling from the dispensary counter to a consultation room to undertake these formal cognitive pharmaceutical services. This change of physical space for the 'examination' of patients' medicines-taking behaviour has altered the community pharmacist-patient relationship and interactions. In this consultation room patients are prepared to divulge more information with community pharmacists having to learn new skills including generating new knowledge in managing this information and the more formal encounters with patients, which starts to take the form of a therapeutic relationship.

These cognitive pharmaceutical services assume that patients' medicine-taking behaviour can be rectified by discussion with a pharmacist (Salter et al, 2007; Desborough et al, 2012). The introduction of 'Healthy Living Pharmacies' aimed to improve health and health inequalities with the focus being placed on community pharmacists to question and help to promote behavioural change to patients' lifestyles as a form of self-discipline (PSNC, 2017c). Patients are increasingly being placed in a position where they have to account for their medicines-taking behaviour and lifestyle, while pharmacists are expected to view patients as individuals who make their own decisions. Pharmacists rely on patients' collaboration as well as managing and dealing with patients' emotions as part of eliciting information from them, as understanding their emotions is the key to understanding their medicines-taking behaviour (Nettleton, 1992; Waring and Latif, 2017). Pharmacists have to take a patient-centred care approach by gauging patients' views and beliefs about their health, disease and medicines to help

influence their medicines-taking behaviour (Horne, 1999; CPPE and NHS Health Education England, 2014). Community pharmacists are required to address patients' adherence, but also provide public health messages about their lifestyle by utilising health coaching and motivational interviewing techniques to support these behavioural changes (Miller and Rollnick, 2009; Melko et al, 2010; Barnett, Jubraj and Varia, 2013). May (1992) suggests taking account of patients' social context and lifestyle is a more subtle way of 'gazing' at patients by reaching further into their thoughts, feelings and lives, thereby having more control over their medicines treatment and health status. Pharmacists rely on patients to assess and maintain their own adherence and healthy lifestyle. Pharmacists' power relies less on discipline but more on surveillance and encouraging patients' self-discipline (i.e., 'normalising' their own behaviour). Waring et al (2016) and Waring and Latif (2017) describe this as a form of 'pastoral power' as pharmacists become "responsible for shaping patients' self-regulating subjectivities" (Waring et al, 2016, p.123). As part of their cognitive pharmaceutical services or 'examination' of patients' medicines use, pharmacists do not physically touch or examine patients but are verbally exploring their minds, by assessing their emotional and physiological responses (e.g., side-effects) to their medicines (Waring et al, 2016; Waring and Latif, 2017). Pharmacists have started to shift the 'spatial' location (i.e., spatialisation refers to a cognitive place or location) in which the medicine as a social object resides in a different spatial location which occupies a 'psycho-social space' between patients' minds and their medication involving more than 'information-giving' as part of pharmacists' 'transformational work' (Nettleton, 1992; Dingwall and Wilson, 1995; Foucault, 2009) (See *Chapter 2, Sections 2.4.4 Dispensing and information-giving and 2.4.5 Surveillance, discipline and pastoral power*).

Community pharmacists as part of MURs and NMS record their interactions with patients as part of their 'examination'. The MURs and NMS records are used as proof that these interactions with patients have taken place. Community pharmacists are, therefore also being surveilled by others (Waring et al, 2016). If community pharmacists assess that a patient's medicines regimen needs to be altered then they will ask the patient to see their GP, leaving the pharmacists with limited decision-making having to defer and refer to the doctor. Community pharmacists in this study prefer the informal dispensary-counter interactions with patients because the formal cognitive pharmaceutical services create a social

distance between themselves and patients. It also allows them to stay in the pharmacy dispensary to maintain oversight over its operation being able to intervene if required instead of being in the consultation room as they are often the only pharmacist in the pharmacy.

Community pharmacists in this study explain that patients are familiar with using them as an independent informal source of information about their medicines or disease whereas the formal cognitive pharmaceutical services mean patients' GPs are informed in a report about their discussions with the pharmacist. Some patients feel that this may impact adversely on their relationship with their GP possibly for being 'found out' that they are not 'good patients' by not following the GP's instructions.

The MURs and NMS require community pharmacists to be proactive in approaching and recruiting patients who they consider would benefit from these cognitive pharmaceutical services as there is no demand from patients themselves for these. Patients may choose not to see the pharmacist or to remain silent or provide answers they think the pharmacist is looking for to avoid any further prying into their lives (Hibbert, Bissell and Ward, 2002; Waring et al, 2016). GPs do not respond to the MUR reports nor do they refer patients for MURs resulting in pharmacists undertaking these services in isolation from the primary care team (McDonald et al, 2010).

It has been suggested that community pharmacists' status might have been enhanced through these new roles being funded by the NHS based not only on their pharmaceutical knowledge but also on their knowledge about patients' health and lifestyle (McDonald et al, 2010). This can be viewed as pharmacists moving away from informal information-giving which has historically always taken place at the dispensary-counter with Harding and Taylor (1997) stating that pharmacists have always had a social "mandate to provide or offer information/advice" (p. 554) towards being more proactive in developing and delivering cognitive pharmaceutical services with the aim of benefiting the health economy through improving patients' adherence and self-management to stay healthy (McDonald et al, 2010; Elliott et al, 2014; Waring et al, 2016).

These cognitive pharmaceutical services offer community pharmacists and the whole pharmacy profession the opportunity to make jurisdictional claims to these services (McDonald et al, 2010; Waring and Latif, 2017). Pharmacists will have to

make this jurisdictional claim in the public arena so that the public supports the need for these services by creating a demand (Abbott, 1988).

Nettleton (1992) describes how dentists have been able to convince the public and the State of the value of funding them to surveil patients' healthy mouths and teeth every 6 to 12 months as part of preventative and public health measures. The pharmacy profession has not asserted its jurisdictional claim to cognitive pharmaceutical services for patients with chronic illnesses despite compelling economic reasons for this.

Waring and Latif (2017) suggest that these cognitive pharmaceutical services are merely delegated to community pharmacists by doctors (GPs), the more powerful profession (Nancarrow and Borthwick, 2005), because they have no time to provide these services (Eaton and Webb, 1979). Pharmacists can be viewed as encroaching on GPs' territory, which may explain why GPs largely ignore MUR reports (McDonald et al, 2010).

Although society is aware of the economic impact regarding adherence issues for patients with chronic illnesses there does not appear to be a coherent or systematic effort to address this. The pharmacy profession has not taken a lead by drawing attention to this in the media or by speaking up on behalf of patients, thereby missing an opportunity to demonstrate that they should be the profession undertaking cognitive pharmaceutical services to support patients with their medicines-use and empowering patients to self-manage their medicines and chronic illnesses (See *Sections 6.3.4 Acting as healthcare professionals*).

6.2.4 Encroachment, delegation or a new jurisdiction

Community pharmacists are not making jurisdictional claims to doctors' (GPs') work but want to pursue a re-professionalisation strategy whereby GPs delegate routine work to them by retaining the overall supervisory responsibility for patients' care. This is to free up GPs' time allowing them to focus on more complex clinical work, although this strategy seems more wishful thinking than reality. Similar findings were made by Edmunds and Calnan (2001). Community pharmacists are aware of barriers in place such as competition between GPs and community pharmacies for services, being isolated from the primary care team, being linked to retail, not having access to patients' medical records, having weak relationships with GPs and being overwhelmed by the increasing numbers of prescriptions while

having little time for anything else (See *Section 6.6.1 Dependency on doctors*). They do not pursue re-professionalisation strategies due to their increasing workload in terms of the services they already deliver, wanting to retain the status quo while feeling secure in their current roles.

NHS pharmacists have evolved and established their pharmacy practice on the wards not through encroachment or delegation as claimed by Eaton and Webb (1979) and Mesler (1991). Instead they are adding to and complementing doctors' and nurses' practice. NHS pharmacists moved their pharmaceutical surveillance function previously carried out in the pharmacy dispensary on to the wards thereby developing their clinical pharmacy knowledge and skills enabling them to undertake more sophisticated pharmaceutical surveillance of doctors' prescribing. They are however still dependent on doctors to be able to carry out pharmaceutical surveillance on the wards, not because of delegated tasks but because doctors retain the responsibility for patient care and are influential and powerful stakeholders in healthcare (See *Section 6.6.1 Dependency on doctors*). NHS pharmacists' core function of pharmaceutical surveillance has filled a gap on the wards which other professions have not previously identified or claimed as theirs. Pharmacists are not in competition with other professions over their jurisdictional claims of pharmaceutical surveillance. It is not a jurisdiction that another profession has vacated but rather an existing jurisdiction that pharmacists have developed and expanded further and is now being claimed as theirs. NHS pharmacists do not only undertake pharmaceutical surveillance on the wards but also throughout their organisation or NHS trusts in terms of how medicines are used. Abbott's (1981,1988) 'vacancy model' implies that there are finite areas of jurisdictions, which are subject to inter-professional competition. According to this a profession cannot occupy a jurisdiction without finding a vacant one or fighting for an existing one (e.g. initially through encroachment or delegation) based on professions being part of an inter-related system of professions. Abbott's (1988) 'vacancy model' of "zero-sum conceptualisation" (Mesler, 1991, p. 325) of jurisdictions provides an inadequate explanation in the case of NHS pharmacists (See *Chapter 2, Section 2.3.3 Professions as an inter-related system*).

6.2.5 Pharmacy interventions

As part of their pharmaceutical surveillance pharmacists look for problems or discrepancies that need to be rectified, referring to these as pharmacy interventions. Pharmacists give examples of pharmacy interventions that have reduced potential harm to or saved patients' lives. Pharmacists are in the paradoxical situation that if they inform the public about these it will damage the public's trust in doctors and NHS trusts and could adversely affect their relationships with doctors, which they depend on (See *Section 6.6.1 Dependency on doctors*). Instead pharmacists' pharmaceutical surveillance is concealed from the public's view with pharmacists working "behind the scenes" (Mesler, 1991, p.325). The public remains unaware of pharmacists' impact on reducing harm to patients and in saving lives. The outcome is that a large part of pharmacists' contribution to healthcare remains hidden, implicitly affecting their status in healthcare. They therefore find it difficult to take their jurisdictional claim to pharmaceutical surveillance into the public domain (Abbott, 1988), instead remaining the hidden healthcare profession.

Pharmacists' recounting of their pharmacy interventions has many of the features of 'atrocities stories'. Dingwall (1977) and Allen (2001), demonstrated that nurses use 'atrocities stories', which are vivid accounts about others, to address uncertainty about professional boundaries and to redress or compensate for power imbalance due to status inequalities.

Pharmacists' atrocities stories have a social purpose in terms of defining them as a professional group by creating internal social cohesion by affirming shared problems. Their use of atrocities stories represents the asymmetrical power differences within the healthcare hierarchy due to their subordination to doctors. These 'atrocities stories' are used to share common issues and contributions pharmacists make to healthcare to demarcate professional boundaries between them and others and as a way of legitimising their jurisdictional claim to pharmaceutical surveillance. These atrocities stories are used within pharmacy to demonstrate, often to themselves, that healthcare will not function without them (i.e., that there will be many more unexplained deaths). Dingwall and Wilson (1995) explain that pharmacists' claim of preventing harm and death to patients may not "necessarily be honoured by others" (p.124).

These atrocity stories are also used to demarcate boundaries between NHS pharmacists and community pharmacists. NHS pharmacists recite atrocity stories about community pharmacists not having intervened in doctors' prescribing resulting in harm to patients, which reflects badly on the pharmacy profession. NHS pharmacists use these atrocity stories to determine which pharmacists are the competent ones, thereby implying that community pharmacists are not as competent as they are. These atrocity stories add to the intra-professional tensions between community and NHS pharmacists (See *Section 6.7 Intra-professional tensions*).

6.3 Images of pharmacists

Pharmacists perceive that the public views them as 'shopkeepers' and 'sticking labels on boxes' based on their familiarity with 'retail' pharmacy, regardless of the healthcare setting in which they work. This confirms Abbott's assertion that the public are "unaware of internal hierarchies" (p.120) within pharmacy which means that the "breadth of intra-professional status narrows to a nearly uniform picture" (p. 121) of a typical community pharmacist. These images and stereotypes of pharmacists impact on their practice and status providing an important measure about how they are valued by society (Abbott, 1988). An image is a mental representation that is evident in everyday life and it influences interactions with and expectations people have towards each other. An image conveys messages about how pharmacists are viewed or perceived by others but is also determined by how pharmacists perceive themselves (Snyder, 1981). The image of pharmacists is important as it influences how they respond to themselves and others. Stereotypes can result in prejudice and wrong assumptions about individuals or groups of people.

Cunningham (1999) refers to a stereotype as "a cognitive framework whereby characteristics are attributed to an entire group of people" (p. 46) that forms "a set of well-learned, widely shared, immediately evoked, and socially validated beliefs about a social group" (Lott and Saxon, 2002, p. 482). Stereotypes are cognitive short cuts or simplistic classification systems used by the human mind allowing better use of peoples' capacity to process large volumes of information. These cognitive short cuts act as energy saving processes allowing energy to be directed to processing other information (Macrae, Milne, Bodenhausen, 1994). It is a way

of making generalisations about a profession, with Schneider (1992) arguing that, “the ability to generalise is a central, primitive, hard-wired cognitive activity” (p. 8).

6.3.1 Shopkeepers and sticking labels on boxes

Pharmacists’ shopkeeper image is associated with selling sundry products rather than with delivering healthcare (Birchall, 2014) and is reinforced by the physical space in ‘retail’ pharmacy. The study by Rapport, Doel and Jerzembek (2009) concludes that a community pharmacy is “not a space that invites patients in to attend a consultation and spend time with a professional” (p. 321) but is designed for patients to buy a product and then move on. This shopkeeper image generates mistrust and is perceived as a barrier to closer working relationships between community pharmacists and GPs (Edmunds and Calnan, 2001; Hughes and McCann, 2003; McDonald et al, 2010). This study shows that pharmacists’ image of shopkeepers is sometimes reinforced by GP practice staff treating them as ‘retailers’ affording them no or very little professional courtesy, which impacts negatively on pharmacists’ self-image and devalues their efforts. This was emphasised by a community pharmacist who became visibly upset during the study interview when reflecting on difficulties in interacting with GP practices.

Gallagher and Gallagher (2012) and Cook and Stoecker (2014) suggest that inter-professional education and practice placements working alongside other healthcare professionals are ways of trying to dispel negative stereotypes professions may hold of each other. This does not address the physical space of ‘retail’ pharmacy and the associated powerful image of community pharmacists as shopkeepers.

Pietroni (1991) explains that stereotypes are often negative and may be an indicator for “much more powerful archetypical forces” (p. 62). A study by Takase, Kershaw and Burt (2002) on nurses’ perceptions of how others viewed them, found that this affected their self-image. If nurses perceived the public’s image to be negative they were more likely to develop a negative self-concept (Takase, Maude and Manias, 2006). Strasen (1992) produced a ‘self-image model’ demonstrating how self-image influences the actions of professionals and this in turn determines their performance. This explains how the public’s image of the pharmacy profession as ‘shopkeepers’ and ‘sticking labels on boxes’ affects pharmacists’ self-image, which in turn affects what they do in practice (Strasen, 1992). Snyder (1981) argues that:

“When individuals use their stereotyped beliefs as guides for regulating their interactions with others, they may constrain the others’ behavioural options in ways that produce actual behavioural confirmation for these stereotyped beliefs of the target”. (p.193)

Stereotypes affect how one group may treat another, which leads to “changes in behaviour of the stereotyped group” (McGarty, Yzerbyt and Spears, 2002, p.10). Pharmacists may behave in ways that fulfil the expectations others have of them, which becomes a self-fulfilling prophecy serving to reinforce negative images of pharmacists (Hilton and von Hippel, 1996). Pharmacists’ confidence in their abilities as healthcare professionals may be eroded because of this negative image as shopkeepers. Community pharmacists themselves reinforce this by avoiding addressing certain healthcare and lifestyle issues with patients because they do not consider that the ‘retail’ environment of a community pharmacy is the right place for them to be discussed. They are concerned about losing customers who may not welcome talking about these health and lifestyle issues with their community pharmacist (See *Section 6.2.3 Cognitive pharmaceutical services*).

Pharmacists feel that it is the image of pharmacists as shopkeepers that is shown in the media and not an image of pharmacists as healthcare professionals who are medicines experts on medicines-use. Forrester (2000) argues that images projected on television or in the media are used by viewers to form an overall stereotype of pharmacists. Pharmacists’ lack of visibility in the media results in the public being unaware of what pharmacists do reinforcing the pharmacy profession being shopkeepers and the hidden healthcare profession.

The image of ‘sticking labels on boxes’ or ‘counting tablets’ is linked to pharmacists’ practice of dispensing. There are references in the literature to pharmacists as ‘pill counters’ working at the back of the pharmacy dispensary (Varnish, 1998; Pottie et al, 2009). This metaphorically speaking, leaves an impression of pharmacists being placed out of sight contributing to the perception of them being ‘invisible’ or an ‘unremarkable character’ (Poirier and Lipetz, 1987; Rosenthal and Tsuyuki, 2010; Carlsson, Renberg and Sporrang, 2012; Elvey, Hassell and Hall, 2013).

The images of pharmacists of sticking labels on boxes and as shopkeepers means that the public are able to evaluate and assess the work pharmacists do as these images are not associated with any mystique or special knowledge and skills

whilst the public is unaware of the 'checking' that lies behind 'sticking labels on medicines boxes' (Harding and Taylor, 2002). Pharmacists in this study would like to dispel their images as shopkeepers and sticking labels on boxes. They are aware that it is the dispensing of medicines that forms the visible act of their pharmacy practice and that it is the prompt dispensing of medicines that matters most to other healthcare professionals and patients regardless of the healthcare setting (van Mil, Schulz and Tromp, 2004).

6.3.2 The 'medicines police'

Other healthcare professionals view pharmacists as the 'medicines police'. This image is linked to their core function of pharmaceutical surveillance, which involves checking or surveilling the work of others to ensure legal and best practice standards relating to medicines use is maintained (See *Section 6.2 The core function that defines pharmacy*). This aspect of pharmacists' practice is not always appreciated by other healthcare professionals who see them as interfering in their practice. Pharmacists are aware that the image of the medicines police acts as a barrier to establishing closer working relationships with other healthcare professionals. The medicines police image gives pharmacists some power or control over other healthcare professionals, which they reinforce if it means other healthcare professionals comply with standards for medicines-use as this improves patient safety. Pharmacists thereby give credence to others' stereotypical view of them as the medicines police. Pharmacists' self-image is not that of the medicines police. Instead they compare themselves to detectives with a higher status than policemen. Pharmacists thereby inadvertently adopt other healthcare professionals' view of them by depicting a self-image that is akin to the police (See *Section 6.6.1 Dependency on doctors*).

6.3.3 Pharmacy practice - myths versus reality

Initially as part of the study interviews community pharmacists and NHS pharmacists and in particular hospital pharmacists, tried to paint an ideal self-image of their pharmacy practice.

Community pharmacists depict community pharmacy as a local neighbourhood shop, a central hub in the local community, having good relationships with GPs and being available for informal advice and where they personally know the

majority of their customers including their social circumstances. In contrast to this ideal image, community pharmacists came across as lone practitioners who are isolated from the rest of the primary care team and are over-worked having to manage an increasing number of prescriptions with little time for anything else.

Hospital pharmacists conjure up an ideal self-image of being fully integrated into multi-disciplinary teams participating in ward rounds and in decision-making in collaboration with doctors at the point of prescribing and working closely with them around delivering patient care. They feel valued by consultants because of their contribution to improving patient care.

The reality differed from these ideal self-images. Hospital pharmacists do not prioritise attending consultant-led ward rounds, are marginalised from the multi-disciplinary teams and their pharmacy practice is undertaken in isolation from these activities. Pharmacists report duplication of tasks between themselves and doctors. They fail to see that these occur because they generally do not record the work they do so that this is shared with others. Hospital pharmacists are unable to commit to a consistent input on consultant-led ward rounds, appearing to opt in and out (See *Section 6.6.1 Dependency on doctors*). They prioritise checking and processing discharge prescriptions on the wards to facilitate prompt discharges of patients. This was previously undertaken in the pharmacy dispensary. The impression is that most of their time on the wards is spent undertaking work previously done in the pharmacy dispensary. Clinical pharmacy in hospitals appears to be an enhancement of the dispensing process rather than an activity undertaken by pharmacists independent of this dispensing process. The only exception to this is mental health and community health services pharmacists from two NHS trusts where the medicines supply function is contracted out to another provider, although nursing staff still associate these pharmacists with being part of the medicines supply function. Based on both community and hospital pharmacists' acts of practice, other healthcare professionals are unclear what pharmacists' practice consists of and how they contribute to patient care besides dispensing medicines.

It can be speculated that pharmacists use these ideals of their pharmacy practice as re-professionalisation strategies to maintain or increase their status. These ideal self-images can act as desirable visions for the profession or as barriers if

they are deluded about the reality, meaning that the pharmacy profession will fail to address the underlying problems and causes of not being able to achieve its ideal self-image.

Dingwall and Allen (2001) talk of a profession looking back to a 'golden age' in history where it prospered. They explain this view is based on a myth of the profession that has little bearing on reality. The authors argue that a profession will use this myth to justify its current re-professionalisation strategies to expand its practice, to make claims about its status and to influence stakeholders in an economic, social and political context. Studies by Elvey, Hassell and Hall (2013) and Birchall (2014) show pharmacists continue to associate themselves with their past image of compounding medicines including viewing the pestle and mortar as a symbol of the tools of the trade. Elvey, Hassell and Hall (2013) argue that this past image of pharmacists is recognised by pharmacists, the public and other healthcare professionals with pharmacists having special knowledge that no other healthcare professional possesses. It is argued that this image does not reflect a golden age, as compounding medicines is a technical function which kept pharmacists at the back of the 'shop'. The authors maintain that the loss of compounding medicines meant pharmacists lost a core function that defined them professionally and provided them with status, whereas the act of dispensing does not draw on their knowledge and skills (Harding and Taylor, 1997; Harding and Taylor, 2002). Elvey, Hassell and Hall (2013) conclude that pharmacists find it difficult to move away from this past image reinforcing the view that pharmacy has not found a consistent image to fill this void while reinforcing the myth of the pharmacy profession.

Pharmacists in this study refer to the past as a time when their knowledge and skills were underutilised and less patient-focused. Instead they talk of improvements made to pharmacy practice where community pharmacy has taken on the provision of additional pharmaceutical services (e.g., supplying emergency hormonal contraception), and hospital pharmacists have moved out of the hospital pharmacy dispensary on to the wards, interacting with doctors and other healthcare professionals. This study found that pharmacists' re-professionalisation strategies do not involve recreating a past myth of the pharmacy profession. Instead pharmacists paint an ideal self-image of pharmacy that they wish to convey to others, even if this does not reflect reality.

There is a mismatch between the public's perception of pharmacy and the pharmacy profession's perception of itself. If there are discrepancies between what the public expects of pharmacy and what the pharmacy profession believes it is offering or can potentially offer, this can result in incongruity between the expectations the public and patients have of pharmacists and their experience and acceptance of pharmaceutical services that pharmacists are capable of delivering.

6.3.4 Acting as healthcare professionals

Zellmer (2002) argues that the pharmacy profession can only start to address or eliminate stereotypes if it admits that these negative stereotypes exist and starts to act in a way it wishes to be perceived by others. Zellmer (2002) and van Mil, Schulz and Tromp (2004) urge pharmacists to start acting as healthcare professionals by taking on this "burden" (van Mil, Schulz and Tromp, 2004, p. 309) of responsibilities that comes with being healthcare professionals by being concerned about appropriate medicines-use in society (Hepler and Strand, 1990). They can only do this by starting to move away from the act of dispensing (van Mil, Schulz and Tromp, 2004) (See *Chapter 2, Section 2.3.2 The 'power approach'*).

Abbott (1988) confirms that it is the act of professional practice that is seen and assessed by the public which determines how their practice is viewed impacting on their professional status in society (See *Chapter 2, Sections 2.3.4 Professional status* and *Chapter 6, Section 6.3.3 Pharmacy practice – myths versus reality*). This leads to the question of whether pharmacists have changed their practice and started to act as healthcare professionals or if they are continuing to practise the way they have always done. Although this study did not include others' perceptions of pharmacists, and was based on pharmacists' own perceptions of how they consider they are viewed by others, the images they paint of pharmacists shows they are not viewed as healthcare professionals by the public in the same way doctors and nurses are. This was confirmed by pharmacists' views that other healthcare professionals or patients are often unaware that they are registered with a regulatory body therefore not regarding them as healthcare professionals with responsibilities for aspects of patients' care (See *Section 6.5.2 Registered healthcare professionals*).

As long as pharmacists remain the hidden healthcare profession they have little hope of extending their pharmacy practice by making new jurisdictional claims in healthcare as a way of maintaining and enhancing their professional status. The physical image of a 'retail' shop remains a barrier for the public and for community pharmacists in viewing themselves as healthcare professionals. This in turn impacts on the rest of the pharmacy profession as the public bases its assessment of the whole profession on community pharmacists as representing a 'typical pharmacist' (Abbott, 1988).

6.4 Pharmacists - who are they?

The image a profession has of itself is linked to its professional identity and the work it does (Ibarra, 1999; Nobel et al, 2014):

“Professional identity forms the core of what it means to be a professional and influences how professionals function in their role”.
(Nobel et al, 2014, p.328)

Professional identity is a complex concept whereby individuals through professional socialisation processes reach an understanding of their profession in conjunction with their own self-concept, allowing individuals to clearly articulate their role, philosophy and approach to others inside and outside their profession (Brott and Myers, 1999). Brott and Myers (1999) argue that professional identity “serves as a frame of reference for carrying out work roles, making significant decisions and developing as a professional” (p.339) and is a developmental process that starts during training and continues throughout a professional career. Ibarra (1999) and Wenger (2000) confirm that professional identity formation is ongoing and evolving explaining how “images of desired future selves serve as catalysts for identity development” (Ibarra, 1999, p. 766) indicating that future aspirations impact on professional identity. Vignoles, Schwartz and Luyckx (2011) state that, “identity involves people’s explicit and implicit responses to the question “who are you?”” (p. 2).

In the context of this study the self-concept is the meaning pharmacists hold of themselves and how they view themselves. Baxter (2011) explains that professional identity is part of belonging to a particular professional group including how this group interacts, compares and differentiates itself from other professional groups. This is referred to as collective professional identity. This collective professional identity includes pharmacists developing a view of “who

they are” or rather the collective response to the question “who are we?” based on, for example how others may act towards them and their evaluation or perception of themselves. This collective professional identity helps to explain the meaning pharmacists hold of themselves, how they view themselves and how they distinguish themselves from other professions.

6.4.1 Medicines experts

Wenger (2000) argues that being a pharmacist is not enough to constitute a collective professional identity. It is the experience as a professional in learning and creation of knowledge through interaction with different situations and people that determines this identity:

“Our identities determine with whom we will interact with in a knowledge sharing activity, and our willingness and capacity to engage in boundary interactions”. (Wenger, 2000, p. 239)

Pharmacists have a collective professional identity as medicines experts (or drug experts). They base this on their knowledge of both the science and clinical use of medicines, including having an in-depth understanding of the legal and best practice frameworks for medicines-use in different healthcare contexts, which they apply to reduce harm to patients. Pharmacists feel they are the only healthcare professionals with the main focus on medicines and medicines-use describing this as being the ‘raison d’être’ of the pharmacy profession.

NHS pharmacists also have a collective professional identity as ‘clinical pharmacists’. They use this identity not only to differentiate themselves from other healthcare professionals but also from community pharmacists, who they do not consider as being ‘clinical’.

Community pharmacists have two often conflicting professional identities, one being a medicines expert and the other a pharmacy manager or business person managing a commercial retail shop, having to achieve performance targets and generating profits for the owner of the retail pharmacy (See *Section 6.5.3 Professionalism and commercialism*).

Pharmacists’ collective professional identity is as a medicines expert. However NHS pharmacists do not recognise community pharmacists as being medicines

experts, thereby almost denying that there is a collective professional identity that applies to all pharmacists (See *Section 6.7 Intra-professional tensions*).

Elvey, Hassell and Hall's (2013) study of pharmacists' professional identities rejects a collective professional identity, instead identifying that pharmacists have multi-faceted identities suggesting that they lack a clear sense of professional identity. The authors closely link each identity to specific areas of pharmacists' activities such as providing medicines advice to other healthcare professionals and patients which is linked by the authors to the identity of 'the medicines advisor'. The authors found a total of nine different sub-identities but appeared to omit some activities such as education and training. The only exception is the pharmacists' identity as 'the unremarkable character'. It is difficult to understand how pharmacists relate to this identity, unless being linked to them as the hidden healthcare profession. Based on the authors' rationale for determining an identity, pharmacists will only have a collective professional identity if they undertake one activity. In practice pharmacists undertake several different and various activities. A collective professional identity escaped Elvey, Hassell and Hall (2013) who rejected the identity of the medicines expert (drug expert) as their focus was either to identify a different collective professional identity or several different sub-identities. It seemed that the authors found the concepts of role or activities (i.e. what they do) and identity (i.e. who they are) difficult to separate particularly as they are closely linked. Added to this is that Elvey, Hassell and Hall (2013) did not identify a sub-identity for pharmacists providing care to patients but instead found a sub-identity of pharmacists as 'social carers' based on pharmacists sometimes going out of their way for patients. The authors also did not explore the core function that defines pharmacy, which may have aided them in determining a collective professional identity for pharmacists (Dingwall and Wilson, 1995). In contrast to Elvey, Hassell and Hall (2013), this study found that pharmacists share a core function of pharmaceutical surveillance which is linked to their identity as the medicines expert.

Pharmacists view themselves as both scientists and clinicians, which they consider a strength emphasising their academic background, and forming the basis of their identity as the medicines expert. Elvey, Hassell and Hall (2013) found being a 'scientist' is an identity pharmacists associate themselves with although they concluded that pharmacists still need to make the transition from

scientists to clinical healthcare professionals. This is in line with Pietroni's (1991) assertion that there are negative connotations to the image of 'scientists' due to associations of pharmacists being isolated practitioners wearing white coats working in the back of a shop, counting tablets doing 'boring work' and not directly being involved with patients (Willis, Hassell and Ko, 2007; Jesson et al, 2008) (See *Section 6.3.1 Shopkeepers and sticking labels on boxes*). Pharmacists in this study did not consider these two sub-identities, of being a clinician and scientist, as being mutually exclusive, but as a strength.

6.4.2 A weak collective professional identity

Pharmacists' collective professional identity of being the 'medicines expert' is one they expect other healthcare professionals to acknowledge despite being aware that they are often associated with the act of dispensing (See *Section 6.3 Images of pharmacists*).

Other healthcare professionals sometimes consider themselves as 'medicines experts', thereby rejecting pharmacists as the rightful 'medicines experts' in healthcare. This challenges pharmacists' collective professional identity at the micro-level giving them a sense of professional dejection. This is linked to the overarching theme in this study of pharmacists as the 'hidden healthcare profession' adding to their weak collective professional identity. Despite pharmacists having a collective professional identity, it is ill-defined and weak leading to role blurring, confusion of responsibilities and the feeling of either being under- or over-utilised (Hall, 2005; Elvey, Hassell and Hall, 2013).

At the national level this increases pharmacists' vulnerability when dealing with powerful stakeholders (e.g. the State that makes healthcare funding decisions) or when defending their existing jurisdictions or in inter-professional competition for new jurisdictional claims (Elvey, Hassell and Hall, 2013). This weak collective professional identity affects pharmacists' practice and status in society and may be the cause of the pharmacy profession being poorly integrated and corporately organised at the macro-level. It makes it difficult for them to assert themselves as visible healthcare professionals including articulating clearly what their contributions to healthcare are:

"Where professional identity is weak or ill-defined, there may be little scope for resisting bureaucratic requirements, whereas distinctive

and well-organised professions may be more able to retain an independent approach". (Hudson, 2002, p.11)

This weak professional identity is also partly caused by the intra-professional split between community pharmacists and NHS pharmacists (clinical pharmacists) (See *Section 6.7 Intra-professional tensions*).

6.5 Professionalism and pharmacists

Pharmacists link their professionalism and claim to status to their identity as 'medicines experts'. This study found that pharmacists have not engaged with professionalism as an enabling ideology, instead they view professionalism as a tool used by others to control their practice whereby they themselves incorporate professionalism into their work which then affects their behaviour and performance (Evetts, 2013) (See *Chapter 2, Section 2.3.5 Professionalism as a discourse*).

6.5.1 Professionalism in pharmacy practice

Professionalism for pharmacists in this study is an evolving continual practical reflective learning process based on their practice of interacting with patients, pharmacy peers and other healthcare professionals as they mature, including using more experienced pharmacists as role models (Droege, 2003; Schafheutle et al, 2010; Elvey et al, 2015). Evetts (2013) maintains that education, training and in particular practical experience are fundamental prerequisites for professionalism. It is in undertaking pharmacy practice that pharmacists learn professionalism providing them with the discretion to use their judgement to make decisions based on their competencies.

Pharmacists find it difficult to engage with professionalism as a fluid and complex concept. The core function of pharmaceutical surveillance involves checking the work of others to reduce or mitigate risks as a way of creating social order (See *Section 6.2 The core function that defines pharmacy*). Rosenthal and Tsuyuki (2010) argue that pharmacists' rule bound practice reduces or minimises the need for them to exercise discretionary decision-making in highly complex situations (See *Chapter 3, Section 3.3.2.4 Pharmacists' mind-set*). This in turn can be an explanation as to why they have not engaged with professionalism to the same extent as doctors and nurses (Kitson et al, 2012), indicating that professions engage differently with this concept. Elvey et al (2015) found that there are

differences between pharmacists' and other professions' understanding of professionalism, leading them to conclude that each profession should define what professionalism means from its own perspective.

Taylor and Harding (2007) and Schafheutle et al (2012) point out that the foundation to professionalism is established during pharmacists' undergraduate education and pre-registration year. Christou and Wright (2011) argue that pharmacy students' exposure to professionalism is inadequate due to limited contact with pharmacy practice during their undergraduate degree, making them ill-prepared for entering the practice setting. This reinforces the importance of undergraduate pharmacists learning professionalism through engagement with pharmacy practice (See *Section 6.7.2 Limited socialisation*). There is limited research into experienced practising pharmacists' professionalism (Elvey et al, 2015).

6.5.2 Registered healthcare professionals

In terms of the sociology of the professions the functionalist, social closure and systems of professions perspectives all view professional regulation as being important for a profession in terms of social closure and its jurisdiction, although there is limited research on what it means for individual professionals to be registered (Abbott, 1988; Saks, 2012, 2016; Adams, 2015) (See *Chapter 2, Section 2.3.7 Professional regulation*).

Pharmacists in this study have conflicting views about being registered and whether this provides them with status or not. Pharmacists articulate how professional regulation (i.e., being registered with a regulatory body) affects, controls and modifies their behaviour both in their practice but also outside of the workplace. This modification in behaviour is motivated by the negative aspect of being a registered professional (i.e., fear of being disciplined). This appears to be more powerful than pharmacists being motivated by positive aspects such as their desire to deliver high standards of services to patients and to increase their clinical autonomy. Using professionalism as an enabling ideology can be employed as a re-professionalisation strategy to determine and improve standards for pharmacy practice from within the profession.

Although professional registration is seen as desirable for professions at the national level it has a tendency to be linked with discipline and sanctions potentially affecting individual practitioners' livelihoods with their income being at risk (Quick, 2011). Pharmacists' professionalism can be viewed as a tool for the State via their regulatory body to exercise disciplinary mechanisms as a way of monitoring them through annual fees and declarations, including having their continuous professional development records called for inspection on a regular basis. It is no longer enough to be on a professional register but increasingly professionals are being asked to demonstrate their continued capabilities to be able to practise (Becher, 1999; Evetts, 2013).

This has connotations of the Foucauldian concept of the State's disciplinary power of being able to control and influence professionals with limited cost implications for the State through the professionalisation process by professionals themselves meeting the cost of being registered (Foucault, 1977). The State justifies this by arguing that this will benefit public safety through the notion of a professional's responsibilities and accountability not to their own profession, but instead to the State, via the regulatory body, that acts on behalf of the public to protect it (See *Chapter 2, Section 2.3.2.1 Power and knowledge*).

Pharmacists noted that pharmacy technicians' professionalism did not improve once they became registered, thereby devaluing professional registration. Similarly when Operating Department Practitioners became registered it did not re-professionalise them as little changed in terms of their practice such as cementing or expanding their jurisdiction or increasing their autonomy or accountabilities (Timmons, 2011).

A profession being recognised by the State and being registered with a regulatory body no longer provides the same status as it might have in the past. Instead it allows the State to exercise disciplinary control from a distance. Johnson (1972) predicted this development of state-mediated professions where the State controls them through the regulatory and economic route. The State mediates between the professions and their clients or public by deciding what services need to be delivered through determining what services will receive NHS funding. Therefore, the State, as a significant stakeholder, determines what patients' pharmaceutical needs are by controlling the NHS funding of these services. Professionalism in this

context is an economic way whereby the State being the major employer or funding provider of healthcare, can extend its control of healthcare professionals. The State maintains power and control over a profession as it grants them licences to practise, partly funding the professional education system, influencing the standard of practice and regulation around this and funding the services provided by practitioners (Evetts, 2003, 2013).

The State uses professionalism as leverage to control and facilitate professional change. Although the discussion above implies that professions and the State are two opposite forces, the reality is that there is some interdependency, with more powerful and well-organised professions such as doctors having considerable political, sociological and economic influence to negotiate with the State (Freidson, 2001). In contrast pharmacy lacks this negotiating power due to not being a cohesive and 'corporately' well organised profession (Smith, Picton and Dayan, 2013) (See *Section 6.7 Intra-professional tensions*).

The role of the State is critical when discussing professions, as it is the State that legitimises a profession and its professional activities (Evetts, 2013; Saks, 2016). Abbott (1988) underplays the influence of the State on professions instead focusing more on competing professional groups in terms of their re-professionalisation strategies. Being a registered healthcare professional no longer affords them increased jurisdiction or autonomy or status in society as has previously been postulated in the trait approach and the social closure perspective (Witz, 1992; Macdonald, 1995; Saks, 2012, 2016). It is more important for a profession to be corporately organised with the aim of increasing its political power, influence and interdependency with the State to improve its negotiating and bargaining position.

6.5.3 Professionalism and commercialism

Community pharmacists are under pressure to reach commercial corporate performance targets in terms of completing MURs (NHS funded Medicines Use Reviews) even when they consider patients do not require this. If a MUR is not appropriate then a community pharmacist, as a professional should have enough autonomy to use their judgement to determine if a patient will benefit from a MUR or not. There is an expectation that as professionals community pharmacists are able to resist these commercial pressures place on them. McDonald et al (2010)

showed that pharmacists are “under pressure to offer MURs to patients, based on the commercial needs of the pharmacy rather than the patient” (p.456), implying that pharmacists undertake some MURs that are of little benefit to patients. This threatens pharmacists’ “ability to exercise discretion and control over their work” (McDonald et al, 2010, p. 456). Similar findings were made by Bradley, Ashcroft and Noyce (2012). The implication is that there is a threat to pharmacists’ professionalism from the commercial pressures placed on their performance to meet service targets.

This confirms the recurring issue in the literature that there is conflict between pharmacists’ hybrid roles as healthcare professionals and pharmacy managers, which affects their sense of professionalism and by patients and themselves not fully regarding a ‘retail’ pharmacy as a place that delivers healthcare but rather as a place from where prescription medicines are obtained (Birenbaum, 1982; Edmunds & Calnan, 2001; Hibbert, Bissell and Ward, 2002; Hughes and McCann, 2003; Bush, Langley and Wilson, 2009) (See *Chapter 3, Section 3.3.2.2 Community pharmacy and commercialism*).

It is important to examine wider systems and how they influence pharmacists’ judgement and autonomy when exploring professionalism (See *Chapter 2, Section 2.3.5 Professionalism as a discourse*). Organisations delivering healthcare should behave in a pro-social manner, otherwise pharmacists’ professionalism may be undermined (Bishop and Rees, 2007).

Professionalism is used as a discourse by owners of community pharmacies employing pharmacists to enable professional change and control as a way of determining conduct and working practices (See *Chapter 2, 2.3.5 Professionalism as a discourse*). Larger corporate business, via the head office, constructs and dictates professionalism by setting organisational standards with no or little consultation with pharmacists. This type of discourse where an organisation imposes its interpretation of professionalism on its employees that is not aligned with a profession’s own professionalism removes a large part of autonomy and discretionary judgement from the individual practitioner (Hafferty and Castellani, 2010; Evetts, 2013). Instead this organisational professionalism acts as a disciplinary mechanism where the individual’s conduct and performance is called

into question if they do not conform to the organisation's standards and targets (Jacobs et al, 2013).

Pharmacists' own professionalism is breached if they do not act in the best interests of patients but instead aim to purely increase profits. This causes conflict when community pharmacies with a focus on their profit margin and shareholders, deliver healthcare within a largely socialised healthcare system such as the NHS (Anderson, 2002). The result can be that the public and patients lose trust in pharmacists with a resultant reduction in status.

If community pharmacies do not behave as organisations delivering healthcare but instead as retailers where their interpretation of professionalism relates to increasing sales and generating income with little regard for their responsibilities to patients, the NHS and society, then individual employees, such as community pharmacists have limited choice in acting as professionals in that context. Instead they become employees with a role in generating profit and by that they may compromise their own professionalism. They may eventually lose pride in their professionalism, becoming de-motivated and de-professionalised, and lose autonomy, which undermines their status in society (Rapport et al, 2010, 2011; Morton et al, 2015).

Professionalism for pharmacists is about being controlled from afar instead of taking pride in their own professionalism. The conflict between commercialism and professionalism is still an issue for community pharmacists, which continues to threaten the status of the profession.

6.6 Inter-professional relationships

Abbott (1988) states that inter-professional relationships are fundamental to the development of professions and it is the control of work that brings them into conflict with each other asserting that inter-professional "competition is a fact of professional life" (p. 2) (See *Chapter 2, Section 2.3.3 Professions as an inter-related system*).

This study found that an important inter-professional relationship for pharmacists is with doctors, who they academically align themselves with (See *Section 6.6.1 Dependency on doctors*).

Nursing is a profession that applies re-professionalisation efforts that increasingly interfere with pharmacists' jurisdiction as they are developing their roles, being recognised as specialists or advanced nurse practitioners with an increasing number also gaining prescribing rights (See *Chapter 3, Section 3.3.2.3 Prescribing*). Pharmacists view nurses as a profession with limited knowledge of medicines (See *Section 6.6.2 Nurses – friend or foe?*).

Pharmacists delegate work to pharmacy technicians to allow them to undertake clinical pharmacy work as part of their re-professionalisation strategies (See *Section 6.6.3 Pharmacy technicians – a help or hindrance?*).

6.6.1 Dependency on doctors

Professional relationships with doctors are important to pharmacists. The Collaborative Working Relationships (CWR) model and Community of Practice (CoP) model by Wenger and Laver (1991) are used to explore and illustrate the pharmacist-doctor relationship by placing this in context.

This study shows that pharmacists have to demonstrate to doctors they are competent before earning their trust and an interdependent relationship is established, which allows pharmacists to apply their clinical pharmacy knowledge and skills with doctors accepting their recommendations. The pharmacist-doctor relationship is established at the individual level and is not transferable to another pharmacist, who will separately have to earn that doctor's trust. If this trust is not earned, then a doctor may disregard a pharmacist's recommendations.

Studies by Edmunds and Calnan (2001), Hughes and McCann (2003) and Bush, Langley and Wilson (2009) explored community pharmacist – GP relationships and found barriers such as community pharmacists' shopkeeper image and inter-professional competition. This study found that a further barrier is that they work for two different organisations mainly communicating over the telephone via intermediaries such as GP receptionists.

There is limited understanding of the complex relationships between healthcare professionals (D'Amour et al, 2005). Earning trust and the interdependence dynamic between pharmacists and doctors has been described in a theoretical Collaborative Working Relationship (CWR) model developed by McDonough and Doucette (2001) and by Bradley, Ashcroft and Noyce (2012) in their conceptual

model of GP-community pharmacist collaboration (GPCPC). Both models are based on community pharmacist-GP inter-professional relationships. According to a review by Bardet et al (2015) the CWR model is commonly used to explore the community pharmacist-GP inter-professional relationship in the literature. This CWR model acknowledges that these relationships take a long time to establish and are sustained only if both parties consistently contribute through regular contact (Scanzoni, 1979). The CWR model assumes that the pharmacist is proactive in initiating the relationship by actively pursuing this. It is only towards the later stages of the development of these relationships that collaboration and interdependence between the two parties is achieved.

The CWR model describes five stages of the pharmacist-doctor relationship: starting from a position of 'professional awareness', moving to 'professional recognition', to 'exploration and trial', to 'professional relationship expansion' and finally to a 'commitment to the collaborative working relationship'. The CWR model does not include a stage prior to 'professional awareness' where this relationship is 'non-existent' (i.e., the doctor ignores contact made by the pharmacist) as was highlighted by some community pharmacists in this study.

Bradley, Ashcroft and Noyce's (2012) conceptual model of GP-community pharmacist collaboration (GPCPC) includes three collaborative stages: (i) 'isolation', (ii) 'communication' and (iii) 'collaboration'. The GPCPC model was developed relying heavily on the views of GPs rather than community pharmacists. The GPCPC model was specifically developed for the GP–community pharmacy relationship making it less applicable to pharmacists working in other healthcare settings where pharmacists do not work in professional isolation, unlike community pharmacists.

Bradley, Ashcroft and Noyce (2012) identified that community pharmacists and GPs have different perceptions of collaborative working relationships. GPs perceive that when things are going well communication with community pharmacists was not necessary. This contradicts the CWR model, which relies on both parties contributing to the relationship with regular and consistent input (McDonough and Doucette, 2001).

The CWR model best supports the findings from this study. The various CWR stages can be viewed as different evolutionary stages in the individual pharmacist-

GP relationship. It can also be viewed as a continuum used to illustrate where pharmacists from different healthcare settings are in terms of their CWR with doctors.

Community pharmacists in this study had the least developed relationships with doctors (GPs). Mental health pharmacists had the most developed relationships giving examples of CWR with this being due to a long-standing culture of working as part of multi-disciplinary teams (MDTs). Hospital pharmacists covered the range from 'professional recognition' to 'professional relationship expansion'. Community health services pharmacists covered all five, so were difficult to place.

Before pharmacists invest in the pharmacist-doctor relationship they assess whether a doctor is 'pro-pharmacy' or not. This is a strong indicator for the success of establishing this relationship (McDonough and Doucette, 2001). Doctors dismissing pharmacists' input consider that this will not benefit their practice.

The CWR and GPCPC models both imply that pharmacists' practice changes over time as the CWR progresses through the different stages as the pharmacist and doctor become interdependent, having mutual respect for each other's professional knowledge and a recognition of their complementary roles in delivering patient care with a shared focus. Therefore, pharmacists develop and expand their clinical expertise and practice further as the pharmacist–doctor CWR evolves. The assumption is therefore that mental health pharmacists, who already have CWR with doctors, have developed their clinical pharmacy practice further compared with for example hospital pharmacists.

Pharmacists are frustrated when doctors dismiss their prescribing recommendations without considering these before making a decision. Broom et al (2015) translate this frustration as jurisdictional uncertainties. Pharmacists in this study did not display jurisdictional uncertainties and were certain about their jurisdiction and boundaries. This is not surprising as pharmacists uphold the legal and professional standards through their 'pharmaceutical surveillance'. They often find different methods or strategies of modifying doctors' prescribing behaviours when this is required.

As the pharmacist-doctor relationship is established at the individual level there can be examples of full collaborative working relationships in any healthcare

setting. This makes it difficult to make any claims outside the context of this study. The CWR and GPCPC models both describe different stages of the pharmacist-doctor CWR. It should be noted that these models do not provide any answers or solutions about how to solve problems with these relationships.

This study confirms that there is power asymmetry in the pharmacist–doctor relationship with doctors determining the extent pharmacists are able to apply to their pharmacy practice (See *Chapter 2, Section 2.4.2 Medical hegemony and jurisdictional uncertainties* and *Chapter 3, Section 3.3.3.2 Doctors and other healthcare professionals*).

Based on the data from this study, community pharmacists do not participate in multi-disciplinary teams (MDTs). Instead they are professionally isolated from the primary care MDTs.

Hospital and mental health pharmacists regularly attend multi-disciplinary ward rounds. To further contextualise their involvement in attending ward-rounds and how this facilitates them increasing their clinical pharmacy knowledge and skills, the Community of Practice (CoP) framework by Wenger and Lave (1991) is used. The authors claim that CoPs are everywhere and that people are involved in several CoPs whether at work or at home. Wenger and Lave (1991) place learning in the context of social relationships in situations of co-participation, with learning taking place by members actively participating in a CoP.

A CoP consists of “an aggregate of people who come together around mutual engagement and a common endeavour” (Eckert and McConnell-Ginet, 1998, p. 490) wanting to achieve a shared purpose. It is through these social relations, by members being involved in developing relationships over time within a CoP that provides a platform for collective learning resulting in shared practices. Shared practices are ways of approaching and doing tasks or activities that are shared amongst its members. A CoP is organised around an area or areas of knowledge and activities providing members of the CoP with a sense of joint enterprise, a common purpose and identity. Members of the CoP are categorised as core, peripheral or marginal depending on their level of participation and engagement within the CoP (Wenger, 1998). Core members participate fully in the CoP. Peripheral members are not core members but they do contribute and engage in

some of the practices of the CoP that still impact on the overall CoP. Marginal members do not always participate in the CoP and have less influence.

MDTs can be conceptualised as a CoP of collaborative working, which has elements of collaborative learning. Community of Practice (CoP) occurs when people have common interests over an extended period to solve a problem (Wenger, 1998). Using this model of CoP, pharmacists working within MDTs engage as learners in a process of both personal and professional transformation. This leads them to expand their professional roles and clinical pharmacy practice. This in turn alters the norms of the MDT and therefore also its culture, or CoP, and implicitly the NHS trusts in which they work. Therefore, MDTs are where professionals effectively share knowledge and learning across the traditional professional boundaries for the direct benefit of patients but also for direct and indirect benefit to members of the MDTs jointly learning from each other and being able to apply what they have learnt.

Mental health pharmacists prioritise attending MDTs although they span several MDTs, resulting in them being peripheral members (CoP).

Hospital pharmacists in this study do not participate in regular MDTs and are marginalised members. It is possible that there may be instances where pharmacists alternate between being peripheral and marginal members of the MDTs.

These shifts between pharmacists becoming marginalised to peripheral members of a MDT should not be confused with levels of participation in the CoP alternating between being active to passive, which is a separate issue. The latter refers to 'active to passive' as being reflective or 'observing' other MDT members' relational interactions (Wenger, McDermott, and Snyder, 2002).

Applying this CoP model to MDTs demonstrates that pharmacists participating in them as peripheral members have a positive effect on developing the pharmacist-doctor relationship including being able to learn and expand their own clinical pharmacy practice.

Hospital pharmacists talk of being fully integrated into the MDTs on the inpatient wards (See *Section 6.3.3, Pharmacy practice - myths versus reality*). Applying the

CWR and CoP models shows that hospital pharmacists' relationships with doctors may not have fully reached the collaborative stage and that they are marginalised members due to prioritising other ward-work rather than attending MDT ward-rounds.

Wenger (1998) did not consider that members of one CoP could alternate between being a peripheral and marginalised member. The CoP framework is mainly used to explain how newcomers to a CoP develop from being marginalised, to peripheral, to becoming a core member as they learn more. Nevertheless, the CoP is a useful framework to help explore pharmacists' involvement with MDTs and placing this in context.

This study shows that pharmacists negotiate with doctors to establish collaborative working relationships as these allow them to develop their clinical pharmacy practice and the level of pharmaceutical surveillance they are able to undertake, which increases their clinical autonomy and authority as 'medicines experts' while raising their professional status. The building of relationships with doctors can be viewed as a process whereby pharmacists aim for doctors to share some of their 'power' with them despite the power-asymmetry in the pharmacist-doctor relationship, which is something pharmacists accept as a way of extending their own clinical pharmacy practice.

As part of these negotiations pharmacists reinforce the traditional healthcare setup of doctors being in charge of the patient making the final decision regarding diagnosis and determining the treatment. It is within this traditional setup that pharmacists have the opportunity to expand their clinical pharmacy practice including increasing their level of 'pharmaceutical surveillance' without challenging doctors' existing jurisdiction (See *Section 6.2 The core function that defines pharmacy*).

Different authors have argued that pharmacists, in defending their own core activities of dispensing of medicines, have had to uphold doctors' monopoly of diagnosing and making treatment decisions as part of a bargaining position (Eaton and Webb, 1979). This study offers a different explanation for why pharmacists are reinforcing doctors' monopoly of diagnosing and treating patients.

Although NHS pharmacists are part of MDTs they still retain a certain distance and independence preventing them becoming fully integrated due to their core function of pharmaceutical surveillance. The analogy is that the 'police' cannot be fully integrated into the community they serve (See *Section 6.3.2 The 'medicines police'*). This should not be interpreted as a negative development but a desirable one for patient safety and is the reason pharmacists are part of the MDT in the first place.

6.6.2. Nurses - friend or foe?

This study found that pharmacists consider nurses to be at a lower professional hierarchal status than themselves due to their lack of knowledge of medicines (Hind et al, 2003). Although pharmacists work at establishing relationships with nurses, it is not nurses they want to discuss clinical pharmacy issues with, but doctors.

Nurses attempt to manage or control pharmacists by for example bleeping them to demand they attend the ward to check discharge prescriptions or the community pharmacist spending time finding a prescription a GP practice has misplaced. Pharmacists do not appreciate being ordered about by nurses but comply to a point with their requests. In general, pharmacists do not let nurses interfere with their medicines expertise. It is an issue of contention for pharmacists, when for example specialist nurses do not treat them with professional courtesy in relation to medicines or medicines-use. Pharmacists feel that nurses sometimes undertake professional work in terms of medicines (e.g., recommending treatments) without fully understanding the implications of what they are doing, leaving the impression that pharmacists consider that nurses sometimes act as unconsciously incompetent (i.e., they are unaware that they have a deficiency of knowledge in the area concerned). Salhani and Coulter (2009) found in their study that ward nurses were following re-professionalisation efforts of applying dominance and control over other healthcare professionals, even if they were hierarchically above them, to resist their intrusion on nurses' own work content. The authors found that the ward pharmacist resented nurses' interference which resulted in nurses excluding them from decision-making activities by not referring to the pharmacist unless when necessary implying that pharmacists are dependent on nurses drawing some issues to their attention. Salhani and Coulter's (2009) study cannot

corroborate the findings from this study but it does provide a flavour of the complex interdependencies and relationships between professionals. There is little in the literature about the pharmacist-nurse relationship.

Nurses currently follow re-professionalisation strategies that affects pharmacists' areas of expertise (e.g., recommending specialist treatments and becoming independent prescribers) by training to become advanced nurse practitioners (ANPs), which includes prescribing, physical assessments and diagnosis, disease management, medication reviews and helping patients manage their medicines (DH, 2010; Baileff, 2015). It will only take some changes to the nursing undergraduate degree and in their training to become ANPs to cover subject areas such as therapeutics and pharmacology that will result in nurses posing a greater threat to pharmacists in extending their jurisdiction. Although nurses do not display a desire to take over pharmacists' jurisdiction they are able to weaken the ability for pharmacists' to protect and increase their future jurisdictional claims (Parkin, 2016).

Abbott (1988) argues that for a profession to retain "control of knowledge and its applications means dominating outsiders who attach that control" (p. 2). Pharmacists do not try to dominate nurses to retain control of their knowledge and skills. It is as if pharmacists do not perceive nurses as inter-professional competitors for future jurisdictional claims or consider them a threat to their own re-professionalisation efforts.

Abbott (1988) focuses on inter-professional competition based on the assumption that another profession wishes to encroach on another profession's jurisdiction. Abbott does not address situations where a profession, that may not have a desire to take over another profession's established jurisdiction, may nevertheless put forward some competing advances that will weaken the other profession's capacity to secure and expand its area or future area of jurisdiction. Pharmacists in this study see themselves as medicines experts partly because of their knowledge about medicines-use in particular referring to their theoretical undergraduate pharmacology training. ANPs are able to develop practical experience of regularly managing and monitoring patients who are taking medicines. This is an area of practical experience pharmacists lack as they are involved in patient care only briefly and intermittently and in the inpatient setting

sometimes without communicating with patients and often without their knowledge. This weakens pharmacists as medicines experts as there are areas of practical clinical application they are missing which nurses increasingly are acquiring.

6.6.3 Pharmacy technicians - a help or hindrance?

Pharmacists in this study felt the greatest threat to their jurisdiction comes from pharmacy technicians, in particular in hospitals, where they are increasing their scope of practice and their autonomy. Pharmacy technicians, having taken on some of the pharmacists' 'dirty work', allow pharmacists to utilise their clinical pharmacy knowledge and skills. Pharmacy technicians have in some hospitals taken over managing the pharmacy dispensary, with pharmacists having lost that control. Pharmacy technicians extend their jurisdictional claim by encroaching on pharmacists' boundaries by undertaking medicines reconciliation on wards including approaching doctors to discuss any discrepancies with patients' medicines. This provides them with more autonomy by not relying on pharmacists to raise these with doctors.

Other healthcare professionals including doctors are unaware of the differences between pharmacists and pharmacy technicians. This creates tension and conflict between pharmacists and pharmacy technicians, although relations in the workplace are not acrimonious.

Abbott (1988) argues that subordinate groups can have advantages for the dominant profession as it enables this group to focus on extending its jurisdiction. Delegation of routine and less interesting work increases the dominant profession's jurisdiction. For the pharmacy profession this subordination creates what Abbott (1988) refers to as "fuzzy workplace jurisdiction" (p. 72). Abbott argues that, "maintenance of subordination in the workplace requires bringing all this public clarity" (p. 72). The public has limited understanding of what pharmacists do particularly on inpatient wards. This means pharmacy technicians have an opportunity to increase their jurisdiction without this altering the public's perception of pharmacists. According to Abbott (1988) this can cause a problem, as the public will not be able to reinforce pharmacy technicians' subordination to pharmacists in the same way the public does with doctors and nurses. The problem is that pharmacists and pharmacy technicians are already viewed by others collectively as 'pharmacists', although there are significant differences in

their educational attainment and background. The legislation may currently protect pharmacists by making the distinction between pharmacists and pharmacy technicians but legislation can be changed. Although any changes will take time, it only requires the political will for these changes to be made to allow pharmacy technicians to take over some of the traditional work currently undertaken by pharmacists in for example, the pharmacy dispensary.

6.7 Intra-professional tensions

All professions have internal segments that lead to intra-professional divisions resulting in intra-professional differentiation in status (Bucher and Stauss, 1961; Abbott, 1988; Macdonald, 1995). Previous studies have found there are several different segments within the pharmacy profession often relating to the type of organisations pharmacists work in and their role within them (See *Chapter 2, Section 2.4.3, Internal divisions*). This study presumed at the outset that there were intra-professional divisions within pharmacy based on the assumption that the nature of pharmacy practice varies depending on the healthcare setting in which pharmacists work (See *Chapter 3, Section 3.3.1 Intra-professional divisions*).

6.7.1 Internal divisions or a spilt?

According to Birenbaum (1982) and Holloway, Jewson and Mason (1986) the intra-professional tensions between community and NHS pharmacists can be traced back to the inception of hospital pharmacy suggesting these mainly relate to hospital pharmacists re-professionalising pharmacy by embracing clinical pharmacy which was viewed as a significant paradigm shift for the pharmacy profession. Community pharmacists did not see these developments as necessary, resisting this modernisation of pharmacy (Holloway, Jewson and Mason, 1986).

Despite this it was an unexpected finding in this study that NHS pharmacists felt as strongly as they did that community pharmacists reflect badly on the profession due to not having developed their practice beyond the act of dispensing and working in 'retail' shops. In contrast NHS pharmacists are in the process of abandoning the hospital pharmacy dispensary to focus on the clinical pharmacy aspects of their practice.

Macdonald (1995) refers to a quote from *Alice Through the Looking Glass* to illustrate that a profession needs to continuously develop and re-professionalise to retain its current position and status in society and that it has to work even harder to develop further from its current position. The implication is that if a profession relies on the status quo this constitutes de-professionalisation with subsequent loss of status:

“Now, here, you see, it takes all the running you can do, to keep in the same place. If you want to get somewhere else, you must run at least twice as fast as that!”. (Lewis Carroll, *Alice Through the Looking Glass*)

NHS pharmacists predict that the de-professionalisation of community pharmacists will lead to a new type of non-clinical pharmacy professional evolving concerned with medicines supply, procurement and technical dispensing activities, replacing community pharmacists.

Goode (1957) describes a profession as a ‘community’ that is bound together by a sense of shared identity, values and consensus of its social mandate in society. Freidson (2001) concurs that to be considered a profession there should be a strong sense of community with a profession being ‘corporately’ organised at the macro-level (See *Chapter 2, Sections 2.3.6 Defining professions and 2.4.3 Internal divisions*). According to Goode’s (1957) and Freidson’s (2001) descriptions of a profession, NHS pharmacists and community pharmacists do not appear to belong to the same cohesive community and therefore are two different professions.

This returns the discussion to what constitutes or defines a profession and if pharmacy is one or two different professions due to it having different visions and values which act as a barrier for pharmacy forming a cohesive community at the macro-level in its bargaining with the State and other stakeholders (Saks, 2016). This study calls into question if it is sufficient to be considered part of the same profession by sharing the same undergraduate education and being registered with the same regulatory body.

6.7.2 Limited socialisation

Pharmacists in England mainly establish their collective professional identity and values once they start to work within their chosen healthcare setting. According to Harding and Taylor (2006) this is because pharmacy students have limited

exposure to practice placements, which are considered important opportunities for their professional socialisation. This is unlike medical and nursing students who are professionally socialised into their respective professions during student practice placements providing them with distinct collective professional identities and values (Harding and Taylor, 2006). Socialisation involves:

“The acquisition of attitudes and values, of skills and behaviour patterns making up social roles established in social structures”.
(Merton, Reader and Kendal, 1957, p. 41)

Community pharmacists refer to starting as pharmacy managers the day after having registered as a pharmacist. NHS pharmacists initially join junior pharmacist rotations in hospitals completing a post-graduate diploma in pharmacy practice. After that there is no formal career pathway besides applying for jobs within a higher pay band. NHS pharmacists pursue a goal of specialising in a clinical area as a re-professionalisation strategy to gain individual recognition and implicit collective recognition and status. If NHS pharmacists wish to progress this means having to move into management as pharmacist consultant posts have not materialised as expected (See *Chapter 3, Section 3.3.2.1 Education as a re-professionalisation strategy*).

Therefore, limited professional socialisation takes place once pharmacists are registered, which is partly caused by an inadequate career structure.

Larson (2013) argues that one professionalisation strategy for a profession is to have a formal career structure that allows registered practitioners to progress to different levels of specialisation through a formal process of being trained in practice by more experienced practitioners. Larson's (2013) point is that a profession with an embedded formal career structure has stability in society. This is because their professional association and employing organisations will have accepted these career structures including the additional training and supervisory requirements to support these. Larson (2013) explains that this professionalisation strategy helps maintain a profession's status in society as well as continuing the professional socialisation process, which implicitly ensures the elite of the profession can exert some social control and practice standards over practitioners that are moving through this formal career structure. It is speculated that this contributes towards a profession being more cohesive including fostering an overall “ideological solidarity within the profession” (Larson, 2013, p. 227).

This study shows that community pharmacists' work situation maintains their professional isolation from the point of becoming registered pharmacists. This isolation involves separation from their pharmacist peers and other healthcare professionals. Community pharmacists' professional isolation together with limited professional socialisation can explain why NHS pharmacists view community pharmacists to be less 'professional' than themselves (Larson, 2013).

The consequence of limited professional socialisation has contributed to pharmacists having a weak collective professional identity, lacking universal shared values and having no ideological professional solidarity, all contributing to the lack of professional cohesion (Smith, Picton and Dayan, 2013) (See *Chapter 6, Section 6.4.2 A weak collective professional identity*).

6.7.3 Diversification - strength or weakness?

Bucher and Strauss (1961) and Abbott (1988) explain that emergence of different specialisms and interests within a profession lead to the development of sub-groups, which are implicitly important for its continued re-professionalisation efforts. These developments are known but the significance and implications are rarely acknowledged or explored in the sociological literature. Bucher and Strauss (1961) observed that within a profession (medicine) there is internal divisiveness because of divergent interests resulting in competing and conflicting specialist sub-groups. These sub-groups are formed as a profession matures:

“In so far as collegueship refers to a relationship characterised by a high degree of shared interests and common symbols, it is probably rare that all members of a profession are even potentially colleagues”. (Bucher and Strauss, 1961, p. 330)

Each sub-group within a profession will engage in claim-making activities. The aim is to persuade others within their own profession and stakeholders outside the profession about their importance in furthering the profession by seeking recognition of being authoritative in their particular professional area as a way of gaining intra-professional status. Although community versus NHS pharmacists are sub-sector groups it can be argued that they behave in a similar way to specialist sub-groups. Lawson (1991) argues that a profession generally engages in problem-solving. However, each sub-group within a profession also engages in problem-setting when there are disagreements between the different sub-groups. Lawson (1991) describes each sub-group as a 'paradigmatic community' to denote

differences in the approach to problem-setting within each sub-group trying to convince the profession to take on their particular approach. The outcome is internal jockeying for political position within a profession between the different sub-groups. This demonstrates that intra-professional divisions involve some competition and conflicts that are continuous, fluid and dynamic. However, Bucher and Strauss (1961) predict that no one sub-group generally emerges as a dominant group because of these dynamic processes. The risk to a profession is when these sub-groups spend most of their time on infighting.

Abbott's (1988) explanations of intra-professional divisions are limited to differentiation of internal professional status ranking and internal competition over a particular claim to jurisdictional control. These explanations do not adequately address the findings from this study. Abbott (1988) does not explore intra-professional divisions and its impact on a profession. Instead he has a tendency to conceptualise professions as if they remain homogenous possibly making the assumption that intra-professional divisions can be contained within a profession instead of resulting in internal fragmentation or a split. Abbott (1988) acknowledges that he has not fully explored or emphasised intra-professional divisions although this is important for the re- or de-professionalisation of a profession and its status.

Johnson (1972) views a profession as homogenous by which he means that a profession has "homogeneity of outlook and interests" (p. 53) with a clearly agreed mission and vision with a low degree of divergent specialisation. Unlike Bucher and Strauss (1961), Johnson (1972) argues that specialisation and development of sub-groups within a profession will threaten it and adversely affect its re-professionalisation efforts. If a profession is one homogenous group then the danger is that this leads to stagnation and de-professionalisation. This will eventually lead to loss of its jurisdiction and status. Nancarrow and Borthwick (2005) argue that diversity within a profession results in expansion of professional boundaries and that intra-professional changes form part of a profession's re-professionalisation efforts. This implies that intra-professional divisions can strengthen a profession by encompassing all its members' varied interests, whereas this study points towards a situation where this internal diversification no longer has a re-professionalising effect, but instead turns into an internal split, which has a de-professionalising effect on the whole profession.

6.7.4 Unified or multiple voices

Another assumption made in the sociology of the professions is that a profession is organised corporately by one single professional association that may also act as its self-regulator (Macdonald, 1995; Saks, 2016). In the case of the pharmacy profession there are several professional associations that claim to represent its interests (See *Chapter 3, Section 3.3.4.1 Political autonomy*). The Royal Pharmaceutical Society is the main professional association but not the only one claiming to represent pharmacy.

Macdonald (1995), Larson (2013) and Saks (2016) point out that it is in influencing political processes and establishing political networks that are important for a profession as a way of defending its jurisdiction and of extending its scope of activities or boundaries (See *Chapter 2, Section 2.3.2 The 'power approach'*). It is therefore important that a profession is able to unite and speak with one voice:

“Professional unity is necessary if a professional body is to be sufficiently impressive to obtain state recognition”. (Macdonald, 1995, p.199)

Macdonald (1995) refers to this as regulatory bargaining. He explains this political bargaining as being a continuous process between a profession and the State, which is of “the greatest importance in shaping professional development and change” (Nancarrow and Borthwick, 2005, p. 903). A profession requires a corporate professional association to manage, liaise and negotiate with the State but also with other important stakeholders and in fostering relations with other professions, the public and with its own members and to advocate the profession’s position.

It is rarely acknowledged that if a profession is represented by one unifying corporate professional association it will need to accommodate a conglomerate of different sub-groups. This professional association will have to order and control various semi-autonomous sub-groups by getting them to sign up to a common alliance such as generating a foundation of unifying principles based on common interests that are central to all, shared values and a clear vision for the future to create a cohesive whole as a way of strengthening the profession rather than letting intra-professional divisions result in fragmentation or a split. Macdonald

(1995) notes that the profession-state relationship at some point has been influenced by internal conflicts within a profession:

“The professional/state relationship in Britain, especially as concerns the striking of the ‘regulative bargain’, has been more influenced by internal conflict within the occupation at certain periods than by anything else”. (Macdonald, 1995, p. 118)

According to Smith, Picton and Dayan (2013) the pharmacy profession has no shared values or common vision for the future. Instead the profession is represented by several different professional associations that claim to represent the profession or segments of it. Therefore, for these different associations or organisations to effectively represent the entire pharmacy profession they will need to work together through forming formal partnerships or coalitions.

The problem with fragmentation or a split within a profession is that it results in lack of cohesiveness, which spills over into the public and political arenas demonstrating a weak profession. This makes it difficult for a profession to speak with a unified voice. It weakens a profession’s bargaining position and its effectiveness in influencing or shaping policies if policy-makers receive conflicting messages from multiple sub-professional groups claiming to speak on behalf of the profession (Dowdall, 2017). Other stakeholders may take advantage of this weakness, for example politicians may seek to increase competition as a way of reducing costs or other professions may seek to expand their boundaries and jurisdiction at the expense of the pharmacy profession. It can be surmised that this eventually will lead to the de-professionalisation of the profession.

Larson (2013) and Abbott (1988) acknowledge that in reality there are intra-professional divisions and intra-professional status differences within a profession. The social closure perspective is based on the assumption that any intra-professional division can be contained so that at the national level a profession via its professional association is presented as a cohesive group (Macdonald, 1995; Saks, 2016). Murphy (1986) explains that it is this cohesiveness within a profession that is an important resource or prerequisite for the social closure perspective in a profession’s negotiations with the State and other external stakeholders (See *Chapter 2, Section 2.3.2 The ‘power approach’*).

Prevailing sociology of the professions theories imply that professions will always resist de-professionalisation processes through different mechanisms. The

pharmacy profession's lack of resistance to de-professionalisation could indicate that other sociology theories are required to explore or explain this further in terms of the pharmacy profession. The data from this study do not lend support to the neo-Weberian social closure perspective because the pharmacy profession does not follow the course of action that is considered normal for a profession to defend its niche of work.

6.8 Summary

This study explored pharmacists' perceptions of the nature of pharmacy practice, using a Foucauldian perspective to identify the core function that defines the pharmacy profession as pharmaceutical surveillance. In its broadest sense, the social objects for pharmacists are 'medicines' and 'medicines-use', which their pharmaceutical surveillance services are directed towards with the aim of reducing risk related to medicines-use in different social contexts to improve patient safety. Pharmaceutical surveillance is about pharmacists surveilling other healthcare professionals' practice related to medicines-use (e.g., prescribing or administration) and patients' medicines-taking behaviour. The core function places the pharmacy profession and the nature of pharmacy practice in a more favourable light than previously suggested in the sociology literature.

This 'pharmaceutical surveillance' provides pharmacists with subtle power over doctors and other healthcare professionals. Pharmacists work as an agent of the State as their pharmaceutical surveillance contributes to the economic use of medicines within NHS trusts and with community pharmacists undertaking formal cognitive pharmaceutical services to influence patients' behaviour and lifestyles in order to adhere to their medicines to help contain costs and reduce medicines waste. Pharmacists have a role in developing cognitive pharmaceutical services in healthcare. Despite community pharmacists being funded by the NHS to provide some of these services, the pharmacy profession has not made a jurisdictional claim to this area of practice by gaining the right to perform these formal cognitive pharmaceutical services. Controlling this area of practice through defining best practice standards and more importantly by making this claim in the public arena generates a demand for these services along with the State sanctioning the pharmacy profession to lead on these services.

NHS pharmacists' pharmaceutical surveillance does not constitute an encroachment or delegation from doctors as claimed in the literature, but rather the development of their existing pharmaceutical surveillance which they move from the pharmacy dispensary to the wards. NHS pharmacists are making jurisdictional claims to pharmaceutical surveillance on the wards but find it a challenge to take this to the public arena as it is a difficult message to convey that pharmacists prevent medication errors made by other healthcare professionals.

Doctors retain medical hegemony over pharmacists' practice regardless of the healthcare setting in which they work, which pharmacists accept. When doctors and pharmacists work closely together this enhances pharmacists' learning by developing their clinical pharmacy knowledge and skills enabling them to undertake more comprehensive pharmaceutical surveillance.

Images of the shopkeeper and sticking labels on boxes link pharmacists to the act of dispensing in a 'retail' shop, regardless of the healthcare setting pharmacists work in, asserting Abbott's (1988) claim that the public has an image of the profession based on 'typical community pharmacists'. These images affect pharmacists' practice thereby reinforcing these images.

Pharmacists have not engaged with professionalism as an enabling ideology based on what professionalism means for them as a re-professionalisation strategy. Instead they perceive professionalism as disciplinary mechanisms whereby their regulatory body, via the State, controls and modifies their behaviour being monitored from afar. The conflict between professionalism and commercialism continues to be an issue for community pharmacists, which threatens their status.

According to Abbott (1988) focusing on pharmacists' professional life by exploring the nature of pharmacy practice can aid in explaining more about the pharmacy profession and how it is organised at the macro-level. Despite all pharmacists sharing the same core function, NHS pharmacists consider they have little in common with community pharmacists in terms of their pharmacy practice (i.e., the level of pharmaceutical surveillance they are able to undertake), clinical pharmacy knowledge and skills, professional identity, inter-professional relationships, work environment, career patterns, aspirations and re-professionalisation strategies. In addition NHS pharmacists are disappointed that community pharmacists have not

been able to develop their practice past the act of dispensing including having failed to develop cognitive pharmaceutical services further to enhance the status of pharmacy. Community pharmacists are overwhelmed by their current workload, wanting to maintain the status quo which de-professionalises the pharmacy profession.

There are factors besides having completed the same undergraduate degree and being registered with the same regulatory body that makes members belong to the same profession, with socialisation being an important element. Professional socialisation can strengthen and create a distinct collective professional identity including facilitating ideological solidarity within a profession (Harding and Taylor, 2006; Larson, 2013). It was speculated that part of the reason for this split within the pharmacy profession is due to a lack of socialisation through practice placements for pharmacy students and when working as practising pharmacists. This is compounded by most community pharmacists working in relative isolation from their pharmacy peers from the point of becoming registered.

This internal split at the micro-level is played out at the macro-level, where the pharmacy profession lacks professional cohesion and is represented by different professional bodies all claiming to represent the profession resulting in fragmentation weakening their political bargaining position and with policy-makers receiving conflicting messages. This split at the macro-level can lead to de-professionalisation of the profession. The data from this study does not support the neo-Weberian social closure perspective because the pharmacy profession does not follow the actions considered to be normal for a profession in achieving social closure.

There is limited public awareness of the pharmacy profession and of their professional dilemmas and therefore limited public support. Pharmacists remain the hidden healthcare professional with the profession being fragmented and therefore weak. The next chapter will conclude this thesis covering the contributions made to knowledge about the pharmacy profession and theories on the sociology of the professions including suggestions for potential future research.

CHAPTER SEVEN: Reflexivity and reflection

7.1 Introduction

The previous chapter discussed the findings by placing these into a wider context using the working theories on the sociology of the professions. This qualitative collective case research study was based on the researcher's interpretation of moving from the data to the theme and sub-themes that constituted the findings.

The researcher followed a process of reflexivity which Lincoln and Guba (2000) describe as "the process of reflecting critically on the self as researcher, the 'human instrument'" (p.183) as a way of articulating and clarifying how the researcher influenced the research process. This is to allow the reader to better understand how the researcher arrived at the different interpretations or decisions made during the research processes and as a way of maintaining the integrity of this qualitative research. The researcher maintained a Researcher Journal throughout this study.

This chapter covers researcher reflexivity and reflection and discusses the strengths and limitations of this study. Reflexivity is a term referred to as the process of the researcher being conscious of and reflective about how they influence the study and their own subjective position in the study (Lincoln and Guba, 2000; Langdrige, 2007). There is criticism in the literature that although reflexivity is considered crucial in qualitative research it is rarely fully addressed but merely mentioned (Langdrige, 2007; Holliday, 2007). In contrast to this, reflexivity can also result in researchers being self-indulgent in an attempt to demonstrate their influence to prove the validity of a study using this process as if the "confessional abdicates responsibility" (Langdrige, 2007, p.61). This section builds on insights into how the role and position as a researcher influenced the study.

7.2 Reflexivity and reflection

The concepts of reflection and reflexivity are often used interchangeably. Reflection refers to a researcher criticising their tacit understanding of research practice as a process of enabling them to make new sense of situations (Droege, 2003). There are similarities between reflection and reflexivity but the latter is more active and deeper than reflection (Dowling, 2006).

There are different definitions used for reflexivity. Reflexivity responds to the realisation that researchers and their methods interact and are entangled in the social world they study (Holliday, 2007). Reflexivity is a way of recognising “the involvement of the researcher as an active participant in the research process” (King, 2004, p. 20) and is “the process of reflecting critically on the self as a researcher, the ‘human as instrument’” (Lincoln and Guba, 2000, p. 183) and is a way to “arrive at fresh understandings” (Holliday, 2007, p.138). Therefore, researchers are reflexive when they are aware of the multiple influences they have on the research process and how the research process affects them.

7.2.1 Qualitative research approach

Often research studies are presented as final products where the research question and approach are clearly stated leaving an impression that determining this is a simple process. For this study there were many decision-making processes in terms of shaping the research question, deciding on the methodological approach, the data collection and analysis methods including considering the different philosophical perspectives or paradigms, none of which were straight forward. There were many uncertainties including having to explore research processes further and there were some false starts before eventually deciding on the final research question, methodological approach, methods and research paradigms. During the actual research process these were re-visited and further uncertainty ensued, with having to make further decisions and putting forward arguments for the choices made:

“Undertaking this research has been a journey of ‘thinking’ rather than a pre-determined process. This journey is not a process of doing what I wanted to do but rather a process where I actively had to engage with the research process, the literature and data being caught up in cycles of interpretations and questioning previous assumptions. This often involved going back to the literature for more answers or inspiration, but also sometimes losing my way, often only to find that I ended up going back to the same place but with a different perspective”. (Researcher Journal)

Throughout the study the researcher had to question and evaluate her assumptions and preconceptions. Some of this reflexivity and reflection has been incorporated in the text of this thesis. The purpose was to allow the reader to assess how and to what extent the researcher’s interests, assumptions and role as

a pharmacist and researcher influenced the study and to be as open and transparent as possible (Holliday, 2007; Simons, 2009).

7.2.2 Engaging with the sociology of the professions

The researcher acknowledged that undertaking research about the pharmacy profession where the participants were also pharmacists could result in not being as critical of the data and of the pharmacy profession as perhaps a researcher from outside the profession might have been. The researcher had to develop an awareness to critically consider her interpretation of the data and literature. Using theories on the sociology of the professions allowed understanding and interpretation of the pharmacy profession in a different way, providing a more critical view.

The researcher had to engage with and understand many new concepts, for example in terms of research methodologies and the sociology of the professions. Understanding the difference between the terms 'role' and 'identity' may seem simple enough but it was only by engaging with role theory (Biddle, 1986) and with the notion of identity (Gegas, 1982; Vignoles, Schwartz and Luyckx, 2011) that the differences between these two concepts became clear. Initially in the study the researcher focused on 'role' and 'role theory'. This resulted in the study coming to a halt during the data analysis phase.

There was a major shift and refocus once the word 'roles' was substituted with the 'nature of pharmacy practice'.

Dowling (2006) maintains that reflexivity is not only achieved through self-reflexivity as almost private contemplation described as 'introspection' (Finlay, 2002a, 2002b) but also through creating tension, for example as that between academic supervisors as 'critical friends' and the researcher. One such significant tension was when the academic supervisor challenged the researcher to consider and to reflect further on the findings made in terms of the image of pharmacists, relating this to the sociology of the professions. This also involved challenging the researcher to adopt a broader perspective of the pharmacy profession utilising theories on the sociology of the professions. This meant the researcher re-visited the theories on professions, in particular Abbott's (1988) *System of professions. An essay on the division of expert labor* and the neo-Weberian social closure

perspective (Witz, 1992; Macdonald, 1995; Saks, 2016), with a renewed and clearer focus, which started to make sense. This brought in a different perspective enabling the researcher to view the pharmacy profession through a less familiar 'lens'.

This tension or challenge resulted in a shift in how the researcher started to approach and think about the study. Anafara and Mertz (2006) explain this process of engaging with theories as, "to understand a theory is to experience a shift in one's mental structure and discover a different way of thinking" (p. xiv). Bissell and Traulsen (2005) believe this exposure to theory can affect researchers on a personal level as everything we learn, or changes in how we view the world will change us on a personal level.

7.2.3 Research question

Initially the researcher knew the general area or topic of the research but was not quite sure of the research question. Engaging with the literature demonstrated that there were gaps in research exploring how pharmacists themselves perceive their role in healthcare as well as sociologists having neglected studying pharmacists. This initially led to the research questions: *How do pharmacists working in different healthcare settings perceive their professional roles?* and: *What are the similarities and differences in these pharmacists' perceptions of their professional roles in relation to the healthcare setting in which they work?*

The developmental nature of the research process, through constant reflection of the research, and eventually engaging with the literature and theories on the sociology of the professions helped to evolve and shape the focus of this study. Throughout the data collection and analysis phases and the continuing review of the literature, the researcher realised that the initial focus was too narrow which needed to be broadened as this narrow focus on pharmacists' roles was restricting the study. This resonated with O'Leary's (2004) view that a research question guides the body of literature accessed but also the sociology theories are engaged with. Creswell (2007) suggests that researchers should aim to state the broadest research question possible. One of the initial reasons for exploring pharmacists' perceptions of their professional roles was also to relate this to their place in society in terms of the profession's status although this was never initially articulated.

Through processes of reflection the researcher came to the realisation that this research had all along also been about pharmacists' practice which is linked to their status (See *Chapter 2, The sociology of the professions and pharmacy*).

The other realisation following revisiting the researcher's journal and re-reading the literature was to re-formulate the aim of the study identifying the core function that defines the pharmacy profession:

"Is there a fundamental generic role or function that forms the basis of the pharmacy professional regardless of whether they are working in community pharmacy or hospital? Why is this important? If it is possible to identify or define this fundamental core function then this would help pharmacists to articulate to themselves and others what their contributions are to healthcare. It will also make others understand that pharmacy is more than dispensing. Is this possible as there are so many different and varied aspects to their professional roles?". (Researcher Journal, early entry)

The study was, therefore, not limited to how pharmacists perceived their professional roles (or professional work) in healthcare although this did form the core part of the research. During the study the research question was therefore reformulated to: *How do pharmacists working in different healthcare settings perceive their status in society today?* The four study aims were formulated to guide the study (See *Chapter 2, The sociology of the professions and pharmacy*).

7.2.4 Interviewing fellow professionals

The researcher reflected on undertaking interviews of fellow professionals. There appeared to be a pre-understanding between the researcher and participants that they were part of the same profession sharing the same technical language. This may have led the researcher to make some incorrect assumptions about what was said. She tried to be conscious of this by asking the participant for clarification, which did lead to some instances where a participant's body-language indicated that they felt the researcher, as a pharmacist, should have understood what they meant, although all participants were polite and explained a concept or situation when asked to elaborate further. Being part of the same profession made it possible to pursue issues in more depth due to the fact that the researcher did not have to seek explanations of common terminology or concepts (Chew-Graham, May and Perry, 2002).

The participants gave the impression that they wanted to help the researcher. They sought reassurance that they had answered a question fully for example by asking 'I hope this answers the question?'. Some of the participants viewed the interview as a test or as a way of the researcher trying to 'catch them out' despite reassurance to the contrary, which was not expected. Coar and Sim (2006) noted similar responses when they interviewed fellow general practitioners for their studies.

Interviewing fellow professionals did provide interesting insights. Some did not feel they had to be 'politically correct' as there appeared to be a certain unsaid understanding between the researcher and participant. Conversely there were also examples where participants responded in a less open way to maintain a positive professional image and distance (Coar and Sim, 2006).

After the interview some participants responded that it either felt like a job interview or being psychoanalysed or made them reflect on their professional work, which was not something they had previously done. One participant reported feeling exhausted after the interview. This could have been because some participants may have felt under scrutiny or not being familiar with being asked open-ended questions which encouraged them to reflect and talk about their own practice to elicit their personal perceptions, experiences and views. Possibly the only situation where pharmacists have experience of being asked open-ended questions may have been in a job interview situation.

7.2.5 Analysing and making sense of the data

Semi-structured interviews, the primary data for this study, rely on the assumption that the participant is able and willing to provide the information and that this information is there to be discovered. The researcher is then tasked with turning these subjective experiences into representations that allow interpretation and reveal insights more generally than that beyond the individual participant (King and Horrocks, 2010). The amount of data collected was overwhelming and the researcher felt a sense of responsibility towards the participants to represent the findings in a way that made sense to them. The researcher tried to represent the views of the participants, negotiating between different perspectives and different contexts such as the healthcare setting, which was achieved by analysing each case study separately before undertaking the collective case study. It was a

difficult experience having to make choices during the data analysis and interpretation phases. Simons (2009) reports that these aspects are the most underreported in the literature, particularly as they rely on the researcher's experience and interpretive skills which are often "personal and intuitive" (Simons, 2009, p.117). (See *Chapter 4, Section 4.10.3 Moving from data to theme*).

Several authors on qualitative research remind researchers that 'data do not speak for themselves' but that it is the researcher that makes sense of the data, identifies the themes, reveals the insights and generates the explanations (Simons, 2009; Merriam, 2009). The researcher had to accept that in a constructivist collective case study her role as researcher influenced the data but that this did not invalidate the interpretations of the findings, but instead acknowledged that these relied on the researcher's reflections on prior experience and intuition as a way of increasing the understanding of a complex issue (Simons, 2009).

It was only when considering the literature reviews and the theories on the sociology of the professions, as a way of adopting an overall conceptual framework and perspective to make sense of the data and placing the findings in context, that it was possible to move forward with the data analysis.

The initial findings were revisited several times during the study including the transcripts and raw data (voice recordings) to undertake further data analysis based on the renewed perspective moving the analysis from being data-driven to an interpretative data analysis providing insight and understanding. The researcher came to understand, implicitly and explicitly that there must be some guiding thoughts at work when going from the raw data, to the data analysis, to the findings, discussion and conclusion (Bissell and Traulsen, 2005):

"I felt there should be a common core function shared by all pharmacists regardless of the healthcare setting. I could not articulate what this was. This common core function eluded me when undertaking with-in case analysis. I wanted to look beyond dispensing as some pharmacists in this study were not involved in any dispensing activities. The clinical pharmacy activities on the inpatient wards appeared to be an enhancement of the medicines supply function. Pharmacists in the NHS (cases of HPs, MHPs and CHSPs) were undertaking several different activities unrelated to dispensing of medicines which was more than providing medicines advice or information-giving. It was when undertaking the cross-case analysis that I started to think that this core function appeared to be linked to some type of quality control or quality assurance function. I

could not move this forward. It was several combinations that helped to shift my thinking. I re-read the paper by Dingwall and Wilson (1995) who referred to community pharmacists as acting as “disciplinary agents” (p.120). I tried to look towards other professions thinking dentists and pharmacists as professions had common issues around professionalism. I was exploring pharmacists’ autonomy and their power using the sociology of the professions. I had previously looked at Foucault’s work but had found this difficult to access. I discussed this with my academic supervisor who recommended that I obtained the book by Sarah Nettleton examining dentistry using Foucault, making his work easier to comprehend. I revisited the data, the with-in case analysis and cross-case analysis again. It became apparent that the core function that had previously eluded me was what I referred to as ‘pharmaceutical surveillance’. Once I had identified this as the core function it was difficult to understand why I had not seen this much earlier in the process”. (Researcher Journal)

Participants in some instances hinted at pharmacy workforce issues around a mainly female-dominated profession, and being towards the mid-to-end of their career. Some female participants talked of having or currently working part-time to balance work and family life. One participant expressed frustration over having to manage a mainly female work-force as most worked part-time and the impact on a small department when they go on maternity leave. Some participants who referred to being towards the mid-to-end of their careers felt that promotion opportunities were no longer available to them and that they had missed out on past and also on current educational opportunities while accepting that there was no possibility of career progression. Instead they focused on being content in their current position. Although the researcher acknowledges that a mainly female work-force will have implications for the pharmacy profession as would issues around older pharmacists towards the mid-end of their career, it was not within the scope of this study. These topics could form research topics in their own right.

7.2.6 Writing style

The writing style for the thesis became an issue. Although the researcher’s research paradigm was constructivist, her position within this paradigm was close to the post-positivist paradigm (See *Chapter 4, Section 4.3.1 Researcher paradigm*). It can be argued that writing in the third person, being a passive voice, is a way of trying to convey objectivity. This was not the intention. Instead the researcher tried to position herself in the study by referring to ‘the researcher’ when sharing her views, thoughts or opinions. It was decided not to write in the

first person as this was more difficult although it would possibly have felt more honest and transparent by having a more active voice in the research.

Researchers writing in the third person could inadvertently silence both the participants and the researcher which is contradictory to qualitative research. Another criticism of writing in the third person is that there is a danger of a researcher not taking responsibility for the data analysis and the interpretation (Holliday, 2007). It can also be argued that writing in the third person could resonate with 'bracketing' or epoché used in phenomenology where the researcher tries to set aside their experience in an attempt to take a fresh perspective on the topic under investigation (Langdrige, 2007). The researcher argues that it is not possible to truly bracket off a researcher's preconceptions and again this was not the researcher's intention. The researcher did try to position herself in the study as 'the researcher' by aiming for reflexivity.

7.2.7 Doing research whilst working

In the literature the assumption is often that researchers are either already working in a research environment or undertaking the research full-time. There is little in the literature on undertaking research whilst also working in practice and how this may impact on the research process. The paradox between work and undertaking research was noticeable. There were competing priorities between work, family life and the study, which were not always easy to balance. There were many times where work took priority over the study, due to various tight and important deadlines for various projects or having to deal with internal organisational changes including having to cover for pharmacy staff being on long-term sick-leave or difficulties in recruiting for new posts. The researcher tried to manage this by ring-fencing time for the study, but in practice this was difficult.

Another aspect was that the thought-processes required for work versus research were very different. This made it difficult to sit down for short periods of time to work on the study. Addressing work problems required using convergent thought-processes relying on logical thinking by analysing different options available and making a decision relying less on creativity in identifying a solution. In contrast, when working on the study, a different mind-set was required. This involved having to change from convergent thinking to more divergent thought-processes allowing for more creative thinking being more open or susceptible to new information (O'Leary, 2004). Switching between the different ways of thinking or mind-sets and

work versus study, were more difficult during times when there was increased work-pressure.

The impression when interviewing pharmacists was that they are hard-working and dedicated. Regardless of the healthcare setting in which they worked they all wanted to and did feel they made a difference to patient care. The findings and discussion did not appear to be positive towards community pharmacists which does not reflect the researcher's personal view but emerged through engaging with the theories on the sociology of the professions.

7.2.8 Sense checking the findings

The final findings from this study were presented to stakeholders who were considered to be knowledgeable about the pharmacy profession as a way of sense checking the findings made (See *Section 7.3, Research strengths and limitations*). The feedback from these peer review(s) was a way to check the findings again to ensure the interpretations made by the researcher made sense to the pharmacy profession and to assess that the claims made were appropriate for the data collected and the arguments around it and that these claims corresponded or rang 'true' to other pharmacists (Holliday, 2007).

7.3 Research strengths and limitations

Some of the strengths and limitations of this study have been discussed in the text of this thesis. However, some of these warrant separate discussion. The methodology alongside the rationale for justifying its use and appropriateness was discussed in *Chapter 4, Methodology and methods*.

In retrospect the biggest limitations of the study were the broad and wide ranging nature of the research question although there were some limitations such as the research design to ensure the study did not become too unwieldy, this being a known disadvantage of case study research (Crowe at al, 2011). However, it is also this broad scope of this study that is its strength. It allowed a fuller and broader exploration of the nature of pharmacy practice which may otherwise not have been possible.

This was a qualitative collective case study conducted with practising pharmacists working in four different healthcare settings: community pharmacy, hospital, mental health and community health services. To the researcher's knowledge this

is the first study that has explored pharmacists' perceptions of the nature of pharmacy practice related to the healthcare setting in which they work including comparing similarities and differences. The strength of this study was that by comparing the findings between the different cases allowed issues to be identified which may not otherwise have been discovered.

This study was based on purposive sampling with pharmacists putting themselves forward to participate in this study therefore, this study may mainly have included pharmacists who were interested in developing the pharmacy profession. Although both independents, large and small multiples chains of community pharmacies were invited to participate, only community pharmacists working for one large multiple (4) and one small multiple (1) came forward. All community pharmacists had been employed in that particular community pharmacy for several years. Their perceptions may not reflect that of community pharmacists who work as locums, those working for independents or those working for the much larger multiples.

There were politically driven changes taking place within the NHS organisational structure during this study. This included the end of Primary Care Trusts (PCTs) and establishment of Clinical Commissioning Groups (CCGs), however, this change to the NHS did not affect this study. The study was carried out at practice-level with these changes not affecting pharmacy staff working at the 'coal face'. One particular issue that took place in 2016 was the reduction in the overall global sum allocated to community pharmacies and the increase in funding by NHS England to allow GP practices to directly employ pharmacists to work within GP practices (NHS England, 2017; PSNC, 2017d). It is unclear what impact these developments will have long-term on, for example community pharmacists.

The data analysis involved the researcher's interpretation, which can be viewed as introducing 'bias' into the findings made. The researcher was reflective and aimed to be transparent in undertaking the study including the data analysis. The findings and arguments presented throughout this thesis represent the researcher's interpretations which is not the same as the researcher's personal views. Instead what has been presented is based on the data collected and interpretations made by engaging with the theories on the sociology of the professions and engagement with the literature where relevant.

The semi-structured interview data were collected during 2012. This could have rendered these data historical. However, the literature on the sociology of the professions confirms that changes to professionals' practice and jurisdiction can take decades (Abbott, 1988). Policy documents relating to the pharmacy profession, for example, *Now more than ever: Why pharmacy needs to act* report from the Nuffield Trust (Smith, Picton and Dayan, 2014), reached similar conclusions as the Nuffield Foundation Review of Pharmacy of 1986. Engaging with the academic literature and research shows that limited changes have taken place within the pharmacy profession over the last few decades.

The high-level findings from this study were presented in 2016 to two different groups of experienced practising pharmacists. One group consisted of 12 experienced community pharmacists and a second group of 15 senior pharmacists and 5 senior pharmacy technicians employed with a background in hospital, mental health, community health services and community pharmacy, respectively. The aim was to give credibility to or 'sense check' the findings to test if they reflected current pharmacy practice and resonated with these experienced practising pharmacists. These high-level findings were presented with selective quotes from the study data. It was re-confirming when these two separate groups of pharmacists were discussing the findings, that they provided further examples from their own practice that were similar to those already included in this study. This also included some that had not been presented to these two groups due to time-constraints. The second group when discussing the study findings used 'pharmaceutical surveillance' which they had only just been introduced to. This seemed to provide them with a term to describe an essential function of pharmacy which had not previously been available to them. It was clear from both presentations that the findings resonated with both groups of pharmacists adding to the confidence that the findings from this study were both current, relevant and provided further insight into pharmacists' practice. The findings are theoretically transferable including providing a good insight and could be useful in other similar contexts although the findings are not statistically generalisable. The findings, discussion and conclusion can also be considered as lessons learnt from this sociological examination of the pharmacy profession utilising a qualitative collective case study methodology (See *Chapter 4, Methodology and methods*).

This study was designed to only obtain pharmacists' perceptions, which is a limitation as it excludes the public or other healthcare professionals' perceptions of them.

The pharmacists included in this study may not be typical of the broader pharmacy workforce and it is not known if their perceptions and views of pharmacy practice presented in this thesis reflect all experienced pharmacists' understanding of pharmacy practice.

This study assumed from the outset that there were professional divisions between pharmacists working within different healthcare organisations not taking account of other divisions that exist within the pharmacy profession which can be considered a limitation (See *Chapter 2, Section 2.4.3 Internal divisions and Chapter 3, Section 3.3.1 Intra-professional divisions*).

In exploring the collective case of the pharmacy profession it was disconcerting to see that, although pharmacists are now working for commissioning groups, in primary care and are embedded within the hospital setting, that any real evolution or changes to the pharmacy profession and their pharmacy practice has not taken place. It may be that these professional developmental changes are subtle or that this is linked to the pharmacy profession having been unable to unite as a way of re-professionalising the entire pharmacy profession. The largest proportion of pharmacists work in community pharmacies, and working in a 'retail shop' continues to be a barrier for taking on new clinical services and for patients and other healthcare professionals to view community pharmacists as healthcare professionals.

Any research will have to have a limited scope to help keep a clear focus as a way of strengthening a study. Conversely this also introduces limitations in what is explored. This study had a broad scope which created some difficulties but meant it touched on many inter-dependent factors. Each of these could be a separate research project. The danger of this is that there will also be some factors that cannot be included and explored, which is then a limitation.

Pharmacists' practice is affected by complex multiple factors and different contexts both at the micro-, meso- and macro-level. Some are subtle and some are not, and it is acknowledged that it is impossible to unearth them all. Therefore,

approaching the data theoretically with reference to theories on the sociology of the professions helped to guide the study.

This study did not include a discussion of the potential impact of the mobilisation of the pharmacy profession into global professional associations (e.g., International Pharmaceutical Federation) and how this may transcend or be organised differently to that of the State (See *Chapter 1, Section 1.4 The international context of pharmacy*).

7.4 Further developments of pharmacy in England

Since completion of this study, in April 2016 NHS England commissioned an independent review of future commissioning models for community pharmacy in England (Sukkar, 2016b). This report by The King's Fund, *Review of Community Pharmacy Clinical Services* (Murray, 2016) (referred to as 'The Murray Report') was published in December 2016, reaffirming some of the issues raised in the *Now or Never. Shaping pharmacy for the future* (Smith, Picton and Dayan, 2013) and the Nuffield Trust report of 2014, *Now more than ever: Why pharmacy needs to act* (Smith, Picton and Dayan, 2014) and incorporated the vision from the *Community Pharmacy Forward View* (Pharmacy Voice, PSCN and RPS, 2016).

The 'Murray Report' (Murray, 2016) found that following the Department of Health White Paper *Pharmacy in England – Building on strengths – delivering the future* (DH, 2008) progress remains limited, noting that "patients and the public still do not benefit from the full range of skills that community pharmacists possess and that the White Paper envisaged" (Murray, 2016, p.5) (See *Chapter 1, Section 1.3 The socio-political and economic context*).

The 'Murray Report' found some of the barriers in place for community pharmacists taking on more clinical services were poor integration within the NHS and weak relationships between GPs and community pharmacists and both of these barriers were confirmed by this study. Murray argues that if community pharmacists were digitally better connected to primary care teams by being able to access patients' clinical records to record their contributions to patient care this would provide community pharmacists with greater visibility in healthcare but also increase their responsibilities and accountabilities. Murray (2016) re-confirms this about community pharmacists:

“Reliance on operating primarily as a supply function will not serve patients, the taxpayer or the NHS well in future years and it is in everybody’s interests to ensure that the skills of community pharmacists and their staff are better deployed and utilised”. (Murray, 2016, p.15)

The Professional Standards Authority (PSA) is the watchdog that oversees the work of nine statutory bodies that regulate health professionals in the UK and social workers in England, including the GPhC. In 2015 the PSA reviewed current regulators for health care recommending reforms to the existing regulatory system by reducing the current number of regulators (PSA, 2015). In 2016 the PSA considered an option whereby “those working in ‘High Street’ practice” (p.5, PSA, 2016) such as pharmacists, dentists and others would share one professional regulator (PSA, 2016). These proposed reforms have the potential to significantly change the current landscape for the regulation of health professionals including pharmacists.

7.5 Summary

This researcher’s position in the study was covered. The strengths and limitations of this study were discussed. The findings from the study were presented to two different groups of experienced pharmacists and both confirmed that the findings resonate with them and the nature of their pharmacy practice. The next chapter concludes this thesis, including the contributions made to knowledge in terms of the pharmacy profession in England and the sociology of the professions, including suggesting areas for future research.

CHAPTER EIGHT: Conclusion

8.1 Introduction

There has been limited sociological attention given to the pharmacy profession and this has mainly focused on community pharmacists' status generating discussion and debate around the conflict between professionalism and commercialism also in terms of their isolation, relationships with GPs and the act of dispensing (Denzin and Mettlin, 1968; Dingwall and Wilson, 1995; Edmunds and Calnan, 2001; Hughes and McCann, 2003; Rapport, 2010; McDonald et al, 2010; Bradley, Ashcroft and Noyce, 2012). Sociologists have paid less attention to hospital pharmacists who work in a clinical setting with a hierarchical pharmacy-career structure. They undertake a post-graduate diploma in pharmacy practice, form part of multi-professional teams and work alongside pharmacist-peers (Mesler, 1991; Broom et al, 2015). The commercial retail aspects are absent from hospital pharmacists' practice.

To explore the pharmacy profession in England further the purpose of this study was to understand and provide insight into pharmacists' perceptions of the nature of pharmacy practice and the implications this has for them by linking this to their status in society today (Abbott, 1981). This led to the research question: *How do pharmacists working in different healthcare settings perceive their status in society today?*

Working theories on the sociology of the professions formed the basis for exploring the pharmacy profession by informing this study and helping to contextualise and interpret the findings from the qualitative collective case study. The study was consistent with the collective case study methodology approach supporting the exploration of pharmacists' perceptions of the nature of pharmacy practice from four different healthcare settings, as four different case studies. The four case studies were the case of community pharmacists (CP), the case of hospital pharmacists (HP), the case of mental health pharmacists (MHP) and the case of community health services pharmacists (CHPS), respectively. Pharmacists working in hospitals, mental health and community health services were all employed directly by the NHS and worked for NHS trusts, referred to here as NHS pharmacists. Community pharmacists were employed by private organisations working in high-street community pharmacies. The comparison of similarities and

differences across the four case studies revealed new knowledge of the pharmacy profession and facilitated a different perspective not previously reported in the sociology literature. This study has added to what is commonly known about the pharmacy profession towards a deeper understanding of what pharmacists do as part of their pharmacy practice and of the pharmacy profession itself. The study achieved the following aims:

- Identified the core function that defines the pharmacy profession.
- Explored pharmacists' views about how others' perceptions of them affect their pharmacy practice.
- Explored how pharmacists perceive they maintain or extend their pharmacy practice.
- Made comparisons between pharmacists' perceptions of their pharmacy practice in relation to the healthcare setting in which they work.

This study provides a platform for further debate as to what it is pharmacists actually do as part of their pharmacy practice. Pharmacists' jurisdiction, interdependency and reliance on doctors, internal divisions, ambivalence over professionalism and re-professionalisation strategies, which include how these overlap with the perceptions and images of pharmacists that are held by others, is identified and explored.

This concluding chapter draws together the discussion of the findings and reflects upon the key contributions this study has made to the pharmacy profession, the sociology of the professions and includes suggestions for future research.

8.2 Sociological perspectives of the pharmacy profession

This study has contributed to new knowledge or perspectives of the pharmacy profession, which has the potential to change future theoretical thinking and examination of the profession by moving the sociological discussion in a new direction beyond the acts of dispensing and information-giving.

8.2.1 The core function of pharmaceutical surveillance

Dingwall and Wilson's (1995) pivotal paper shifted the sociological understanding of the nature of pharmacy practice by attributing meaning to pharmacists utilising their medicines expertise to symbolically transform chemicals into medicines that improve patient health. The authors found that the core function that defined the pharmacy profession was 'information-giving'. Hibbert, Bissell and Ward (2002), McDonald et al (2010) and Waring et al (2016) suggest that pharmacists' professional status rests on this transformational work of information-giving.

This study drew on a Foucauldian perspective to look beyond more conventional analysis of the nature of pharmacy practice and pharmacists' jurisdictions, in order to consider what the core function is that defines the pharmacy profession. From this perspective it was apparent that this core function was broad and consisted of more than the act of dispensing and the transformational work of information-giving regardless of the healthcare setting in which pharmacists work (Dingwall and Wilson, 1995; Harding and Taylor, 1997; Davies, Barber and Taylor, 2014).

This study found that the social objects for pharmacists are not only medicines, but also about how medicines are used by various actors in different social contexts with the aim of reducing or mitigating risk to improve patient safety. It is pharmacists' social transformation of medicines and medicines-use that dictates how they develop and organise their pharmacy practice of pharmaceutical surveillance in a given healthcare setting.

Experienced pharmacists are aware that there are no other healthcare professionals who have the knowledge and skills to undertake pharmaceutical surveillance to the same standard they do. They utilise their medicines expertise, which includes their pharmacological and technical knowledge of medicines, clinical pharmacy experience, knowledge of legal and best practice guidance and understanding of different actors' behaviours around medicines-use along with their own experience and competencies in mitigating risks related to medicines and medicines-use.

It is through pharmaceutical surveillance that pharmacists bring discipline and order to the social context where medicines are used. As a consequence pharmacists are viewed as the 'medicines police' by other healthcare

professionals. This image also affects pharmacists' inter-professional relationships in that they are never fully integrated into multidisciplinary teams due to their pharmaceutical surveillance function, and of them acting as an agent for the State, for example in helping to contain medicines costs. Previous research failed to explore the medicines police image despite the significance this has for pharmacists in the control and power they have over other healthcare professionals. This power is not seen in terms of dominance and subservience, but is operated by pharmacists through influencing the conduct and behaviour of others in relation to medicines and medicines-use. This disciplinary power is ultimately aimed at ensuring risk related to medicines and medicines-use is managed with patient safety being paramount and pharmacists viewing themselves acting as a safety net in healthcare.

Pharmacists use pharmaceutical surveillance to provide cognitive pharmaceutical services to patients, by utilising their disciplinary power to empower patients by for example providing them with additional knowledge about their medicines, thus allowing them to self-manage their medicines more effectively.

It is through pharmaceutical surveillance that pharmacists intervene to prevent harm to patients, with pharmacists giving examples of having saved patients' lives.

Pharmacists 'power' is reduced because they do not keep contemporaneous patient records of the outcome of their pharmaceutical surveillance 'examination' in line with other healthcare professionals. This makes their practice less visible to others. Therefore, their pharmaceutical surveillance is often hidden to others and is not in the public domain, which means pharmacists remain the hidden healthcare profession.

This finding of 'pharmaceutical surveillance' places the pharmacy profession and the nature of pharmacy practice in a more favourable light than previously suggested in the sociology literature by showing that it is a multifaceted and complex profession that already makes and is capable of significant contributions to healthcare. It is from this position that the pharmacy profession should extend and expand on its scope of practice in healthcare to maintain and increase its status in society.

8.2.2 Subordination increases autonomy

The pharmacist-doctor relationship is important for pharmacists regardless of the healthcare setting. They are reliant on these relationships to perform their work and as part of their re-professionalisation strategies to expand their pharmacy practice including gaining additional clinical pharmacy knowledge and skills. There is power asymmetry in the pharmacist-doctor relationship, which is established at the individual level. The pharmacist has to work at earning the individual doctor's trust to a point where the doctor fully accepts the pharmacist's recommendations. These individual relationships are not transferable to other pharmacists regardless of the healthcare setting. To the researcher's knowledge this has not previously been acknowledged in the literature. It was only by comparing these pharmacist-doctor relationships across the different healthcare settings that placed the developmental stages of these relationships in context. The community pharmacist-GP relationships were limited to professional awareness emphasising their isolation in healthcare, whereas for pharmacists working within the same organisational context as doctors, away from the pharmacy dispensary, these relationships were found to be evolving towards collaborative working relationships, with mental health pharmacists in particular forming collaborative working relationships with mental health doctors.

The study challenged the general perception that pharmacists' subordination to doctors limits their autonomy as this is a narrow view of the reality and complexities of what occurs in practice. It is claimed in the literature that pharmacists' subordination to doctors has a de-professionalising effect on them due to doctors controlling and limiting their practice in healthcare, which reflects the situation for community pharmacists but not for NHS pharmacists (Turner 1995; Bissell and Traulsen, 2005). This study found that pharmacists' subordination to doctors is different for community pharmacists and pharmacists working in NHS trusts.

Abbott (1981) claims that one of the underlying factors for increasing a profession's status is by serving high status clients. Doctors can be viewed as pharmacists' high status clients as it is often doctors that their pharmacy practice is directed towards, thereby increasing pharmacists' relative status. This explains pharmacists' self-interest in reinforcing the traditional medical model where

doctors remain in charge of patient care. As a profession pharmacists are unable to change doctors' dominance in healthcare, which is embedded in society (Lemke, 2002).

Community pharmacists follow a re-professionalisation strategy of wanting doctors to delegate routine tasks to them with Edmund and Calnan (2001) noting that GPs believe delegating tasks to community pharmacists is a "threat to their autonomy and control" (p. 943). In contrast NHS pharmacists view themselves as enablers of doctors' practice, which cannot be described as delegation or encroachment thereby challenging previous assertions in the literature (Eaton and Webb, 1979; Mesler, 1991; Broom et al, 2015). Instead they follow a re-professionalisation strategy by filling a new need they have identified in practice while generating a new demand for their clinical pharmacy services particularly from other healthcare professionals. They are developing new jurisdictional claims for clinical pharmacy, an area not previously claimed by others. Turner (1995) claims that pharmacists' clinical pharmacy re-professionalisation strategy is based on them identifying work doctors do not have time to do. This study refutes this assertion, as doctors do not have the knowledge and skills to undertake this level of pharmaceutical surveillance delivered by experienced clinical pharmacists. NHS pharmacists add their medicines expertise and pharmaceutical surveillance function to doctors' expertise as a way of enabling doctors to, for example, make the right choice when prescribing medicines. Doctors' autonomy and control is not threatened by pharmacists and they are increasingly involving pharmacists due to their clinical pharmacy contributions. In return NHS pharmacists feel valued and integrated within multi-disciplinary teams. They are able to develop clinical specialist pharmacy roles increasing their autonomy which enhances their inter- and intra-professional status. Doctors remain in control of the division of labour due to their dominant position in healthcare. In addition, the public reinforces the perception that doctors are in overall charge of their care, being largely unaware of pharmacists' contributions.

8.2.3 Internal conflict

The neo-Weberian social closure perspective has had a strong impact on the sociology of the professions. Within this social closure perspective professions

pursue and guard their self-interests by seeking to monopolise their jurisdiction by legal means closing off opportunities for those outside their profession. A profession's collective interests are pursued through, for instance, exclusionary or demarcation closure strategies (Witz, 1992; Macdonald, 1995; Saks, 2016). Abbott's (1988) system of professions is centred on inter-professional conflicts, which occurs when a profession impinges on an area of practice already staked out by another profession and over time this conflict changes into a bargaining situation between the two professions (Abbott, 1988; Macdonald, 1995) (See *Chapter 2, Sections 2.3.2 The 'power approach* and *2.3.3 Professions as inter-related systems*).

By exploring pharmacists' perceptions of the nature of their pharmacy practice and linking this to their status, it was found that community pharmacists were relying on the status quo by focusing on the act of dispensing which is de-professionalising the pharmacy profession. Politically the message is that the act of dispensing is no longer sufficient to sustain the pharmacy profession, and can be undertaken by less qualified pharmacy staff as is increasingly the case in some hospital pharmacies.

This was further exacerbated by an internal split between community pharmacists and pharmacists working in other healthcare settings. This split was due to community pharmacists having failed to re-professionalise the profession and being associated with commerce within a socialised healthcare system. In contrast pharmacists employed within NHS hospitals or trusts were trying to re-professionalise the profession by making new jurisdictional claims to clinical pharmacy activities in working alongside other healthcare professionals in caring for patients, and through these efforts were prepared to sever their ties with the dispensary by giving up this part of their existing jurisdiction.

There are therefore different types of conflicts that are internal or external to a profession in addition to inter-professional conflicts and intra-professional divisions. Internal conflict is between members of the same profession and external conflict is with other professions or groups, the State and also sometimes with the public (Abbott, 1988; Macdonald, 1995).

Internal conflict affects the professional association representing the profession at a corporate level in its negotiations or regulatory bargaining with the State and

other key stakeholders at the national level (Macdonald, 1995). Internal conflict affects a profession more than any external conflicts because it weakens the profession, thereby creating a climate that is conducive to its decline.

Community pharmacists and pharmacists working in other healthcare settings are travelling along different professional paths increasingly having less in common professionally. This internal spilt has resulted in the pharmacy profession being in the process of evolving into at least two different professions under the wider umbrella of the 'pharmacy profession'; one being clinical pharmacists working in a purely clinical environment alongside other healthcare professionals and the other concentrating on the dispensary and technical functions.

It was speculated that part of the reason for this internal spilt was due to inadequate professional socialisation of pharmacists during their undergraduate degree through practice placements and once registered due to having a lack of a formal career structure resulting in the absence of any ideological solidarity within the pharmacy profession.

Pharmacists, regardless of the healthcare setting, reinforce doctors' dominance in healthcare as a strategy for either being delegated tasks or to keep other professions from challenging doctors' dominance in healthcare. Nurses are pursuing re-professionalisation strategies that impact on pharmacists' future jurisdictional claims. Pharmacy technicians are also encroaching on pharmacists' existing jurisdictions within the hospital dispensary and with their activities on the wards overlapping with other healthcare professionals not distinguishing between them.

Despite this there was a noticeable lack in pharmacists' perceptions that there were potential threats to their existing jurisdictions or in them making new jurisdictional claims. Pharmacists did not appear to enter into any open disputes or conflicts with other professions nor did they articulate demands that centred on their jurisdictions and new jurisdictional claims.

The pharmacy profession has low public visibility, comes across as an unassuming profession, which lacks professional cohesion at the national level due to internal conflicts and has problems being heard in the public and political arenas.

On a national level a corporately organised pharmacy profession could claim a powerful position in healthcare. The pharmacy profession has not been able to organise itself into a cohesive corporately organised profession at the national level to ensure its long term survival and status (Denzin and Mettlin, 1968; Smith, Picton and Dayan, 2013, 2014).

8.2.4 Healthcare professionals and shopkeepers

This study identified pharmacists as the hidden healthcare profession having previously been described in the literature as invisible (Carlsson, Renberg and Sporrang, 2012) and unremarkable (Elvey, Hassell and Hall, 2013). Pharmacists are not recognised as healthcare professionals by the public as the aspect of their practice that mattered most to other healthcare professionals and patients is prompt dispensing of medicines. The act of dispensing is not sufficient for pharmacists to be viewed as healthcare professionals involved in patients care as it is associated with the image of pharmacists 'sticking labels on boxes'.

Experienced practising pharmacists were unsure if the public, patients and other healthcare professionals are aware that they are registered healthcare professionals. Pharmacists reinforced others' view of them, by being uncertain about viewing themselves as professionals instead perceiving this as a social barrier between themselves and patients.

Pharmacists are viewed as 'shopkeepers' due to working in retail shops. Community pharmacists reinforce this image through their acts of practice, by referring to the community pharmacy as 'the shop', and by not considering this as a place to deliver certain healthcare services due to conflicts between the retail environment and healthcare. This image is reinforced by the physical space of community pharmacies which signal a confusing image of pharmacy being positioned somewhere between retail sales and healthcare and professional and lay care (Anderson, 2002; Rapport, Doel and Jerzembek, 2009). Pharmacists working in other healthcare settings are aware that the public views all pharmacists as 'typical community pharmacists' with this image being associated with 'shopkeepers'. The public is surprised to see pharmacists on inpatient wards, being unaware that they are also involved in their care (Morecroft, Thornton and Caldwell, 2015).

The public's image of pharmacists is powerful in determining if they are considered to be healthcare professionals or not. This has the potential to oppress pharmacy practice by influencing policy-makers in terms of allocation of limited healthcare resources, the practice of pharmacists and inter-professional relationships. The implications of this is significant as pharmacists are trying to develop their practice further in the direction of being more involved in delivering healthcare to patients. These images are mainly negative and restrictive, based on others' perceptions of the profession and its practice. Abbott (1988) argues that to maintain a profession's existing jurisdiction and make new jurisdictional claims it will need to undertake rhetorical work in the public arena to achieve this. Pharmacists' negative images of being shopkeepers and sticking labels on boxes, along with being associated as the hidden healthcare profession, makes it difficult for them to undertake this rhetorical work in the public arena (Abbott, 1988). Pharmacists can only change these images by starting to act in practice in a way they wish to be perceived by others, including the public, as healthcare professionals. This demonstrates the importance of examining a profession's acts of practice and how this is linked to its status in society (Abbott, 1988; Mandy, 2008).

It can be argued that by only including pharmacists' perceptions, this study failed to recognise how the internal and external images of pharmacists are interlinked, which is acknowledged by recommending this as a separate future area of research.

8.2.5 Professionalism as an enabling ideology

Previous research on pharmacists' professionalism in England has focused on pharmacy students (Schafheutle et al, 2012) and pre-registration or early career pharmacists (Elvey et al, 2015; Jee, Schafheutle and Noyce, 2016) all acknowledging that there currently is limited knowledge on professionalism in the pharmacy profession. Elvey et al (2015) found that professionalism is dependent on how a particular profession understands professionalism in relation to the nature of its practice.

Professionalism for pharmacists in this study was a continuously evolving concept based on reflective learning by them undertaking their practice by interacting with patients, pharmacy peers and other healthcare professionals as they developed

and matured as professionals (Elvey et al, 2015; Schafheutle et al, 2010; Droege, 2003).

Pharmacists, in all healthcare settings, emphasised the negative side of being registered relating this to being controlled indirectly from afar by their regulatory body with the threat of sanctions and public humiliation if they found themselves up before a fitness to practise panel. This result is individualised self-regulation of pharmacists' behaviour inside and outside work. Therefore, professionalism can be viewed as a tool for the State, via a regulatory body, of exercising disciplinary mechanisms to control and influence professionals (Evetts, 2013).

The opposing perspective of professionalism is for a profession to use this as an enabling ideology that is attractive as it is supported in seeking and improving its status and recognition including ownership of an area of expertise and knowledge, existing jurisdictions and in making new jurisdictional claims (Evetts, 2013). The balance between the controlling aspects and enabling ideology of professionalism for pharmacists should be shifted more towards the more enabling aspects of professionalism.

Community pharmacists' hybrid roles as professionals and pharmacy managers, affected their sense of professionalism as there are inherent ambiguities between the two. In a retail environment there are commercial incentives to offer products of limited therapeutic value along with the pressure to make a sale with a business ethos of customers always being right, with community pharmacists having an operating stance of the 'financial bottom line'. Community pharmacists have to combine this with delivering healthcare services where there are pressures to challenge customers' choices and lifestyles. This led community pharmacists to reflect that a community pharmacy is not a physical place to deliver certain healthcare services and that the relationship between customers and community pharmacists is different to the relationship patients have with their GPs (Jesson and Bissell, 2006; Greenhalgh et al, 2016). Community pharmacists view patients as customers or consumers that will benefit their commercial business wanting them to return to the community pharmacy.

This dissonance is exacerbated by targets imposed on community pharmacists by their employers resulting in some pharmaceutical services being delivered based on business rather than on individual patients' needs (McDonald et al, 2010;

Sukkar, 2013). Working in a retail environment, having to meet targets and complying with restrictive medicines regulations has reduced community pharmacists' autonomy and judgement introducing an element of disempowerment (Rapport et al, 2010, 2011).

The pharmacy profession has not actively engaged with professionalism in relation to pharmacy practice and what this means for them. Instead professionalism for pharmacists is determined by an external superior authority (i.e., their regulatory body) which has a controlling rather than an enabling effect on the pharmacy profession. Pharmacists do not use professionalism as an enabling ideology of informing and re-iterating to others, including the public, about pharmacy's values and obligations in relation to healthcare and society as part of its re-professionalisation strategies.

8.3 Policy implications for the pharmacy profession

The new knowledge generated from this study can in practice influence the future direction pharmacy is making in new jurisdictional claims to help formulate re-professionalisation strategies for the profession by starting to think about pharmacy practice in a different way. This provides fertile ground for making changes to and revising pharmacists' and the public's understanding of pharmacy and the nature of pharmacy practice.

Pharmacists need to make new jurisdictional claims to an area or aspect of healthcare services to enable them to act as healthcare professionals by moving away from the act of dispensing. This will involve challenging and confronting other professions who may also make a claim to the same area of practice. Knowing that the core function that defines pharmacy is pharmaceutical surveillance allows the profession to expand its practice by building on its strengths when making a new jurisdictional claim instead of expanding into areas unrelated to pharmacy (Harding and Taylor, 1997). The pharmacy profession must start to make its jurisdictional claims by engaging with the public to increase awareness and generate a demand for its services. It should aim for the public to understand what contributions pharmacists make to their care. The profession can claim cognitive pharmaceutical services as its new jurisdiction which has the potential to improve health outcome, reduce medicines waste and contain healthcare costs in supporting patients to adhere to their treatment. The pharmacy

profession should formulate its social mandate to cognitive pharmaceutical services in the public arena clearly stating its responsibilities in serving patients, the public and society (See *Chapter 2, Section 2.3.2 The 'power approach'*).

The pharmacy profession itself needs to actively engage in determining what professionalism as a concept means to pharmacists including the values and behaviours expected. The focus should be on professionalism as an enabling ideology to aid in the re-professionalisation of pharmacists whereby they take pride in their profession by professionalism being operationalised from within the profession.

The 'retail' aspect of community pharmacy continues to be a barrier for pharmacists to be viewed as healthcare providers. The profession needs to find a solution to break with the shopkeeper image and with community pharmacists' isolation, to support its re-professionalisation.

The internal split within the pharmacy profession is partly caused by the lack of ideological professional solidarity. Larson (2013) suggests a re-professionalisation strategy of professional socialisation through establishing a formal career structure which is partly achieved through an additional formal post-graduate career structure and system and supervisory requirements that applies to all pharmacists. Employers should invest in this training and supervisory systems. The political problem is that there are community pharmacists with 5 years training limiting their practice to the act of dispensing which will be a barrier for any commitment to invest further in their post-graduate development. Larson (2013) explains that this additional training should be relevant and must be represented in the acts of pharmacists' practice to confer this status.

8.4 Implications for the sociology of the professions

Working theories from the sociology of the professions were used to explore the nature of pharmacy practice (See *Chapter 2, Section 2.3 Theories from the sociology of the professions*). It was found that some of these theories did not apply to this collective case study of the pharmacy profession. The reasons for this are several but one is that most of these sociology theories are based on examining larger more powerful professions such as medicine, which does not

reflect other less powerful professions (Abbott, 1988; Macdonald, 1995; Saks, 2016).

Intra-professional divisions and internal infighting is acknowledged in the sociology of the professions but not fully addressed (Bucher and Strauss, 1961; Abbott, 1988; Macdonald, 1995). Internal splits and the impact this has on a profession have not been fully explored in the sociology of the professions (Abbott, 1988). The assumption is that a profession is cohesive at the macro-level which is a prerequisite for the social closure perspective in a profession's negotiations with the State and other external stakeholders to resist de-professionalisation processes (Murphy, 1986; Macdonald, 1995; Saks, 2016).

The pharmacy profession, due to a lack of professional cohesion at the macro-level, is not able to resist de-professionalisation processes as the social closure perspective suggests. This study does not lend support to the neo-Weberian social closure perspective because the pharmacy profession does not follow the course of action that is considered normal for a profession in defending itself. In the sociology of the professions being registered with a regulatory body is considered desirable as it brings legitimacy to a profession's activities within society and limits access to a profession (Adams, 2017; Saks, 2012, 2016). This study adds to the evidence that the registration of healthcare professionals no longer provides the same status as it did in the past. A profession does not re-professionalise in terms of the nature of its practice by cementing or expanding its jurisdiction or increasing its autonomy or as a means of social closure as is implied by the neo-Weberian social closure perspective (Macdonald, 1995; Saks, 2016).

In the sociology literature bureaucratic organisations are said to have a de-professionalising effect on professionals (Haug, 1972; Macdonald, 1995). The assumption is that professionals employed in large bureaucratic organisations are controlled through staff management, standardisation, rationalisation, efficiencies and productivity, which have deskilling effects, including stripping away some of their professional autonomy (Haug, 1972; Macdonald, 1995; Evetts, 2003; Suddaby and Muzio, 2015). The essential concepts of professionals are often that they are autonomous and free actors with their activities arranged around their profession's own guidance or standards in contrast to the additional controls and hierarchies within bureaucratic organisations (Macdonald, 1995).

The changes to hospital pharmacists' practice in developing clinical pharmacy within hospitals have re-professionalised pharmacists' practice. These re-professionalisation processes have also resulted in embedding changes within hospitals which have come to accept pharmacists' evolving clinical pharmacy practice, which has been subsequently supported in national policy documents (DH, 2008).

This adds to the evidence that some bureaucratic organisations can work with professions themselves to facilitate opportunities for them in developing their knowledge and skills in what can be described as professional organisations working within a multi-professional environment (Abbott, 1988).

Community pharmacists work for a mixture of small to large commercial organisations centred on the retail aspects. Community pharmacists do not work in what can be described as a professional or multi-professional environment. They have not been able to re-professionalise. Instead their practice continues to be centred on the act of dispensing. The pressures and targets they are placed under by their employers has a de-skilling effect on them (Bush, Langley and Wilson, 2009; Rapport et al, 2010, 2011; Davies, Barber and Taylor, 2014).

This collective case study demonstrated the importance of the inter-link between members of a profession, its practices and the types of organisations its members work for and how this influences their re-professionalisation strategies, professionalism and status.

8.5 Recommendations for future research

This study benefited from a qualitative collective case study methodology, allowing analysis of the similarities and differences between the different cases, which strengthened this study instead of only exploring one case study (e.g. the case of community pharmacists) or examining pharmacists from different sectors without distinguishing between their individual pharmacy practice (See *Chapter 4, Sections 4.4 Collective case study design* and *4.5 Rationale for using collective case study methodology*).

There are a number of limitations to the study presented in this thesis. Firstly the data presented are based on one semi-structured interview rather than on other methods and secondly are based on pharmacists' perceptions, only. This was because for this study a semi-structured interview was the most appropriate

method for eliciting pharmacists' perceptions about the nature of pharmacy practice (See *Chapter 4, Section 4.9 Data collection methods* and *Chapter 7, Section 7.3 Strengths and limitations of the study*).

The method of using written diaries did not produce any further insights that had not already been obtained through the semi-structured interviews (See *Chapter 4, Section 4.9.4 Diary*). The aim of the diaries was to obtain real-time data from participants about the nature of pharmacy practice. Another method that could have been used is voice-recorded or video diaries allowing participants to articulate the issues more extensively to generate insightful real-time data.

There are a number of directions in which the study could be advanced. Pharmaceutical surveillance could provide a useful analytical tool to explore the nature of pharmacy practice further from a sociological perspective and pharmacists' contributions to healthcare including the similarities and differences between pharmacists working in community and hospital pharmacy, respectively (i.e., reduce the number of cases to two to explore these in more depth).

This study found there was an internal split within the pharmacy profession. The result is that at the macro-level the profession is not presented as a cohesive whole, which weakens it by contributing to its decline. Saks (2012) argues that a profession's ability to influence key stakeholders including the State is the most important aspect for it to maintain and gain status. It would therefore be beneficial for future work to also include perspectives of internal and external key stakeholders, which are those who affect or are affected by pharmacists' practice such as policy-makers, professional associations (pharmacy associations but also those related to other associated inter-professional associations), patient groups and representatives from the public. These stakeholder perspectives should also explore images they hold of pharmacy and how these affect how they view the pharmacy profession.

Further research is required as there is a lack of contemporary sociology theories of the professions to help explain intra-professional divisions including when this benefits or can spilt a profession, or indeed to explain why some professions, such as pharmacy, do not follow the course of the neo-Weberian social closure perspective (See *Section 8.4 Implications for the sociology of the professions*).

8.6 Dissemination of findings

It is planned to publish this study in peer-reviewed journals, which will be the real test for this research, where the results will be disseminated and scrutinised by a larger audience.

8.7 Concluding remarks

This study has provided new insights and understanding about the pharmacy profession in England, United Kingdom and the nature of pharmacy practice that has not previously been explored in the sociology literature to the same extent. This is the first study that has articulated the core function that defines the pharmacy profession as being pharmaceutical surveillance regardless of the healthcare setting in which pharmacists work. This helps to shift the sociological understanding of their practice away from dispensing and information-giving. It showed pharmacists already make significant contributions to healthcare. Pharmacists have failed to take their jurisdictional claims into the public domain as a large part of their pharmaceutical surveillance is aimed at doctors' practice. This leaves pharmacists as the hidden healthcare profession as the public is unaware of their contribution. Pharmacists are not recognised as healthcare professionals by the public but as 'typical community pharmacists' with an image as shopkeepers. Pharmacists interpret professionalism as a controlling rather than an enabling ideology.

There internal split between community pharmacists and pharmacists from other healthcare settings is due to differences in practice (i.e., different levels of pharmaceutical surveillance), re-professionalisation strategies and relationships with doctors, including lacking ideological professional solidarity. This weakens the profession and contributes to its decline instead of the profession being presented as a cohesive whole at the macro-level in its negotiations with the State and other key stakeholders. The relative status of the pharmacy profession in society today remains unclear.

REFERENCES

- Abbott, A., 1981. Status and status strain in the professions. *The American Journal of Sociology*, 86 (4) pp. 819-835.
- Abbott, A., 1988. *The system of professions. An essay on the division of expert labor*. Chicago: University of Chicago Press.
- Abu-omar, S.A., Weiss, M.C. and Hassell, K., 2000. Pharmacists and their customers: a personal or anonymous service? *International Journal of Pharmacy Practice*, 8, pp. 135-43.
- Adams, T. L., 2004. Inter-professional conflict and professionalization: Dentistry, and dental hygiene in Ontario. *Social Science & Medicine*, 48, pp. 407-20.
- Adams, T.L., 2010. Profession: A useful concept for sociological analysis? *Canadian Review of Sociology*, 47, pp.49–70.
- Adams, T. L., 2015. Sociology of Professions: International Divergences and Research Directions. *Work, Employment and Society*, 29, pp. 154-165.
- Adams, T. L., 2017. Self-regulating professions: past, present, future, *Journal of Professions and Organization*, 4 (1), pp. 70-87.
- Adcock, H., 2017. Government lawyers defend community pharmacy budget cuts in High Court. *The Pharmaceutical Journal*, March 2017, DOI: 10.1211/PJ.2017.20202497 [online].. Available at: <http://www.pharmaceutical-journal.com/news-and-analysis/news/government-lawyers-defend-community-pharmacy-budget-cuts-in-high-court/20202497.article> [Accessed: 31 March 2017].
- Alberani, V., Pietrangeli, P.D.C. and Mazza, A.M.R.,1990. The use of grey literature in health science: a preliminary survey. *Bulletin of the Medical Library Association*, 78(4), pp. 358-363.
- Al Hamarneh, Y.N., Rosenthal, M., McElnay, J.C. and Tsuyuki, R.T., 2011. Pharmacists' perceptions of their professional role: Insights into hospital pharmacy culture. *Canadian Journal of Hospital Pharmacy*, 64 (1), pp. 31-35.
- Al Hamarneh, Y.N., Rosenthal, M., McElnay, J.C. and Tsuyuki, R.T., 2012. Pharmacists' perceptions of their practice: a comparison between Alberta and Northern Ireland. *International Journal of Pharmacy Practice*, 20(1), pp. 57-64.
- Allen, D., 2001. Narrating Nurses Jurisdictions: "Atrocity Stories" and "Boundary-work". *Symbolic Interaction*, 24(1), pp. 75-103.
- Allmark, P., Boote, J., Chambers, E., Clarke, A., McDonnell, A., Thompson, A. and Tod, A.M., 2009. Ethical issues in the use of in-depth interviews: literature review and discussion. *Research Ethics Review*, 5(2), pp. 48-34.
- All Party Pharmacy Group., 2007. *The Future of Pharmacy. Report of the APPG inquiry*. London: All Party Pharmacy Group.
- Allsop, J., 2006. Medical dominance in a changing world: the UK case. *Health Sociology Review*, 15, pp. 444-57.

Altman, I., MacAdam, A. and Stew, G., 2014. An exploratory qualitative case study of community pharmacists' perceptions of their professional roles. *International Journal of Pharmacy Practice*, 22 (Suppl. 2), pp. 21.

Anafara, V.A. and Mertz, N.T., (Eds), 2006. *Theoretical Frameworks in Qualitative Research*, London: SAGE Publications Ltd.

Andalo, D., 2015. Technicians are seeking powers that would threaten patient safety, claims PDA. *The Pharmaceutical Journal*. 23/30 May 2015, 294, (7863/4). URI: 20068529. [online]. Available at: <http://www.pharmaceutical-journal.com/news-and-analysis/news/technicians-are-seeking-powers-that-would-threaten-patient-safety-claims-pda/20068529.article?adfesuccess=1> [Accessed: 31 March 2017].

Andalo, D., 2017. Pharmacy Voice to close in April 2017. *The Pharmaceutical Journal*, March 2017 DOI: 10.1211/PJ.2017.20202490 [online]. Available at: <http://www.pharmaceutical-journal.com/news-and-analysis/news/pharmacy-voice-to-close-in-april-2017/20202490.article> [Accessed: 31 March 2017].

Andalo, D. and Sukkar, E., 2015. Risks and benefits of pharmacists accessing patients' summary care records. *The Pharmaceutical Journal*. 11 July 2015, Vol 295, No 7870, URI: 20068889 [online] Available at: <http://www.pharmaceutical-journal.com/news-and-analysis/news/risks-and-benefits-of-pharmacists-accessing-patients-summary-care-records/20068889.article> [Accessed 31 March 2017].

Anderson, S., 2001. The historical context of pharmacy. In: K. Taylor and G. Harding (Eds). *Pharmacy Practice*. London: Taylor and Francis, pp. 3-30.

Anderson, S., 2002. Profile of the Professions. The state of the world's pharmacy: a portrait of the pharmacy profession. *Journal of Interprofessional Care*, 16 (4), pp. 391-404.

Anderson, S., 2007. Community pharmacy and public health in Great Britain, 1936 to 2006: how a phoenix rose from the ashes. *Journal of Epidemiology and Community Health*, 61, pp. 844-848.

Anderson, S., 2015. The historical context of pharmacy and pharmacy practice. In: G. Harding, and K. Taylor (2nd Eds). *Pharmacy Practice London*: Taylor and Francis, pp. 4-27.

Andrews, T.M., and Wærness, K., 2011. Deprofessionalization of a female occupation: Challenges for the sociology of professions. *Current Sociology*, 59(1), pp. 42-58.

Anthony, S. and Jack, S., 2009. Qualitative case study methodology in nursing research: an integrative review. *Journal of Advanced Nursing*, 65 (6), pp. 1171-1181.

Antoniou, S., Webb, D.G., McRobbie, D., Davies, J.G., Bates, I.P., 2005. A controlled study of the general level framework: Results of the South of England competency study. *Pharmacy Education*, [S.I.], v. 5, Jun. 2015. ISSN 1477-2701 [online]. Available at: <<http://fipcc.com/pharmacyeducation/article/view/171/146>> [Accessed: 31 March 2017].

- Appleton, J. and King, L., 1997. Constructivism: A Naturalistic Methodology for Nursing Inquiry. *Advances in Nursing Science*, 20(2), pp. 13-22.
- Appleton, J. and King, L., 2002. Journeying from the philosophical contemplation of constructivism to the methodological pragmatics of health services research. *Journal of Advanced Nursing*, 40 (6), pp. 641-648.
- Armstrong, D., 1995. The rise of surveillance in medicine. *Sociology Health and Illness*, 17, pp. 393-440.
- Armstrong, D., 2002. Clinical autonomy, individual and collective: the problem of changing doctors' behaviour. *Social Science & Medicine*, 55, pp.1771-1777.
- Arnold, L. and Stern, D.T., 2006. What is medical professionalism?. In: D.T., Stern, (Eds.), *Measuring Medical Professionalism*, Oxford University Press, Oxford, pp. 15-38.
- Ayres, L., Kavanaugh, K. and Knafelz, K.A., 2003. Within-Case and Across-Case Approaches to Qualitative Data Analysis. *Qualitative Health Research*, 13 (6), pp. 871-883.
- Backman, K. and Kyngäs, H.A., 1999. Challenges of the grounded theory approach to a novice researcher. *Nursing and Health Sciences*, 1, pp. 147-153.
- Baileiff, A., 2015. The role of advanced nurse practitioners. *Nursing in practice*, 84 [online]. Available at: <http://www.nursinginpractice.com/article/role-advanced-nurse-practitioners> [Accessed: 31 March 2017].
- Baker, C., Wuest, J. and Stern, P.N., 1992. Method slurring: the grounded theory/phenomenology example. *Journal of Advanced Nursing*, 17(11), pp. 1355-1360.
- Barber, N., 2005. The pharmaceutical gaze – the defining feature of pharmacy?, *The Pharmaceutical Journal*, 275, p. 78.
- Barbour, R.S., 2001. Checklists for improving rigour in qualitative research: a case of the tail wagging the dog? *British Medical Journal*, 322, pp.1115-1117.
- Bardet, J.D., Vo, T.H., Bedouch, P. and Allenet, B., 2015. Physicians and community pharmacists collaboration in primary care: A review of specific models. *Research in Social and Administrative Pharmacy*, 11(5), pp. 602-602.
- Barnett, N., 2009. How we should promote pharmacy through the media. *The British Journal of Clinical Pharmacy*, 1, pp.85 -87.
- Barnett, N., Jubraj, B. and Varia, S., 2013. Adherence: are you asking the right questions and taking the best approach?. *The Pharmaceutical Journal*, 291, pp. 153-156.
- Baqir, W., Clemerson, J. and Smith, J., 2010. Evaluating Pharmacist prescribing across the north east of England. *British Journal Clinical Pharmacy*, 2, pp. 147-149.
- Baxter, J., 2011. *Public sector professional identities: a review of the literature*. The Open University, UK. The Open University, UK.

- Baxter, P. and Jack, S., 2008. Qualitative Case Study Methodology: Study design and Implementation for Novice Researchers. *The Qualitative Report*, 13 (4), pp. 544-559.
- Becher, T., 1999. *Professional Practices Commitment and Capabilities in a Changing Environment*. New Brunswick, New Jersey: Transaction Publishers.
- Berenguer, B., La Casa, C., de la Matta, M.J. and Martin- Calero, M.J., 2004. Pharmaceutical care: past, present and future. *Current Pharmaceutical Design*, 10(31), pp. 3931–46.
- Bhakta, H., 2010. Moving from the Community to Hospital, *Tomorrow's Pharmacist* [online]. Available at: <http://www.pharmaceutical-journal.com/publications/tomorrows-pharmacist/moving-from-the-community-to-hospital/11048421.article>. [Accessed: 31 March 2017].
- Biddle, B.J., 1986. Recent developments in role theory. *Annual Review of Sociology*, 12, pp 67-92.
- Birchall, G., 2014. Mirror Image: Shopkeeper or professional – which image is pharmacy projecting to the public? *Chemist and Druggists* [online]. Available at: <http://www.chemistanddruggist.co.uk/feature/mirror-image>. [Accessed: 31 March 2017].
- Birenbaum, A., 1982. Reprofessionalization in pharmacy. *Social Science and Medicine*, 16, pp. 871-878.
- Bishop, J. and Rees, C.E., 2007. Hero or has-been: is there a future for altruism in medical education? *Advanced Health and Science Education Theory Practice*, 12 (3), pp. 391-399.
- Bissell, P. and Traulsen, J.M., 2005. *Sociology and Pharmacy Practice*. 1st ed. London: Pharmaceutical Press.
- Bissell, P, Traulsen, J.M., Haugbølle, L.S., 2002. How relevant is Marxist sociology for pharmacy practice?. *International Journal of Pharmacy Practice*, 10, pp. 127-140.
- Bissell, P., Cooper, C., Guillaume, L., Anderson, A., Avery, A., Hutchinson, A., James, V., Lymn, J., Marsden, E., Murphy, E., Ratcliffe, J., Ward, P. and Woolsey, I., 2008. *An Evaluation of Supplementary Prescribing in Nursing and Pharmacy*. London: Department of Health.
- Black, J., 2002. *Critical Reflections on Regulation* Discussion Paper No 4 – Centre for analysis of risk and regulation at the London School of Economics and Political Sciences. London: LSE.
- Blumer, H., 1986. *Symbolic Interactionism: Perspectives and Method*. Reprint from 1969. University of California Press: Los Angeles.
- Boardman, H. and Fitzpatrick, R. (2001). Self reported clinical pharmacist interventions under-estimate their input to patient care. *Pharmacy World and Science*, 23(2), pp.219-224.

- Bogdan, R.C., & Biklen, S.K., 2007. *Qualitative research for education: An introduction to theories and methods*. 5th ed. Boston: Pearson Education.
- Bowling, A., 2002. *Research Methods in Health. Investigating Health and Health Services*. 2nd ed. Maidenhead: Open University Press.
- Bradley, F., Ashcroft D.M. and Noyce, P.R., 2012. Integration and differentiation: A conceptual model of general practitioner and community pharmacist collaboration. *Research in Social and Administrative Pharmacy*, 8, pp. 36 -46.
- Brannick, T. and Coghlan, D., 2007. In Defense of Being “Native”: The Case for Insider Academic Research. *Organizational Research Methods*, 10, pp. 59-74.
- Brante, T., 1988. Sociological Approaches to the Professions. *Acta Sociologica*, 31, 2, pp. 119-142.
- Braun, V. and Clarke, V., 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, pp 77-101.
- British Dental Association, 2013. Dentists reminded of ‘Dr’ title guidance. [online] Available at: <https://www.bda.org/news-centre/latest-news-articles/43280-dentists-reminded-of-dr-title-guidance> [Accessed: 31 March 2017].
- Britten, N., 2001. Prescribing and the defence of clinical autonomy. *Sociology of Health & Illness*, 23 (4), pp. 478-496.
- Brodie, D.C., 1981. Pharmacy’s societal purpose. *American Journal of Hospital Pharmacy*, 38, pp. 1893–1896.
- Broom, A., Broom, J., Kirby, E. and Scambler, G., 2015. The path of least resistance? Jurisdictions, responsibility and professional asymmetries in pharmacists’ accounts of antibiotic decisions in hospital. *Social Science and Medicine*, 146, pp. 95-103.
- Brott, P. E., and Myers, J. E., 1999. Development of professional school counselor identity. *Professional School Counseling*, 2(5), pp. 339-348.
- Brown, D. and Ferrill, M.J., 2009. The Taxonomy of Professionalism: Reframing the Academic Pursuit of Professional Development. *American Journal of Pharmaceutical Education*, 73(4), Article 68.
- Bryant, L.J.M., 2009. General practitioners’ and pharmacists’ perceptions of the role of community pharmacists in delivering clinical services. *Research in Social and Administrative Pharmacy*, 5, pp. 347-362.
- Bucher, R., and Strauss, A., 1961. Professions in Process. *The American Journal of Sociology*, 66 (4), pp. 325-334.
- Buckley, P., Grime, J. and Blenkinsopp, A., 2006. Inter-and intra-professional perspectives on non-medical prescribing in an NHS trust. *Pharmaceutical Journal*, 277, pp. 394-398.
- Burr, V., 1995. *An Introduction to Social Constructionism*. London: Routledge.

- Burrell, G. and Morgan, G. 1979. *Sociological Paradigms and Organizational Analysis: Elements of the Sociology of Corporate Life*. London: Heinemann Education.
- Bush, J., Langley, CA. and Wilson, K.A., 2009. The corporatization of community pharmacy: Implications for service provision, the public health function, and pharmacy's claims to professional status in the United Kingdom. *Research in Social and Administrative Pharmacy*, 5, pp. 305-318.
- Calvert, RT., 1999. Clinical Pharmacy – a hospital perspective. *British Journal of Clinical Pharmacology*, 47, pp. 231-238.
- Carlsson, J.R., Renberg, T. and Sporrang, S.K., 2012. Drug experts of the future, today? Depiction of the pharmacist profession in Swedish professional and lay print media. *Research in Social and Administrative Pharmacy*, 8, pp. 133-144.
- Centre for Pharmacy Postgraduate Education (CPPE) and NHS Health Education England, 2014. *Consultation for pharmacy practice: taking a patient-centred approach*. A CPPE distance learning programme for pharmacy professionals. Outset Publishing Ltd, Sussex.
- Centre for Workforce Intelligence. 2012. *Education commissioning risks summary Pharmacy workforce*. Report by Mouchel Management Consulting Ltd. Woking.
- Centre for Workforce Intelligence. 2013. *A strategic review of the future pharmacist workforce. Informing pharmacist student intake*. London
- Charmaz, K., 2000. Constructivist and objectivist grounded theory. In N. K. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (2nd Ed) Thousand Oaks, CA: Sage, pp. 509 -535.
- Charmaz, K., 2006. *Constructing Grounded Theory. A Practical Guide Through Qualitative Analysis*. London: Sage Publications Limited.
- Chew-Graham, CA., May, CR. and Perry, MS., 2002. Qualitative research and the problem of judgement: lessons from interviewing fellow professionals. *Family Practice*, 19, pp. 285-289.
- Child, D., Cooke, J. and Hey, R., 2011. Clinical Pharmacy. In: M. Stevens (Eds) *Hospital Pharmacy* (2nd Ed). Pharmaceutical Press. pp. 139-161.
- Christou, M. and Wright, D., 2011. Engendering and appraising professionalism within UK pharmacy pre-registration year: Identifying the current barriers. *Pharmacy Education*, 11(1), pp. 107-144
- Coar, L. and Sim, J., 2006. Interviewing one's peers: methodological issues in a study of health professionals. *Scandinavian Journal of Primary Health Care*, 24, pp. 251-256.
- Coleborn, J., 2014, Mind the gender gap, *Clinical Pharmacist*, 6 (8). DOI: 10.1211/CP.2014.20066743 [online]. Available at: <http://www.pharmaceutical-journal.com/publications/previous-issues/cp-october-2014/what-are-the-barriers-to-closing-the-gender-gap-in-senior-roles-in-pharmacy/20066743.article> [Accessed: 31 March 2017].

- Collins, A., 2016. Pharmacists and GPs: A complicated history. *Chemist and Druggist* [online]. Available at: <http://www.chemistanddruggist.co.uk/feature/pharmacists-and-gps-complicated-history> [Accessed: 31 March 2017].
- Cook, K. and Stoecker, J., 2014. Healthcare student stereotypes: A systematic Review with Implications for Interprofessional Collaboration. *Journal of Research in Interprofessional Practice and Education*, 4(2), pp. 1 – 13.
- Cooper, R.J., Anderson, C., Avery, T., Bissell, P., Guillaume, L., Hutchinson, A., James, V., Lymn, J., McIntosh, A., Murphy, E., Ratcliffe, J., Read, S., Ward, P., 2008. Nurse and pharmacist supplementary prescribing in the UK – A thematic review of the literature. *Health Policy*, 85, pp. 277-292.
- Cooper, R.J., Bissell, P., Ward, P., Murphy, E., Anderson, C., Avery, T., James, V., Lymn, J., Guillaume, L., Hutchinson, A. and Ratcliffe, J., 2012. Further challenges to medical dominance? The case of nurse and pharmacist supplementary prescribing. *Health*, 16(2), pp. 115-133.
- Corden, A. and Sainsbury, R., 2006. *Using Verbatim Quotations in Reporting Qualitative Social Research: The views of research users*. Social Policy Research Unit, University of York, York.
- Cotter, SM., Barber, ND. and McKee, M., 1994. Hospital clinical pharmacy services provided to primary care. *International Journal of Pharmacy Practice*, 2(4), pp. 215-219.
- Creswell, J.W., 2007. *Qualitative Inquiry & Research Design: Choosing Among Five Approaches*. 2nd ed. Thousand Oaks, California: Sage.
- Creswell, J.W., 2009. *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. 3rd ed. Thousand Oaks, California: Sage.
- Crompton, R., 1987. Gender, Status and Professionalism. *Sociology*, 21, 3, pp. 413-428.
- Crotty, M., 1998. *The foundations of social research*. London: Sage
- Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A. and Sheikh, A., 2011. The case study approach. *BMC Medical Research Methodology*, 11, p. 100 [online]. Available at: <http://www.biomedcentral.com/1471-2288/11/100> [Accessed: 31 March 2017].
- Cruess SR. and Cruess, RL., 2000. Professionalism: a contract between medicine and society. *Canadian Medical Association Journal*, 162 (5), pp. 668-669.
- Cunningham, A., 1999. Nursing Stereotypes. *Nursing Standard*, 13 (45), pp. 46-47.
- Cupchik, G., 2001. Constructivist Realism: An Ontology That Encompasses Positivist and Constructivist Approaches to the Social Sciences. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, [S.l.], v. 2, n. 1, Feb. 2001. ISSN 1438-5627. [online]. Available at: <http://www.qualitative-research.net/index.php/fqs/article/view/968/2112> [Accessed: 31 March 2017].

Cutcliffe, J.R., 2005. Adapt or adopt: developing and transgressing the methodological boundaries of grounded theory. *Journal of Advanced Nursing*, 51(4), pp. 421-428.

Cutler, S., 2011. What Does Medicines Optimisation Mean for Pharmacy Professionals? *Pharmaceutical Journal*, 287, pp. 606-607.

D'Amour, D., Ferrada-Videla, M., San Martin Roderiquez, L. and Beaulieu, M.D., 2005. The conceptual basis for interprofessional collaboration: core concepts and theoretical frameworks. *Journal of Interprofessional Care*, Supplement 1: pp 116-117.

Davidson, C., 2009. Transcription: Imperatives for qualitative research. *International Journal of Qualitative Methods*, 8 (2) pp. 35-52.

Davies, J.E., Barber, N. and Taylor, D., 2014. What do community pharmacists do?: results from a work sampling study in London. *International Journal of Pharmacy Practice*, 5(5), pp. 309-318.

Denzin, N.K., & Lincoln, Y.S., 2005. Introduction: The discipline and practice of qualitative research. In: N.K. Denzin & Y.S. Lincoln., eds. *The SAGE handbook of qualitative research*. 2nd ed. Thousand Oaks, California: Sage, pp. 1-29.

Denzin N.K., and Mettlin, C.J., 1968. Incomplete professionalization: the case of pharmacy. *Social Forces*, 46, pp. 375-381.

Department of Health, 2000. *Pharmacy in the future: implementing the NHS Plan. A programme for pharmacy in the National Health Service*. London. Department of Health.

Department of Health, 2003. *A vision for pharmacy in the new NHS*, London. The Stationary Office.

Department of Health, 2005. *Choosing health through pharmacy. A programme for pharmaceutical public health 2005-2015*. London. Department of Health.

Department of Health, 2006. *Improving Patients' Access to Medicines: A Guide to Implementing Nurse and Pharmacist Independent Prescribing within the NHS in England*. Gateway reference: 6429. London Department of Health.

Department of Health, 2007. *Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century*. London. The Stationary Office.

Department of Health, 2008. *Pharmacy in England: building on strengths – delivering the future. (Cm 7341)*. London. The Stationary Office.

Department of Health, 2010. *Advanced Level Nursing. A Position Statement*. Department of Health. Gateway 15133. [online]. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215935/dh_121738.pdf. [Accessed: 31 March 2017].

Department of Health, Department for Environment, Food and Rural Affairs. 2013. UK five year antimicrobial resistance strategy 2013 to 2018. London: Department of Health.

- Desborough, JA., Sach, T., Bhattacharya, D., Holland, RC. And Wright, D., 2012. A cost-consequences analysis of adherence focused pharmacist-led medication review services. *International Journal of Pharmacy Practice*, 20(1), pp. 41-49.
- Dingwall, R., 1976. Accomplishing profession, *The Sociological Review*, 24 (2), pp. 331-349.
- Dingwall, R., 1977. "Atrocity stories" and Professional Relationships. *Work and Occupations*, 4(4), pp. 371-396.
- Dingwall, R. and Allen, D., 2001. The implications of healthcare reforms for the profession of nursing. *Nursing Inquiry*, 8, (2), pp. 64-74.
- Dingwall, R. and Fenn, P., 1987. "A respectable profession?" Sociological and economic perspectives on the regulation of professional services. *International Review of Law and Economics*, 7, pp. 51-64.
- Dingwall, R. and Wilson, E., 1995. Is pharmacy really an "incomplete profession"? *Perspective on Sociology Problems*, 7, pp 111-128.
- Dixon-Woods, M., Yeung, K. and Bosk, C.L., 2011. Why is UK medicines no longer a self-regulatory profession? The role of scandals involving "bad apple" doctors. *Social Science and Medicine*, 73(10), pp. 1452-1459.
- Dowdall, M., 2017. Government unclear about who speaks for pharmacy, Alistair Burt tells conference. The *Pharmaceutical Journal*, PJ February 2017 DOI: 10.1211/PJ.2017.20202340 [online]. Available at: <http://www.pharmaceutical-journal.com/news-and-analysis/news/government-unclear-about-who-speaks-for-pharmacy-alistair-burt-tells-conference/20202340.article> [Accessed: 31 March 2017].
- Dowling, M., 2006. Approaches to reflexivity in qualitative research. *Nurse Researcher*, 13(3), pp. 7-21.
- Dowling, M., 2007. From Husserl to van Manen. A review of different phenomenological approaches. *International Journal of Nursing Studies*, 44, pp. 131-142.
- Droege, M., 2003. The Role of Reflective Practice in Pharmacy. *Education for Health*, 1 (16), pp. 68-74.
- Duerden, M., Avery, T. and Payne, R., 2013. *Polypharmacy and medicines optimisation. Making it safe and sound*. London: The Kings Fund.
- Eades, C.E., Ferguson, J.S. and O'Carroll, R.E., 2011 Public health in community pharmacy: A systematic review of pharmacist and consumer views. *BMC Public Health*, 11, 582. [online]. Available at: <http://bmcpublihealth.biomedcentral.com/articles/10.1186/1471-2458-11-582> [Accessed: 31 March 2017].
- Eaton, G. and Webb, B., 1979. Boundary encroachment: pharmacists in the clinical setting. *Sociology of Health and Illness*, 1(1), pp. 69-89.
- Eckert, P. and McConnell-Ginet, S., 1998. Communities of Practice: Where Language, Gender, and Power All Live. In: J. Coates, ed. *Language and Gender: A Reader*. Oxford. Blackwell, pp. 484-494.

- Edmunds, J. and Calnan, M.W., 2001. The reprofessionalisation of community pharmacy? An exploration of attitudes to extended roles for community pharmacists amongst pharmacists and General Practitioners in the United Kingdom. *Social Science & Medicine*, 53, pp. 943-955.
- Elliott, R.A., Boyd, M.J., Waring, J., Barber, N., Mehta, R., Chuter, A., Avery, A.J., Tanajewski, L., Davies, J., Salema, N., Latif, A., Gkountouras, G., Craig, C. and Watmough, D., 2014. *Understanding and Appraising the New Medicines Service in the NHS in England* (029/1024). London: Department of Health Policy Research Programme.
- Elston, MA., 1991. The politics of professional power: medicine in a changing health service. In: Gabe, J., Calnan, M. and Bury, M., eds. *The Sociology of the Health Service*. London: Routledge, pp. 58-88.
- Elvey, R., Hassell, K., and Hall, J., 2013. Who do you think you are? Pharmacists' perceptions of their professional identity. *International Journal of Pharmacy Practice*, 21, pp. 322-332.
- Elvey, R., Hassell, K., Lewis, P., Schafheutle, E., Willis, S. and Harrison, S., 2015. Patient-centred professionalism in pharmacy: values and behaviours. *Journal of Health Organization and Management*, 29 (3), pp. 413 – 430.
- Epstein, R.M. and Hundert, E.M., 2002. Defining and assessing professional competence, *Journal of the American Medical Association*, 287 (2), pp. 226-235.
- Evetts, J., 2003. The sociological analysis of professionalism: Occupational change in the modern world. *International Sociology*, 18(2), pp. 395–415.
- Evetts, J., 2006. Introduction: Trust and Professionalism: Challenges and Occupational Changes. *Current Sociology*, 54(4), pp. 515-531.
- Evetts, J., 2011. A new professionalism? Challenges and opportunities. *Current Sociology*, 59(4), pp. 406-422.
- Evetts, J., 2013. Professionalism: Value and Ideology. *Current Sociology*, 61(5-6), pp. 778-796.
- Fertleman, M., Barnett, N. and Patel, T., 2005. Improving medication management for patients: the effect of a pharmacist on post-admission ward rounds. *Quality and Safety in Health Care*, 14, pp. 207-211.
- Finlay, L., 2002a. 'Outing' the researcher: the provenance, process and practice of reflexivity. *Qualitative Health Research*, 12 (4), pp. 531-545.
- Finlay, L., 2002b. Negotiating the swamp: the opportunity and challenge of reflexivity in research practice. *Qualitative Research*, 2(2), pp. 209-230.
- Flyvbjerg, B., 2006. Five Misunderstandings about Case-Study Research. *Qualitative Inquiry*, 12 (2), pp. 219-245.
- Ford, J.S. And Reutter, L.I., 1990. Ethical dilemmas associated with small samples. *Journal of Advanced Nursing*, 15, pp. 187-191.
- Forrester, M., 2000. *Psychology of the image*. London: Routledge.

- Foucault, M., 1977. *Discipline and Punish: The Birth of the Prison* [trans, Sheridan, A.M.]. London: Penguin Books
- Foucault, M., 2009, *The Birth of the Clinic* [trans, Sheridan, A.M.]. London: Routledge (First published in 1989).
- Fournier, V., 1999. The appeal to 'professionalism' as a disciplinary mechanism. *Social Review*, 47(2), pp.280–307.
- Fournier, R., 2000. Boundary work and (un)making of the professions. In Malin, N. (ed.) *Professionalism, Boundaries and the Workplace*. London: Routledge, pp.
- Freidson, E., 1970. *Professional dominance: the social structure of medical care*. New York: Atherton Press.
- Freidson, E., 1988. *Profession of Medicine. A study of the sociology of Applied Knowledge*. London: The University of Chicago Press (1970).
- Freidson, E., 1994. *Professionalism Reborn: Theory, Prophecy and Policy*. Cambridge: Polity Press in association with Blackwell Publishers.
- Freidson, E., 2001. *Professionalism: The Third Logic*. London: Polity Press.
- Furlong, P. and Marsh, D., 2002. *A skin not a sweater: ontology and epistemology in political science*. In: Marsh, David and Stoker, Gerry eds. *Theory and Methods in Political Science*, Palgrave Macmillan, pp. 17-41.
- Gabe, J., Bury, M. and Elston, MA., 2004. *Key Concepts in Medical Sociology*. London: Sage Publications
- Gallagher, R.M., and Gallagher, H.C., 2012. Improving the working relationship between doctors and pharmacists: is inter-professional education the answer?, *Advances in Health Science Education*, 17(2), pp. 247-257.
- Gegas, V., 1982. The Self-Concept. *Annual Review of Sociology*, 8, pp.1-33.
- General Medical Council (GMC). 2017. Council [online]. Available at: <http://www.gmc-uk.org/about/council/council.asp> [Accessed: 31 March 2017].
- General Pharmaceutical Council (GPhC), 2012. *Standards of conduct, ethics and performance*. London: General Pharmaceutical Council.
- General Pharmaceutical Council (GPhC), 2013. *Criteria for registration as a pharmacy technician*. London: General Pharmaceutical Council.
- General Pharmaceutical Council (GPhC), 2014. *Registrant Survey 2013. Initial analysis*. General Pharmaceutical Council (GPhC). 2017. Our governing council [online]. Available at: <https://www.pharmacyregulation.org/about-us/who-we-are/gphc-council> [Accessed: 31 March 2017].
- Giam, J.A., McLachlan, A.J. and Krass, I., 2011. Community pharmacy compounding-impact on professional status. *International Journal of Clinical Pharmacy*, 33 (2), pp. 177-182.

Gidman, W. and Cowley, J., 2013. A qualitative exploration of opinions on the community pharmacist's role amongst the general public in Scotland. *International Journal of Pharmacy Practice*, 21, pp. 288-296.

Gidman, W., Hassell, K., Day, J. and Payne, K., 2007. Let's get practical: does it pay for female pharmacists to work?. *The Pharmaceutical Journal*, 278, pp.645-649.

Gidman, W., Ward, P. and McGregor, L., 2012. Understanding public trust in services provided by community pharmacists relative to those provided by general practitioners: a qualitative study. *BMJ*

Open 2012;2:e000939 doi:10.1136/bmjopen-2012-000939

<http://bmjopen.bmj.com/content/2/3/e000939.full> [Accessed 4 July 2016]

Glaser, B.G., 1992. *Basics of grounded theory analysis*. Mill Valley, CA: Sociology Press.

Glaser, B.G. and Strauss, A.L., 1967. *The discovery of grounded theory: Strategies for qualitative research*. Chicago IL: Aldine.

Glesne, C., 2011. *Becoming qualitative researchers: An introduction*. 4th ed. Boston: Pearson Education, Inc.

Goode, W.J., 1957. Community within a community: the professions. *American Sociological Review*, 22, pp. 194-200.

Gorman, E.H., 2014. Professional Self-regulation in North America: The Cases of Law and Accounting. *Sociological Compass*, 8/5, pp. 491-508.

Gorman, E. and Sandefur, R., 2011. 'Golden Age', quiescence, and revival: how the sociology of professions became the study of knowledge-based work. *Work and Occupations*, 38, 3, pp. 275–302.

Gray, N.J. and O'Brien, K.L., 2002. Sad example of profits before patients. *Pharmaceutical Journal*, 269, p. 247.

Green, C. and Hughes, D., 2011. Medicines supply and automation. In: M. Stevens M. *Hospital Pharmacy*. 2nd ed. Pharmaceutical Press. pp. 41-55.

Greenhalgh, T., Macfarlane, F., Steed, L., and Walton, R., 2016. What works for whom in pharmacist-led smoking cessation support: realist review. *BMC Medicine*, 14, 209, DOI 10.1186/s12916-016-0749-5 [online]

<https://bmcmmedicine.biomedcentral.com/articles/10.1186/s12916-016-0749-5>

[Accessed: 31 March 2017].

Greenhalgh, T. and Peacock, R., 2005. Effectiveness and efficiency of search methods in systematic reviews of complex evidence. *British Medical Journal*, 331(7524), pp. 1064-1065.

Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., Kyriakidou, O. and Peacock, R., 2005. Storylines of research in diffusion of innovation: a meta-narrative approach to systematic review", *Social Science & Medicine*, 61 (2), pp. 417-430.

Greenwood, E., 1957. Attributes of a profession. *Social Work*, pp. 45-55.

- Guba, E.G., and Lincoln, Y.S., 1994. Competing Paradigms in Qualitative Research. In: N.K. Denzin and Y.S. Lincoln, Eds, 1994. *Handbook of Qualitative Research*. London: Sage, pp. 105-11.
- Guba, E., and Lincoln, Y., 2005. Paradigmatic controversies, contradictions, and emerging confluences. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (3rd ed., pp. 191-215). Thousand Oaks, CA: Sage.
- Hafferty, F.W. and Castellani, B., 2010. The Increasing Complexities of Professionalism. *Academic Medicine*, 85 (2), pp. 288–301.
- Hall, P., 2005. Interprofessional team work: Professional cultures as barriers. *Journal of Interprofessional Care*, 19(1), pp. 188-196.
- Hammer, DP., 2000. Professional Attitudes and Behaviours: The “A’s and B’s” of Professionalism. *American Journal of Pharmaceutical Education*, 65, pp. 455-464.
- Hammersley, M., 1992. *What’s wrong with ethnography? Methodological explorations*. London: Routledge, 1992.
- Hammersley, M., Gomm, R., and Foster, P., 2000. Case Study and Theory. In: R. Gomm, M. Hammersley and P. Foster, Eds. 2000. *Case Study Method: Key Issues, Key Texts*. London: SAGE Publications, pp. 234-258
- Hanson, EJ.,1994. Issues concerning the familiarity of researchers with the research setting. *Journal of Advanced Nursing*, 20, pp. 940–942.
- Harding, G., 2007. Can professional judgement be taught to undergraduate pharmacy students? *The Pharmaceutical Journal*, 278, p.732.
- Harding, G. and Taylor, K., 1997. Responding to change: the case of community pharmacy in Great Britain. *Sociology of Health & Illness*, 19, pp. 547-560.
- Harding, G. and Taylor, K., 2000. The McDonaldisation of pharmacy. *The Pharmaceutical Journal*, 265, p. 602.
- Harding, G., and Taylor, K., 2002. Social dimensions of pharmacy (2): Power, status and pharmacy. *The Pharmaceutical Journal*, 269, pp. 440-442.
- Harding, G. and Taylor, K., 2004. Pharmacy’s strength lies in its blend of clinical, scientific and social skills. *The Pharmaceutical Journal*, 273(7310), p. 146
- Harding, G., and Taylor, K., 2006. Why pharmacists are needed to help shape students’ professional identity. *The Pharmaceutical Journal*, 277, pp. 766.
- Harding, G. and Taylor, K., 2015. Occupational status of pharmacy. In: G. Harding and K. Taylor, 2nd ed. Eds. *Pharmacy Practice*, CRC Press. pp. 199-214.
- Hart, C., 1998. *Doing a literature review: Releasing the social science imagination*. London: Sage Publications
- Hassell, K., 2012. *CPWS briefing paper: GPhC pharmacist register analysis 2011*. The University of Manchester: Centre for Pharmacy Workforce Studies.
- Hassell, K. and Symonds, S., 2015. The pharmacy workforce. In: G. Harding and Taylor, 2nd ed. 2015. *Pharmacy practice*. CRC Press. pp. 38-39.

- Hatch, J.A., 2002. *Doing qualitative research in education settings*, SUNY Press, New York.
- Haug, M., 1972. Deprofessionalization: an alternative hypothesis for the future. *Sociological Review Monograph*, 20 (S1), pp. 195-211.
- Hay, C., 2002. *Political analysis: a critical introduction*. Basingstoke: Palgrave.
- Health Care Education England and Higher Education Funding Council for England. 2014. *Ensuring a sustainable supply of pharmacy graduates. Analysis of first stage consultation*. October 2012/22. London [online]. Available at: http://www.hefce.ac.uk/media/hefce/content/pubs/2014/201422/HEFCE2014_22.pdf [Accessed: 31 March 2017].
- Health Circular, 1988: *The way forward for hospital pharmaceutical services*. (HC (88) 54) London. HMSO.
- Hean, S., Macleod-Clark, JM., Adams, K. and Humphris, D., 2006. Will opposites attract? Similarities and differences in students' perceptions of the stereotype profiles of other health and social care professional groups. *Journal of Interprofessional Care*, 20, pp.162-181.
- Heidegger, M., 1962. *Being and Time* [trans, Macquarrie, J. and Robinson, E.]. Oxford: Blackwell Publishing Ltd.
- Hepler, CD. and Strand, LM., 1990, Opportunities and responsibilities in pharmaceutical care. *American Journal of Hospital Pharmacy*, 47, pp. 533–43.
- Hewitt, J., 2007. Ethical Components of Researcher – Researched Relationships in Qualitative Interviewing. *Qualitative Health Research*, 17, pp. 1149-1159.
- Hibbert, D., Bissell, P. and Ward, PR., 2002. Consumerism and professional work in the community pharmacy. *Sociology of Health and Illness*, 23(1), pp. 46-65.
- Hind, M., Norman, I., Cooper, S., Gill, E., Hilton, R., Judd, P. and Newby, S., 2003. *Interprofessional perceptions of health care students*. *Journal of Interprofessional Care*, 17, pp. 21-34.
- Hilton, JL. and von Hippel, W., 1996. Stereotypes. *Annual Review of Psychology*, 47, pp. 237-271.
- Hobson, R., Scott, J. and Sutton, J., 2010. Pharmacists and nurses as independent prescribers: exploring the patient's perspective. *Family Practice*. 27(1), pp. 110-120.
- Holliday, A., 2007. *Doing and Writing Qualitative Research*. 2nd ed. London: Sage Publications Ltd.
- Holloway, S.W.F., 1991. *The Royal Pharmaceutical Society of Great Britain: A political and social history, 1841-1991*. London: Pharmaceutical Press.
- Holloway, S.W.F., Jewson, N.D. and Mason, D.J., 1986. 'Reprofessionalization' or 'occupational imperialism': some reflections on pharmacy in Britain. *Social Science in Medicine*, 23 (3), pp. 323-332.

- Holmes, J., 2009. Why professions have protected titles. *The Pharmaceutical Journal*, 282, p. 343.
- Horne, R., 1999. Patients' beliefs about treatment: The hidden determinant of treatment adherence?. *Journal of Psychosomatic Research*, 47(6), pp. 491-495.
- Howard, P., 2012. A survey of NHS consultant pharmacists in England. *European Journal of Hospital Pharmacy*, 19, pp. 251-252.
- Hudson, B., 2002. Interprofessionality in health and social care: The Achilles heel of partnership. *Journal of Interprofessional Care*. 16(1), pp. 7 -17.
- Hudson, B., 2010. How key moments in the Society's history have shaped pharmacy's future. *The Pharmaceutical Journal*, 285, pp. 310.
- Hughes, C.M., Hawwa, A.F., Scullin, C., Anderson, C., Bernsten, C.B., Björnsdóttir, I., Cordina, M.A., Alves da Costa, F., De Wulf, I., Eichenberger, P., Foulon, V., Henman, M.C., Hersberger, K.E., Schaefer, M.A., Søndergaard, B., Tully, M.P., Westerlund, T., McElnay, J.C., 2010
Provision of pharmaceutical care by community pharmacists: a comparison across Europe. *Pharmacy World and Science*, 32 (4), pp. 472-487.
- Hughes, C.M. and McCann, S., 2003. Perceived interprofessional barriers between community pharmacists and general practitioners: a qualitative assessment. *British Journal of General Practice*, 53, pp. 600-606.
- Hughes, D., Myles, S., Longo, M., Lises, C. 2008. *Investigating factors influencing user choices to visit either general practitioners or community pharmacists in the management of minor ailments – piloting a discrete choice experiment*. Pharmacy Practice Research Trust: PPRT, London.
- Hughes, E.C., 1958. *Men and Their Work*. New York. New York: The Free Press.
- Hunt, J.A., 2005. Pharmacy in the modern world 1617 to 1841 AD. In: S. Anderson, Ed, 2005. *Making Medicines. A brief history of pharmacy and pharmaceuticals*. Pharmaceutical Press. London, pp. 57 -76.
- Husserl, E., 1970. *The Crisis of European Sciences and Transcendental Phenomenology* [trans, Carr, D.]. Evanston, IL: North Western University Press.
- Hyett, N., Kenny, A. and Dickson-Swift, V., 2014. Methodology or method? A critical review of qualitative case study reports. *International journal of Qualitative Studies on Health and Well-being*, 9, [Online]. Available at: [10.3402/qhw.v9.23606](https://doi.org/10.3402/qhw.v9.23606) [Accessed: 31 March 2017].
- Ibarra, H., 1999. Provisional selves: Experimenting with image and identity in professional adaptation. *Administrative Science Quarterly*, 44 (4), pp. 764-791.
- International Pharmaceutical Federation. 2015. *Sustainability of Pharmacy Services: Advancing Global Health. International overview of remuneration models for community and hospital pharmacy* (Ref: 09/2015) [Online]. Available at: http://fip.org/files/fip/Sustainability-Pharmacy-Services-Executive_summary_2.pdf [Accessed: 31 March 2017].

- Ipsos Public Affairs. 2015. *Public perceptions of pharmacists*. General Pharmaceutical Council. Final Report. Ipsos MORI.
- Irvine, D., 2006. A short history of the General Medical Council. *Medical Education*, 40, pp. 202-211.
- Jacobs, S., Ashcroft, D., Hassell, K., 2011. Culture in community pharmacy organizations: what can we glean from the literature? *Journal of Health Organization and Management*, 25 (4), pp. 420-454.
- Jacobs, S., Hassell, K., Seston, E., Potter, H., & Schafheutle, E., 2013. Identifying and managing performance concerns in community pharmacists in the UK. *Journal of Health Services Research and Policy*, 18 (3), pp. 144-150 [online]. Available at: DOI:[10.1177/1355819613476277](https://doi.org/10.1177/1355819613476277)
Publication link: [dc88e8ec-33b7-498e-9d42-1b7010e05170](https://pubmed.ncbi.nlm.nih.gov/23620581/) | PubMed:[23620581](https://pubmed.ncbi.nlm.nih.gov/23620581/). [Accessed 31 March 2017].
- Jamie, K., 2014. The pharmacy gaze: bodies in pharmacy practice. *Sociology of Health and Illness*, 36 (8), pp. 1141-1155.
- Jee, S.D., Schafheutle, E.I. and Noyce, P.R., 2016. Exploring the process of professional socialisation and development during pharmacy pre-registration training in England. *International Journal of Pharmacy Practice*, 24(4), pp. 283-293.
- Jenkinson, J., 2012. A 'Crutch to Assist in Gaining an Honest Living': Dispensary Shopkeeping by Scottish General Practitioners and the Responses of the British Medical Elite, ca. 1852-1911. *Bulletin of the History of Medicine*, 86, pp. 1-36.
- Jesson, J. and Bissell, P., 2006. Public health and pharmacy: a critical review. *Critical Public Health*. 16(2), pp.159-169.
- Jesson, J.K., Wilson, K.A., Langley, C.A. and Hatfield, K., 2008. Images of pharmacy as a career: a survey among groups of year 12 students at school. *Pharmaceutical Journal*, 280 (7489), pp. 183-186.
- John, C. and Brown, C., 2017. Technicians and other pharmacy support workforce cadres working with pharmacists: United Kingdom Case Study. *Research in Social and Administrative Pharmacy*, 13, pp. 297-299.
- Johnson, T.J., 1972. *Professions and Power*. London: Macmillian.
- Khan, S., and VanWynsberghe, R., 2008. Cultivating the Under-Mined: Cross-Case Analysis as Knowledge Mobilization [54 paragraphs]. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 9 (1), Art. 34, [online] <http://nbn-resolving.de/urn:nbn:de:0114-fqs0801348> [Accessed; 31 March 2017]
- King, N., 2004. Using interviews in qualitative research. In: G., Symon, and C., Cassell, eds. 2004. *Qualitative methods and analysis in organizational research: A practical guide*. London: Sage. pp. 11-22.
- King, N. and Horrocks, C. 2010. *Interviews in Qualitative Research*. London: SAGE Publications Ltd.

- Kitson, A., Marshall, A., Bassett, K. and Seitz, K., 2012. What are the core elements of patient-centred care? A narrative review and synthesis of the literature from health policy, medicines and nursing, *Journal of Advanced Nursing*, 69, 1, pp. 4-15.
- Kitzinger, J., 1995. Introducing focus groups. *British Medical Journal*, 311, pp. 299-302.
- Koch, T., 1994. Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing*, 19, pp. 976-986.
- Kronus, CL., 1976. The Evolution of Occupational Power. *Work and Occupations*, 3, pp. 3-37.
- Krska, J., Ross, S.M. and Watts, M., 2005. Medication reviews provided by GPs and nurses: an evaluation of their quality. *International Journal of Pharmacy Practice*, 13, pp. 77-84.
- Krska, J. and Morecroft, C.W., 2010. Views of the general public on the role of pharmacy in public health. *Journal of Pharmaceutical Health Services Research*, 1, (1), pp. 33-38.
- Kuhn, T.S., 2012. *The Structure of Scientific Revolutions (with an introductory essay by Ian Hacking)*. 4th ed. London: The University of Chicago Press.
- Kuper, A., Lingard, L. and Levinson, W., 2008. Critically appraising qualitative research. *British Medical Journal*, 337, pp. 687-689 (Cite this as: BMJ 2008; 337:a1035 doi:10.1136/bmj.a1035).
- Kvale, S., 1996. *Interviewing. An introduction to qualitative research interviewing*. California: Sage
- Kvale, S. and Brinkmann, S., 2009. *Interviews. Learning the Craft of Qualitative Research Interviewing*. 2nd ed. London: Sage Publications Ltd.
- Langdrige, D., 2007. *Phenomenological Psychology Theory, Research and Method*. Harlow: Persons Education Limited.
- Lapadat, J and Lindsay, A., 1999. Transcription in research and practice: From standardization in technique to interpretive positioning. *Qualitative Inquiry*, 5 (64), pp. 64-86.
- Larson, MS., 2013. *The Rise of Professionalism*. Berkley. University of California Press. (Original published in 1977 by the University of California press).
- Latif, A., Pollock, K. and Boardman, H., 2011. The contribution of the medicines use review (MUR) consultation to counselling practice in community pharmacies. *Patient Education and Counselling*, 83(3), pp. 336-344
- Latif, A., Pollock, K. and Boardman, H.F., 2013. Medicines use reviews: a potential resource or lost opportunity for general practice? *BMC Family Practice*, 14, 57 DOI: 10.1186/1471-2296-14-57 [online]. Available at: <http://bmcfampract.biomedcentral.com/articles/10.1186/1471-2296-14-57> [Accessed: 31 March 2017].

Latter, S., Blenkinsop, A., Smith, A., Chapman, S., Tinelli, M., Gerard, K., Little, P., Celino, N., Granby, T., Nicholls, P., Dorer, G, 2010. *Evaluation of nurse and pharmacists independent prescribers. Department of Health Policy Research Programme Project 0160108*. University of Southampton, University of Keele.

Lawrence, J., 2014. Disappointment at decision to ignore call to cap pharmacy student numbers. *The Pharmaceutical Journal*, 1 November 2014, Vol 293, No 7834, online | URI: 20066927 [online]. Available at: <http://www.pharmaceutical-journal.com/news-and-analysis/news/disappointment-at-decision-to-ignore-call-to-cap-pharmacy-student-numbers/20066927.article> [Accessed: 31 March 2017]

Lawson, H.A., 1991. Specialization and Fragmentation Among Faculty as Endemic Features of Academic Life. *Quest*, 43, pp. 280-295.

Lemke., T., 2002. Foucault, Governmentality, and Critique. *Rethinking Marxism*, 14 (3), pp. 49-64.

LeVasseur, J.J., 2003. The Problem of Bracketing in Phenomenology. *Qualitative Health Research*, 13(3), pp. 408-420.

Lincoln, Y.S. and Guba, E.G., 2000. Paradigmatic Controversies, Contradictions and Emerging Confluences. In: N.K. Denzin and Y.S. Lincoln, Eds, 2000. *Handbook of Qualitative Research Second Editions*. London. Thousand Oaks, California: Sage, pp. 163-188.

Lord Carter of Coles, 2016. *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations*. An independent report for the Department of Health by Lord Carter of Coles. London.

Lords Sitting, 4 June 1986. *Pharmacy: Nuffield Foundation Report*, 475, pp. 1026-1027. [online] Available at: <http://hansard.millbanksystems.com/lords/1986/jun/04/pharmacy-nuffield-foundation-report> [Accessed: 31 March 2017].

Lott, B. and Saxon, S., 2002. The influence of Ethnicity, Social Class, and Context on Judgements About U.S. Women. *The Journal of Social Psychology*, 142 (4), pp. 481-499.

Lloyd, F. and Hughes, CM., 2007. Pharmacists' and mentors' views on the introduction of pharmacists supplementary prescribing: a qualitative evaluation of views and context. *International Journal of Pharmacy Practice*, 15(1), pp. 31-37

Luck, L., Jackson, D. and Usher, K., 2006. Case study: a bridge across paradigms. *Nursing Inquiry*, 13, pp.103–109.

Macdonald, K., 1995. *The Sociology of the Professions*. London: SAGE Publications Ltd.

Macrae, CN., Milne, AB. and Bodenhausen, GV., 1994. Stereotypes as Energy-Saving Devices: A Peek Inside the Cognitive Toolbox. *Journal of Personality and Social Psychology*, 66 (1), pp. 37-47.

Magirr, P., Grimsley, M., Ottewill, R. and Noyce, P., 2004. The clinical autonomy of community pharmacists in England. 2. Key findings. *International Journal of Pharmacy Practice*, 12(4), pp. 231-238.

- Malson, G., 2015. The role of the consultant pharmacist in the NHS. *Clinical Pharmacist*, 7, (9), DOI: 10.1211/CP.2015.20069457 [online] Available at: <http://www.pharmaceutical-journal.com/careers/career-feature/the-role-of-the-consultant-pharmacist-in-the-nhs/20069457.article> [Accessed: 31 March 2017].
- Mandy, P., 2008. The status of podiatry in the United Kingdom. *The Foot*, 18, pp. 202-205.
- Marshall, C., and Rossman, GB., 2015. *Designing Qualitative Research*. 6th ed. London: SAGE Publications Ltd.
- Martini, L., 2014. With no control on student numbers, tomorrow's pharmacists will have a bleak future. *The Pharmaceutical Journal*, 8 November 2014, Vol 293, No 7835, URI: 20067055 [online]. Available at: <http://www.pharmaceutical-journal.com/opinion/comment/with-no-control-on-student-numbers-tomorrows-pharmacists-will-have-a-bleak-future/20067055.article?adfesuccess=1> [Accessed: 31 March 2017]
- Mason, J., 2002. *Qualitative Researching*. Sage Publications: London
- Masongo, A. 2006. Are pharmacists acting as professionals or are they shopkeepers? *Pharmaciae*, 13 (1), p.16.
- May, C., 1992. Nursing Work, Nurses' Knowledge, and the Subjectification of the Patient. *Sociology of Health and Illness*, 14, (4), pp. 472-487.
- McDonald, R., Cheraghi-Sohi, S., Sanders, C. and Ashcroft, D., 2010. Professional status in a changing world: The case of medicines use reviews in English community pharmacy. *Social Science and Medicine*, 71, pp. 451-458.
- McDonnell, A., Jones, M.L. and Read, S., 2000. Practical considerations in case study research: The relationship between methodology and process. *Journal of Advanced Nursing*, 32(2), pp. 383-390.
- McDonough, R.P. and Doucette, W.R., 2001. Dynamics of pharmaceutical care: Developing collaborative working relationships between pharmacists and physicians. *Journal of the American Pharmaceutical Association*, 41(5), pp. 682–692.
- McGarty, C., Yzerbyt, VY. and Spears, R., 2002. Social, cultural and cognitive factors in stereotype formation. In: C. McGarty, V.Y. Yzerbyt, and R. Spears, Eds. 2002. *Stereotypes as explanations the formation of meaningful beliefs about social groups*. Cambridge University Press, pp. 1-15.
- McLeod, M., Ahmed, Z., Barber, N. and Franklin, B. D., 2014. A national survey of inpatient medication systems in English NHS hospitals. *BMC Health Services Research*, 14 p. 93[online]. Available at: <http://www.biomedcentral.com/1472-6963/14/93> [Accessed: 31 March 2017].
- Melko, C.N., Terry, P.E., Camp, K., Xi, Y. and Healey, M.L., 2010. Diabetes health coaching improves medication adherence: a pilot study. *American Journal of Lifestyle Medicine*, 4 (2), pp. 187 – 194.

- Merriam, S.B., 2009. *Qualitative Research. A Guide to Design and Implementation*. 3rd ed. San Francisco: Jossey-Bass.
- Mertens, D.M., 2005. Research methods in education and psychology: Integrating diversity with quantitative and qualitative approaches. 2nd ed. Thousand Oaks: Sage.
- Merton, R.K., Reader, G.G., Kendal, P.L., 1957. *The student – physician: Introductory studies in the sociology of medical education*. Cambridge Mass: Harvard University Press.
- Mesler, M.A., 1991. Boundary encroachment and task delegation: clinical pharmacists on the medical team. *Sociology of Health and Illness*, 13 (3), pp. 310-331.
- Middleton, H., 2006. What will it mean for technicians to be part of a profession?. *Hospital Pharmacist*, 13, pp. 411-412.
- Miles, M.B. and Huberman, A.M., 1994. *Qualitative data analysis: an expanded sourcebook*. 2nd ed. Sage.
- Miller, G., Franklin, B.D., Jacklin, A.J., 2011. Including pharmacists on consultant-led ward rounds: a prospective non-randomised controlled trial. *Clinical Medicine*, 11 (4), pp. 312-316.
- Miller, W.R. and Rollnick, S., 2009. The things that motivational interviewing is not. *Behavioural and Cognitive Psychotherapy*, 37, pp. 129-140.
- Morecroft, C.W., Thornton D. and Caldwell N.A., 2015. Inpatients' expectations and experiences of hospital pharmacy services: qualitative study. *Health Expectations*, 18, pp.1009–1017.
- Moffatt, F., Martin, P. and Timmons, S., 2014. Constructing notions of healthcare productivity: the call for a new professionalism?, *Sociology of Health & Illness*, 36 (5), pp. 686 – 702.
- Morgall, J.M. and Almarsdóttir, A.B., 1999. No struggle, no strength: how pharmacists lost their monopoly. *Social Science and Medicine*, 48, pp. 1247-1258.
- Morgan D. L., 2007. Paradigms Lost and Pragmatism Regained. Methodological Implications of Combining Qualitative and Quantitative Methods. *Journal of Mixed Methods Research*, 1 (1), pp. 48-76.
- Morse, J.M. and Coulehan, J.L., 2015. Maintaining Confidentiality in Qualitative Research Publications. *Qualitative Health Research*, 25, (2), pp. 151-152.
- Morton, K., Pattison, H., Langley, C. and Powell, R., 2015. A qualitative study of English community pharmacists' experience of providing lifestyle advice to patients with cardiovascular disease. *Research in Social and Administrative Pharmacy*, 11(1), pp. e17-e29.
- Mossialos, E., Courtin, E., Naci, H., Benrimoj, S., Bouvy, M., Farris, K., Noyce, P. and Sketris, I., 2015. From “retailers” to health care providers: transforming the role of community pharmacists in chronic disease management, *Health Policy*, 119 (5), pp. 628-639.

Murphy, R., 1984. The Structure of Closure: A Critique and Development of the Theories of Weber, Collins, and Parkin. *The British Journal of Sociology*, 35 (4), pp. 547-567.

Murphy, R., 1986. Weberian closure theory: a contribution to the ongoing assessment. *British Journal of Sociology*, 37, pp. 21-41.

Murray, R., 2016. Community Pharmacy Clinical Services Review Report, December 2016. The King's Fund. [online]. Available at: <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/12/community-pharm-clncl-serv-rev.pdf> [Accessed: 31 March 2017].

Nancarrow, S.A. and Borthwick, A.M., 2005. Dynamic professional boundaries in the healthcare workforce. *Sociology of Health and Illness*, 27 (7), pp. 897-919.

National Institute for Health and Care Excellence (NICE), clinical guideline 76, full guidance, 2009. *Medicines adherence; involving patients in decisions about prescribed medicines and supporting adherence*. London: The National Institute for Health and Care Excellence.

National Institute for Health and Care Excellence (NICE), 2015. *Medicines optimisation: the safe and effective use of medicines to enable best possible outcomes*. NICE guidance. Published: 4 March 2015 [online]. Available at: <https://www.nice.org.uk/guidance/ng5> [Accessed: 31 March 2017].

National Institute for Health & Clinical Excellence (NICE) and National Patient Safety Agency (NPSA), 2007. *Technical patient solutions for medicines reconciliation on admission of adults to hospital*. DH gateway number 9170 London: NICE.

Nettleton, S., 1992. *Power, pain and dentistry*. Buckingham: Oxford University Press.

NHS England. 2013. *Improving health and patient care through community pharmacy - a call for action*. NHS England, December 2013, Gateway Reference: 00878. [online] Available at: <https://www.england.nhs.uk/wp-content/uploads/2013/12/community-pharmacy-cta.pdf> [Accessed 31 March 2017].

NHS England. 2017. *Clinical Pharmacists in General Practice Pilot*. [Online] Available at: <https://www.england.nhs.uk/gp/gpfv/workforce/cp-gp/> [Accessed 31 March 2017].

Niglas, K., 2010. The Multidimensional Model of Research Methodology: An Integrated Set of Continua. In: A. Tashakkori and C. Teddlie, 2 Eds. 2010. *Sage Handbook of Mixed Methods in Social and Behavioral Research*. SAGE Publications Inc, Thousand Oaks, California, pp. 215-236.

Nieuwlaat, R., Wilczynski, N., Navarro, T., Hobson, N., Jeffery, R., Keepanasseril, A., Agoritsas, T., Mistry, N., Iorio, A., Jack, S., Sivaramalingam, B., Iserman, E., Mustafa, R.A., Jedraszewski, D., Cotoi, C. and Haynes, R.B., 2014. Interventions for enhancing medication adherence. *Cochrane Database of Systematic Reviews*, Issue 11. Art. No.: CD000011. DOI: 10.1002/14651858.CD000011.pub4 [online] <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000011.pub4/full> [Accessed: 31 March 2017].

Nobel, C., O'Brien, M., Coombes, I., Shaw, P.N., Nissen, L. and Clavarino, A., 2014. Becoming a pharmacist: Students' perceptions of their curricular experience and professional identity formation. *Currents in Pharmacy Teaching and Learning*, 6, pp. 327-339.

Ogus, A., 2000. Self-regulation. In: B. Bouckaert, & G. De Geest, Eds. 2000. *Encyclopedia of law and economics*, Vol. I. Cheltenham: Edward Elgar, pp. 587-601.

O'Leary, Z., 2004. *The essential guide to doing research*. London: SAGE publications Ltd.

O'Neill, J. (1986). The Disciplinary Society: From Weber to Foucault. *The British Journal of Sociology*, 37(1), pp. 42-60.

Oswald, K., 2016. The rise of the pharmacy technician: the next step. *The Pharmaceutical Journal*, 296 (7890), pp. 335 -338.

Oxtoby, K., 2014. The stereotypes. *Chemist and Druggists*. 21/03/2014 [online] Available at: <http://www.chemistanddruggist.co.uk/feature/stereotypes> [Accessed: 31 March 2017].

Oxtoby, K., 2015. Proud professional or dispensing drone? *Chemist and Druggists* 10/09/2015.[online]. Available at: <http://www.chemistanddruggist.co.uk/feature/welcome-machine> [Accessed: 31 March 2017].

Paley, J. and Lilford, R., 2011. Qualitative methods: an alternative view. *British Medical Journal*, 342:d424.

Parkin T., 2016. Pharmacy must grab new clinical opportunities. *Clinical Pharmacist*, 8 (5), p. 135.

Parsons, C., 2015. Before eclecticism: competing alternatives in constructivist research, *International Theory*, 7(3), pp. 501-538.

Parsons, T., 1939. The professions and social structure, *Social Forces*, 17 (4), pp. 457-467.

Patton, M., 1990. *Qualitative evaluation and research methods*. Beverly Hills, California: Sage.

Patton, M.Q., 2002. *Qualitative Research and Evaluation Methods*. 3rd ed. Sage Publication Inc: Thousand Oaks, California.

Petrakaki, D., Barber, N. and Waring, J., 2012. The possibilities of technology in shaping healthcare professionals: (Re/De-) Professionalisation of pharmacists in England. *Social Science & Medicine*, 75, pp. 429-437.

Pharmaceutical Services Negotiating Committee (PSNC), 2017a, Essential Services, [online]. Available at: <http://psnc.org.uk/services-commissioning/essential-services/> [Accessed: 31 March 2017].

Pharmaceutical Services Negotiating Committee (PSNC), 2017b, Advanced Services [online]. Available at: <http://psnc.org.uk/services-commissioning/advanced-services/> [Accessed: 31 March 2017].

Pharmaceutical Services Negotiating Committee (PSNC), 2017c, Health Living Pharmacy: Health Promotion ideas for pharmacy teams,[online]. Available at: <http://psnc.org.uk/services-commissioning/locally-commissioned-services/healthy-living-pharmacies/healthy-living-pharmacy-health-promotion-ideas-for-pharmacy-teams/> [Accessed: 31 March 2017].

Pharmaceutical Services Negotiating Committee (PSNC), 2017d, Pharmacy Funding, [online]. Available at: <http://psnc.org.uk/funding-and-statistics/pharmacy-funding/> [Accessed: 31 March 2017].

Pharmacy Voice, Pharmaceutical Services Negotiating Committee (PSNC) and the Royal Pharmaceutical Society, 2016. *Community Pharmacy Forward View*, August 2016.[online]. Available at: <http://psnc.org.uk/wp-content/uploads/2016/08/CPFV-Aug-2016.pdf> [Accessed: 31 March 2017].

Phillips, G., 2014a. How pharmacists could help save the NHS. *British Medical Journal Careers*. [Online] Available at: http://careers.bmj.com/careers/advice/How_pharmacists_could_help_save_the_NHS_03/12/14 [Accessed: 31 March 2017].

Phillips, G., 2014b. Why should the pharmacy student numbers be managed differently to other healthcare professionals? *The Pharmaceutical Journal*, 293, URI 20066898 [online]. Available at: <http://www.pharmaceutical-journal.com/opinion/correspondence/why-should-the-pharmacy-student-numbers-be-managed-differently-to-other-health-professions/20066898.article> [Accessed: 31 March 2017].

Pietroni, P., 1991. Stereotypes or archetypes? A study of perceptions amongst healthcare students. *Journal of Social Work Practice*, 5 (1), pp. 61-69.

Poirier, S and Lipetz, M., 1987. Pharmacy in interprofessional education: a course on images of the health professions in the media. *The American Journal of Pharmaceutical Education*, 51 (2), pp. 133-7.

Pope, C., Ziebland, S. and Mays, N., 2000. Qualitative research in health care. Analysing qualitative data. *British Medical Journal*, 320, pp. 114-6.

Pottie, K., Haydt, S., Farrell, B., Kennie, N., Sellors, C., Martin, C., Dolovich, L., 2009. Pharmacist's identity development within multidisciplinary primary care teams in Ontario; qualitative results from the IMPACT project. *Research in Social and Administrative Pharmacy*, 5, pp. 319 – 326.

Pound P, Britten N, Morgan M, Yardley, L, Pope, C., Daker-White, G. and Campbell, R., 2005. Resisting medicines: A synthesis of qualitative studies of medicine taking. *Social Science and Medicine* 61(1): 133–155.

Professional Standards Authority (PSA), 2015. *Rethinking regulation*. Professional Standards Authority for Health and Social Care August 2015 [online]. Available at: <http://www.professionalstandards.org.uk/publications/detail/rethinking-regulation> [Accessed: 31 March 2017].

Professional Standards Authority (PSA), 2016. *Regulation rethought*. Proposals for reform. Professional Standards Authority for Health and Social Care October 2016 [online]. Available at: <http://www.professionalstandards.org.uk/what-we-do/improving-regulation/regulation-rethought> [Accessed: 31 March 2017].

Quick, O., 2011. *A scoping study on the effects of health professional regulation on those regulated. Final report submitted to the Council for Healthcare Regulatory Excellence*. May 2011.

Ragin, C.C., 1992a. Casing and the process of social inquiry. In: C.C., Ragin, and Becker, H.S., Eds. 1992. *What is a case? Exploring the foundations of social inquiry*. New York: Cambridge University Press, pp. 217-226.

Ragin, C.C., 1992b. Case of “What is a case?”. In: C.C. Ragin and H.S. Becker, Eds. 1992. *What is a case? Exploring the foundations of social inquiry*. New York: Cambridge University Press, pp. 1-18.

Randall, G.E. and Kindiak, D.H., 2008. Deprofessionalization or postprofessionalization? Reflections on the State of Social Work as a Profession. *Social Work in Health Care*, 47(4), pp. 341-354.

Rapport, F., Doel, M.A., Hutchings, H.A., Wright, S., Wainwright, P., John, D.N. and Jerzembek, G.S., 2010. Eleven themes of patient-centred professionalism in community pharmacy: innovative approaches to consulting. *International Journal of Pharmacy Practice*, 18, pp. 260-268.

Rapport, F., Doel, M.A. and Jerzembek, G.S., 2009. “Convenient space” or “a tight squeeze”: Insider views on the community pharmacy. *Health and Place*, 15, pp. 315-322.

Rapport, F., Wright, S., Hutchings, H. and Doel, M., 2011. Patient-centred professionalism and its impact on community pharmacists. *The Pharmaceutical Journal*, 286, pp 112 -113.

Reebye, R.N., Avery, A.J., Bissell, P. and van Weel, C.V., 2002. The issue of territoriality between pharmacists and physicians in primary care. *International Journal of Pharmacy Practice*, 10, pp. 69-75.

Reeves, S., Kuper, A., Hodges, B.D., 2008. Qualitative research methodologies: ethnography. *British Medical Journal*, 337, pp. 512-514.

Richards, L., & Morse, J.M., 2007. *Readme first for a user's guide for qualitative methods*. 2nd ed. Thousand Oaks, California: Sage.

- Richardson, A., 1994. The health diary: an examination of its use as a data collection method. *Journal of Advanced Nursing*, 19, pp. 782-791.
- Richardson, L., 2000. Writing: A method of inquiry. In: N.K. Denzin and Y.S. Lincoln, Eds. 2000. *Handbook of Qualitative Research*. 2nd ed. London: Thousand Oaks: Sage. pp 923-949.
- Ritzer, G., 2000. *The McDonalidization of Society: The Century Edition*. Thousand Oaks, Calif.
- Roberts, A.S., Benrimoj, S.I., Chen, T.F., Williams, K.A., Aslani, P., 2006. Implementing services in community pharmacy: a review of models and frameworks for change. *International Journal of Pharmacy Practice*, 14, pp. 1–8.
- Rolfe, G., 2006. Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Journal of Advanced Nursing*, 53(3), pp. 304-310.
- Rosenthal, M. and Tsuyuki, R.T. 2010. Are pharmacists the ultimate barrier to pharmacy practice change?. *Canadian Pharmacist Journal*, 143, pp. 37-42.
- Royal College of Physicians, Royal College of Nursing. 2012. *Ward rounds in medicine: principles for best practice*. London: RCP.
- Royal Pharmaceutical Society, n.d (no date). *Women and pharmacy. The membership debate*.
- Royal Pharmaceutical Society. 2013. *Medicines Optimisation: Helping patients make the most of their medicines*. London: Royal Pharmaceutical Society.
- Royal Pharmaceutical Society, 2014. *Professional Standards for Hospital Pharmacy Services Optimising Patient Outcomes from Medicines*. London: Royal Pharmaceutical Society.
- Royal Pharmaceutical Society, A career in hospital pharmacy, What do hospital pharmacists do? *Video*. 2015. [online] Available at: <https://youtu.be/FxqVFchQpco> [Accessed; 31 March 2017].
- Royal Pharmaceutical Society, 2016. *Medicines, Ethics and Practice: The guide for pharmacist*. Edition 40. London: Royal Pharmaceutical Society.
- Rushmer, RK & Pallis, G 2003, Inter-Professional Working: The Wisdom of Integrated Working and The Disaster of Blurred Boundaries. *Public Money & Management*, 23, 1, pp. 59-66.
- Ryan, K., Bissell, P. and Traulsen, J.M., 2004. The work of Michael Foucault: relevance to pharmacy practice. *International Journal of Pharmacy Practice*, 12(1), pp. 43-52.
- Saks, M., 2012. Defining a Profession: The Role of Knowledge and Expertise, *Professions and Professionalism*, 2, pp. 1 – 10.
- Saks, M., 2016. A review of theories of professions, organizations and society: The case for neo-Weberianism, neo-institutionalism and eclecticism. *Journal of Professions and Organization*, pp. 1 – 18.

- Salhani, D. and Coulter, I., 2009. The politics of interprofessional working and struggle for professional autonomy in nursing. *Social Science and Medicine*, 68, pp. 1221-1228.
- Salter, C., Holland, R., Harvey, R. and Henwood, K., 2007. "I haven't even phoned my doctor yet." The advice giving role of the pharmacist during consultations for medication review with patients aged 80 or more: qualitative discourse analysis". *British Medical Journal*, doi:10.1136/bmj.39171.577106.55.
- Sandelowski, M., 2011. 'Casing' the research case study. *Research in Nursing and Health*, 34, (2), pp. 153-159.
- Saramunee, K., Krska, J., Mackridge, A., Richards, J., Suttajit, S. and Phillips-Howard, P., 2012. How to enhance public health service utilization in community pharmacy: general public and health providers' perspectives. *Research in Social and Administrative Pharmacy*, 10, (2), pp. 272-84.
- Saramunee, K., Krska, J., Mackridge, A., Richards, J., Suttajit, S. and Phillips-Howard, P., 2015. General public's views on pharmacy public health services: current situation and opportunities in the future. *Public Health*, 129, pp. 706–715.
- Scanzoni, J. (1979) *Social Exchange and Behavioral Interdependence*. In Huston, R. L. B. A. T. L. (Ed.) *Social Exchange in Developing Relationships*. New York, Academic Press.
- Schafheutle, E. I., Hassell, K., Ashcroft, D. M., Hall, J., & Harrison, S., 2010. Learning professionalism through practice exposure and role models. *Pharmaceutical Journal*, 285(7613), pp.164-165.
- Schafheutle, E. I., Hassell, K., Ashcroft, D. M., Hall, J., & Harrison, S., 2012. How do pharmacy students learn professionalism?. *International Journal of Pharmacy Practice*, 20(2), pp.118-128.
- Schneider, D. J., 1992. Red apples, liberal college professors, and farmers who like Bach. *Psychological Inquiry*, 2, pp. 190–193.
- Seston, L., and Hassell, K., 2012. *CPWS briefing paper: GPhC pharmacy technician register analysis 2012*. The University of Manchester: Centre for Pharmacy Workforce Studies.
- Sidhu, A., 2003. Glorified shelf-stackers?. *The Pharmaceutical Journal*. 270 (7234), pp. 152-153.
- Sil, R. and Katzenstein, R.J., 2010. Analytic Eclecticism in the Study of World Politics: Reconfiguring Problems and Mechanisms across Research Analytic Eclecticism in the Study of World Politics: Reconfiguring Problems and Mechanisms across Research Traditions. *Perspectives on Politics*. 8, pp. 441 – 431.
- Simons, H., 2009. *Case Study Research in Practice*. London: SAGE Publications Ltd.

Smith, A. and Darracott, R., 2011. *Review of pharmacist undergraduate education and pre-registration training and proposals for reform, Discussion Paper*, London: Medical Education England.

Smith, J.A., Flowers, P. and Larkin, M., 2009. *Interpretative Phenomenological Analysis. Theory, Method and Research*. London: SAGE Publications Ltd.

Smith, J., Picton, C. and Dayan, M., 2013. *Now or never: Shaping pharmacy for the future*. London: Royal Pharmaceutical Society.

Smith, J., Picton, C. and Dayan, M., 2014. *Now more than ever: Why pharmacy needs to act*. London: Nuffield Trust.

Snowden, M., 2015. Use of diaries in research. *Nursing Standard*, 29, 44, pp. 36-41.

Snyder, M., 1981. On the self-perpetuating nature of social stereotypes. In: D.L. Hamilton, ed, 1981. *Cognitive processes and intergroup behaviour*. Hillsdale, NJ: Lawrence Erlbaum Associates, Publishers. pp. 183-212.

Stake, R., 1995. *The art of case study research*. Thousand Oaks, California: Sage.

Stake, R., 2000. The Case Study Method in Social Inquiry. In: R. Gomm, M. Hammersley, P. Foster. Eds. 2000. *Case Study Method: Key Issues, Key Texts*. London: SAGE Publications, pp. 19-26.

Stake, R. E., 2003. Case Studies. In N. K. Denzin & Y. S. Lincoln, eds. 2003. *Strategies of Qualitative Inquiry*. London: Sage. pp. 134-164.

Stake, R.E., 2005. Qualitative case studies. In: N.K., Denzin, and Y. Lincoln, Eds., 2005. *The Sage Handbook of Qualitative Research*, 3rd ed., Sage, Thousand Oaks, CA, pp. 443-66.

Stake R., 2006. *Multiple case study analysis*. New York: The Guilford Press.

Starks, H. and Trinidad, S.B., 2007. Choose your Method: A Comparison of Phenomenology, Discourse Analysis and Grounded Theory. *Qualitative Health Research*, 17(10), pp. 1372-1380.

Stevenson, F.A., Leontowitsch, M., and Duggan, C., 2008. Over-the-counter medicines: professional expertise and consumer discourse. *Sociology of Health and Illness*, 30 (6), pp. 913-928.

Strand, L.M., Cipolle, R.J., Morley, PC. And Frakes, M.J., 2004. The impact of pharmaceutical care practice on the practitioner and the patient in the ambulatory practice setting: twenty-five years of experience. *Current Pharmaceutical Design*, 10 (31), pp. 3987–4001.

Strasen L.L., 1992. *The Image of Professional Nursing: Strategies for Action*. J.B. Lippincott Company, Philadelphia.

Strauss, A. and Corbin, J., 1998. *Basics of Qualitative Research Techniques and Procedures for Developing Grounded Theory* (2nd Ed), California: Thousand Oaks, Sage.

Suddaby, R. and Muzio, D., 2015. Theoretical Perspectives of the Professions. In: L., Empson, D., Muzio, J., Broschak, and B., Hinings, eds, 2015. *The Oxford Handbook of Professional Service Firms*, Oxford: Oxford University Press, pp. 25-47.

Sukkar, E., 2013. Have medicines use reviews come to represent profit over patient care? *The Pharmaceutical Journal*, 291, p. 137.

Sukkar, E., 2014. Should pharmacies sell electronic cigarettes? *The Pharmaceutical Journal*, October 2014, DOI: 10.1211/PJ.2014.20066760 [online]. Available at: <http://www.pharmaceutical-journal.com/20066760.article> [Accessed: 31 March 2017].

Sukkar, E., 2016a. Community pharmacy in Great Britain 2016: A fragmented market. *The Pharmaceutical Journal*, 296, (7889), pp. 282–283.

Sukkar, E., 2016b. NHS England may be thinking of decommissioning MURs and new medicine service, PSNC fear. *The Pharmaceutical Journal*, DOI: 10.1211/PJ.2016.20201310 [online] <http://www.pharmaceutical-journal.com/news-and-analysis/news/nhs-england-may-be-thinking-of-decommissioning-murs-and-new-medicine-service-psnc-fears/20201310.article>] [Accessed: 31 March 2017]

Takase, M., Kershaw, E., & Burt, L., 2002. Does public image of nurses matter? *Journal of Professional Nursing*, 18 (4), pp. 196-205.

Takase M., Maude P. & Manias E., 2006. Impact of the perceived public image of nursing on nurses' work behaviour. *Journal of Advanced Nursing*. 53 (3), pp. 333–343.

Taylor, K.M.G., Harding, G., 2007. The pharmacy degree: The student experience of professional training. *Pharmacy Education*. 7(1), pp. 83-88.

Taylor, J., Krska, J., Mackridge, A., 2012. A community pharmacy-based cardiovascular screening service: views of service users and the public, *International Journal of Pharmacy Practice*, 20, 5, pp. 277-284.

Taylor, K., Nettleton, S. and Harding, G., 2004. *Sociology for pharmacists*. An introduction. 2nd Ed. London: Taylor and Francis.

The Foster Review, 2006. *The regulation of the non-medical healthcare professions. A review by the Department of Health*, London: Department of Health.

The Nuffield Foundation, 1986. *Pharmacy: The report of a committee of inquiry appointed by the Nuffield Foundation*. London: The Nuffield Foundation.

The Pharmacy Order 2010 (Approved European Pharmacy Qualifications) Order 2010 SI 2010/1620.

This is money, 2014. Compare your pay to the national average in your job: League table of official UK salaries across 400 trades and professions. 12/12/14.[online]: Available at: <http://www.thisismoney.co.uk/money/article-2269520/Best-paid-jobs-2012-Official-figures-national-average-UK-salaries-400-occupations.html> [Accessed: 31 March 2017].

- Thomas, G., 2011. *How to do your case study. A guide for students & researchers*. London: SAGE Publications Limited.
- Thomas, J.A., 2015. Using unstructured diaries for primary data collection. *Nurse Researcher*, 22, 5, pp. 25-29.
- Thomas, M. and Anscombe, J., 2012. *The future of community pharmacy in England*. London: AT Kearney. [online]. Available at: www.atkearney.com/documents/10192/649132/The+Future+of+Community+Pharmacy.pdf/1838dede-b95a-4989-8600-6b435bd00171 [Accessed: 31 March 2017]
- Thomas, M. and Plimley, J., 2012. *The future of community pharmacy in England*. London: AT Kearney [online]. Available at: www.atkearney.com/documents/10192/649132/The+Future+of+Community+Pharmacy.pdf/1838dede-b95a-4989-8600-6b435bd00171 [Accessed: 31 March 2017].
- Tight, M., 2010. The curious case of case study: a viewpoint. *International Journal of Social Research Methodology*, 13, (4), pp. 329-339.
- Timmons, S., 2011. Professionalization and its discontents. *Health*, 15 (4), pp. 337–352.
- Tonna, A.P., Stewart, D.C., West, B. and McCaig, D.J., 2010. Exploring pharmacists' perceptions of the feasibility and value of pharmacist prescribing of antimicrobials in secondary care in Scotland. *International Journal of Pharmacy Practice*, 18, pp.312–319.
- Torjesen, I., 2015. Lower entry standards linked to GPhC exam failure rates. *The Pharmaceutical Journal*, 295, (7878), p. 170.
- Torjesen, I., 2017. Pharmacy funding cuts: The story so far. *The Pharmaceutical Journal*, Vol 298, No 7897, DOI: 10.1211/PJ.2017.20202223. [online]. Available at: <http://www.pharmaceutical-journal.com/news-and-analysis/features/pharmacy-funding-cuts-the-story-so-far/20202223.article> [Accessed: 31 March 2017].
- Traulsen, J. M. and Bissell, P., 2004. Theories of professions and the pharmacist. *International Journal of Pharmacy Practice*, 12, pp. 107-114.
- Turner, B.S., 1995. *Medical Power and Social Knowledge*. 2nd edn. London: SAGE Publications.
- Turner, P., 1986. The Nuffield report: a signpost for pharmacy. *British Medical Journal*, 292, pp. 1031-1033.
- Twigg, M.J., Poland, F. Bhattacharya, D., Desborough, J.A. and Wright, D., 2013. The current and future roles of community pharmacists: Views and experiences of patients with type 2 diabetes, *Research in Social and Administrative Pharmacy*, 9(6), pp. 777-789.
- Underhill, P., 1992. Alternative Views of Science in Intra-professional conflict: General Practitioners and the Medical and Surgical Elite 1815 – 58. *Journal of Historical Sociology*, 5, pp. 322-350.
- Van Maanen, J., 1982. Fieldwork on the beat. In: J. Van Maanen, J.M. Dabbs and R.R. Faulkner, Eds, 1982. *Varieties of qualitative research*, Beverly Hills, CA: Sage, pp. 103-151.

Van Manen, M., 1990. *Researching lived experience: Human science for an action sensitive pedagogy*. New York: State University of New York.

van Mil, J.W., Schulz, M., Tromp, T.F., 2004. Pharmaceutical care, European developments in concepts, implementation, teaching, and research: a review. *Pharmacy World and Science*, 26(6), pp. 303–11.

van Mook, WN., de Grave, WS., Wass, V., O'Sullivan, H. Zwaveling, JH., Schuwirth, LW and van der Vleuten, CP., 2009. Professionalism: evolution of the concept. *European Journal of Internal Medicine*, 20 (4), pp. e81-84.

Varnish, J., 1998. Drug Pushers or health care professionals: the public's perceptions of pharmacy as a profession. *International Journal of Pharmacy Practice*, 6, pp. 13-21.

Vermeire, E., Hearnshaw, H., Van Royen, P. and Denekens, J., 2001. Patient adherence to treatment: three decades of research. A comprehensive review. *Journal of Clinical Pharmacy and Therapeutics*, 26 (5), pp. 331-342.

Verschuren, PJM., 2003. Case study as a research strategy: some ambiguities and opportunities. *International Journal of Social Research Methodology*, 6, (2), pp 121-139.

Vignoles, V.L., Schwartz, S.J. and Luyckx, K., 2011. Introduction: Towards an Integrative View of Identity. In: S.J. Schwartz, K. Luyckx and V.L. Vignoles, Eds., 2011. *Handbook of Identity Theory and Research*. New York: Springer Science and Media, pp. 1-30.

Vogler, S., Habimana, K. and Arts, D., 2014. Does deregulation in community pharmacy impact accessibility of medicines, quality of pharmacy services and costs? Evidence from nine European countries. *Health Policy*, 117, pp. 311-327.

Wang, L., 2012. E-cigarettes: should pharmacists be helping to turn smokers into "vapers"? *The Pharmaceutical Journal*, Vol. 289, p180 | URI: 11105264 [online]. Available at: <http://www.pharmaceutical-journal.com/news-and-analysis/features/e-cigarettes-should-pharmacists-be-helping-to-turn-smokers-into-vapers/11105264.article> [Accessed: 31 March 2017].

Waring, J., Dixon-Woods, M., & Yeung, K. (2010). Modernising medical regulation: where are we now? *Journal of Health Organisation and Management*, 24 (6), pp. 540-555.

Waring, J. and Latif, A., 2017. Of Shepherds, Sheep and Sheepdog? Governing the Adherent Self through Complementary and Competing 'Pastorates', 2017. *Sociology*, pp. 1 – 8.

Waring, J., Latif, A., Boyd, M., Barber, N., Elliott, R., 2016. Pastoral power in the community pharmacy: A Foucauldian analysis of services to promote patient adherence to new medicines. *Social Science and Medicine*, 148, pp. 123-130.

Weaver, K. and Olson, J.K., 2006. Understanding paradigms used for nursing research. *Journal of Advanced Nursing*, 53 (4), pp. 459 – 469.

- Weidmann, A.E, Cunningham, S., Gray, G., Hansford, D., Bermano, G. and Stewart, D., 2012. Views of the Scottish general public on community pharmacy weight management services: international implications, *International Journal of Clinical Pharmacy*, 34 (2), pp. 389-397.
- Weiss, M.C., 2011. Diagnostic decision making: The last refuge for general practitioners? *Social Science and Medicine*, 73, (3), pp.375–382.
- Weiss, M.C. and Sutton, J., 2009. The changing nature of prescribing: pharmacists as prescribers and challenges to medical dominance. *Sociology of Health and Illness*, 31, (3), pp. 406-421.
- Wenger, E., 1998. *Communities of Practice: Learning, Meaning and Identity*. Cambridge: Cambridge University Press.
- Wenger, E., 2000. Communities of Practice and Social Learning Systems. *Organizations*. 7(2), pp. 225 – 246.
- Wenger, E. and Lave, J.,1991. *Situated Learning: Legitimate Peripheral Participation*. Cambridge: Cambridge University Press.
- Wenger, E., McDermott, R., and Snyder, W., 2002. *Cultivating communities of practice: a guide to managing knowledge*. Harvard Business School Press.
- Wiedenmayer, K., Summers, R.S., Mackie, C.A., Gous, A.G.S., Everard, M. and Tromp, D., 2006. *Developing pharmacy practice. A focus on patient care*. Handbook – 2006 Edition. World Health Organization (WHO) and International Pharmaceutical Federation [online]. Available at: <http://apps.who.int/iris/handle/10665/69399> [Accessed: 31 March 2017].
- Wilcock, M. and Harding, G., 2007. General Practitioners' perceptions of medicines use reviews by pharmacists. *The Pharmaceutical Journal*, 279, pp. 501-503.
- Wilcock, M. and Harding, G. 2008. What do pharmacists think of MURs and do they change prescribed medication? *The Pharmaceutical Journal*, 281, p. 163.
- Wilcock, M. and Hughes, P., (2014). GPs perceptions of medicines optimisation principles. *Prescriber*, 25 (8), pp. 13-17.
- Wilensky, H.L., 1964. The professionalization of everyone?. *American Journal of Sociology*, 70, pp. 137-158.
- Williams, K.F., 2007. Re-examining 'professionalism' in pharmacy: A South African perspective. *Social Science and Medicine*, 64, pp. 1285-1296.
- Williams, S.D., Phipps, D.L., Ashcroft, D.M., 2013. Understanding the attitudes of hospital pharmacists to reporting medication incidents: A qualitative study. *Research in Social and Administrative Pharmacy*, 9, pp. 80-89.
- Willig, C. (2013), *Introducing qualitative research in psychology. Adventures in theory and methods*. 3rd Ed. Berkshire: Open University Press.

- Willis, S., Hassell, K. and Ko, S.L., 2007. Images of pharmacy and occupational identity. *The Centre for Pharmacy Workforce Studies Bulletin*, Issue 3 [Online]. Available at: http://sites.pharmacy.manchester.ac.uk/cpws/publications/Bulletins06_08/bulletin3.pdf [Accessed: 31 March 2017].
- Wimpenny, P. and Gass, J., 2000. Interviewing in phenomenology and grounded theory: Is there a difference?. *Journal of Advanced Nursing*, 31(6), pp. 1485-1492.
- Witz, A., 1992. *Professions and Patriarchy*. London: Routledge.
- Wood, K., Gibson, F., Radley, A. and Williams, B., 2015. Pharmaceutical care of older people: what do older people want from community pharmacy? *International Journal of Pharmacy Practice*, 23 (2), pp. 121-130.
- World Health Organization, 2003. *Adherence to long-term therapies. Evidence for Action*. Geneva: World Health Organisation, 2003.
- Worling, P., 2005. Pharmacy in the early modern world 1617 to 1841 AD. In S. Anderson (Ed.) *Making Medicines. A brief history of pharmacy and pharmaceuticals* (pp. 57 to 76). Pharmaceutical Press. London.
- Yardley, L., 2000. Dilemmas in qualitative health research, *Psychology and Health*, 15, pp. 215-228.
- Yin, R.K., 2009. *Case Study Research Design and Methods*. 4th ed. London: SAGE Ltd.
- Zellmer, W.A., 2002. *The conscience of a pharmacist: Essays on vision and leadership for a profession*. ASHP Publication Production Centre.
- Zucker, D.M., 2001. Using Case Study Methodology in Nursing Research. *The Qualitative Report*, 6 (2), pp. 1-13.

The literature search took place at various stages during this study.

Generally the different literature searches were limited to the English language. All the literature published after 2000 relating to the UK was included. These criteria were not strictly applied as some older publications and publications outside the UK were of relevance to this study. The searches took account of the different spellings of search terms such as professionalisation with an s or z, using \$ where relevant: professionalisation.

Early on in the study various search terms were used in searching the Applied Social Sciences Index and Abstracts (ASSIA) database as part of undertaking a broad literature search to help scope this study. The combinations of the different search terms used are listed below:

Pharmacy* OR Pharmacist*	AND	Professional* OR Professionalism OR Professionalisation OR Deprofessionalisation OR Profession	AND	Role\$ OR Responsibility* OR Value\$ OR Socialization* OR Recognition* OR Identity* OR Judgement* OR Boundary* OR Skill* OR Status OR Power OR Identification* OR Perception* OR Knowledge OR Issue* OR Culture OR Value* OR autonomy.
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A subsequent search was undertaken using the following search terms: Professionalism AND pharmacy; Professionalism AND pharmacy; Profession* AND pharmacy, Profession* AND pharmacist and Status AND pharmacist

This time the following databases were used: Applied Social Sciences Index and Abstracts (ASSIA), British Nursing Index (BNI), CINAHL Pluse with full text, International Bibliography of the Social Sciences, EMBASE, Ovid Medline, Web of Science (WOS) and Zetoc (The British Library’s Electronic Table of content service).

It was anticipated from earlier searches of the literature, as part of preparing the research protocol, that there were limited publications relating to pharmacists’ practice. The following databases were accessed in 2015: ProQuest Hospital

Collection, PsycINFO, Wiley online library, British Nursing Index (BNI), Cumulative Index to Nursing and Allied Health Literature (CINAHL) Plus with full text, PubMed, Science Direct, Web of Science (WOS) and Zetoc.

The search terms used were ‘pharmacy’ OR ‘pharmacist’ followed by in different combinations:

	Search terms:
Nature of pharmacy practice	Practice, role, work, experience, skill, clinical, identity, boundary, function, activity, image, stereotypes.
Practice	Prescribing, dispensing, ward rounds, reviews, clinical, errors, interventions.
Status	Status, power, professionalisation, re-professionalisation, de-professionalisation, autonomy, responsibility, value, recognition, judgement, opinion.
Perceptions	Perceptions, attitudes, perspective, experience, self-perceive, self-perceptions, view, voice
Professionalism	Professionalism, professional, socialisation

Plural terms were used where relevant by using prefixes. The search terms were limited to abstracts. If a publication appeared to be of interest then the abstract was read and checked for potential relevance. If of interest then the whole article was scanned. If the facility was available within a database, whereby authors who had referenced a relevant publication were listed, then the titles of those publications were checked. If available the ‘related articles’ featuring in electronic databases was used. If a search resulted in listing over 100 articles then this search would be narrowed further (e.g., using exclusionary terms). Key journals were also searched using their search facility or manually scanned (e.g., International Journal of Pharmacy Practice).

Google and Google Scholar (advanced search) search engines were used. Various websites were accessed such as: Royal Pharmaceutical Society, General Pharmaceutical Society, Department of Health, NHS England, the King’s fund.

Grey literature: Professional journals (e.g., The Pharmaceutical Journal, Clinical Pharmacists, European Hospital Pharmacists, Chemists and Druggists).

Sociological examination of the pharmacy profession:

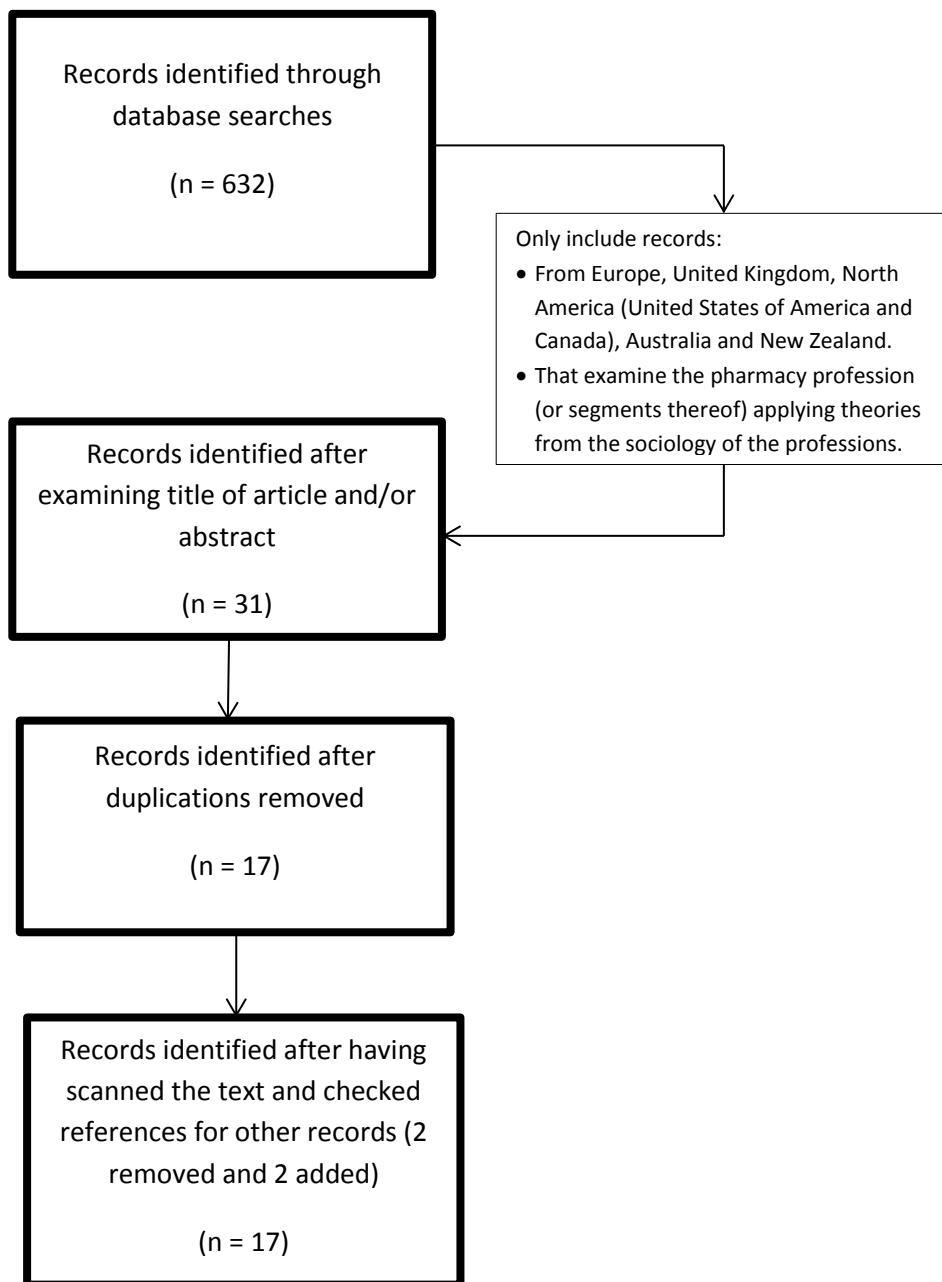
The aim of this review was to identify peer-reviewed articles examining the pharmacy profession applying theories from the sociology of the professions. The following databases were searched: Hospital Premier Collection, Cumulative Index to Nursing and Allied Health Literature (CINAHL) Plus, PsycINFO, Wiley Online Library, Scopus, International Bibliography of Social Science (IBBS), PubMed, Science Direct, Web of Science (WOS) and Zetoc.

Initially the Hospital Premier Collection and Scopus were searched using different search terms and combinations thereof to identify terms that produced the required records. The search term ‘profession’ was added to ensure that only records were identified that would discuss the pharmacy profession from a sociological perspective. The search term ‘sociology’ was not used as this did not provide the required records. The key words from previously identified relevant journals were checked but these were not always helpful. Following these trials and considerations the following search terms were used:

Pharmacy OR pharmacists (title or abstract) AND status (all fields) AND profession (all fields) NOT students (all fields)	Pharmacy OR pharmacists (title or abstract) AND professionalisation (all fields) AND profession (all fields) NOT students (all fields)
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Truncation of pharmac* was not used as this generated journals containing several other words such as pharmacology, pharmaceuticals, pharmaceutical that were not relevant. The search term ‘status’ generated several records as this word is used in contexts unrelated to professional status hence the word ‘profession’ was included. It was not felt that including students’ views on professions would be relevant so these were excluded. The searches were limited to English text but the search was extended to other countries due to the limited number of publications based on UK pharmacists.

The time-line was left open but was set from 1990 to today where the time-line had to be specified or where the default timeline was set to less than that. Only peer-reviewed articles were included. In total 632 records were identified resulting in a total of 17 records were included. See flow-diagram on the next page.



The records were: Denzin and Mettlin (1968), Eaton and Webb (1979), Mesler (1991), Dingwall and Wilson (1995), Harding and Taylor (1997), Morgall and Almarsdóttir (1999), Birenbaum (1982), Holloway, Jewson and Mason (1986), Edmunds and Calnan (2001), Hibbert, Bissell and Ward (2002), McDonald et al (2010), Giam, McLachlan and Krass (2011), Petrakaki, Barber and Waring (2012), Jamie (2014), Broom et al (2015), Waring et al (2016) and Waring and Latif (2017).

This appendix provides basic background information on the pharmacy profession including information on community pharmacy, hospital, mental health and community health services healthcare settings in England to assist the reader of this thesis.

Healthcare setting: community pharmacy

Community pharmacists traditionally take a prescription by a General Practitioner (GP) and will dispense the medication to the patient and advise the patient on the proper use of that medication. Community pharmacies in England are privately owned businesses contracted by the National Health Service (NHS) and funded from the public purse to provide pharmaceutical services. Community pharmacies are divided into multiple or chain firms, smaller chains and independent pharmacies. In England the community pharmacy contract to deliver NHS services consists of three tiers: essential, advanced and locally advanced services. The essential services include, for example dispensing NHS prescriptions, repeat dispensing services and disposal of unwanted medicines (PSNC, 2017a). There are four advanced services that community pharmacies can provide and which they will also receive remuneration for: the Medicines Use Reviews (MURs) service which is aimed at helping patients to get the best out of their medicines, the New Medicines Service (NMS) where pharmacists help support patients using their new medicines most effectively, appliance use reviews and stoma appliance customisation (PSNC, 2017b). Locally advanced services can include supplying emergency hormonal contraception, stop smoking schemes, supervised administration of methadone and minor ailment schemes.

Healthcare setting: acute hospital

Clinical pharmacy has its origins within hospital pharmacy, when pharmacy started to deliver ward-based services initially to provide timely medicines supplies to the wards followed by undertaking clinical pharmacy reviews of inpatients prescribed medicines on the wards. This led to pharmacists being involved with multi-disciplinary ward rounds. In 2007 the role of pharmacists in leading on medicines reconciliation for patients on admission to hospital was endorsed jointly by the National Institute for Health and Care Excellence (NICE) and National Patient

Safety Agency (NPSA) guidance in *Technical patient safety solutions for medicines reconciliation on admission of adults to hospital* (NICE and NPSA, 2007) cementing the pharmacist's role on the wards further. This document was replaced by the NICE report, *Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes* (NICE, 2015) in March 2015, which does not stipulate pharmacy responsibility as clearly as the previous document.

Within the acute hospital setting pharmacists work as part of a larger team of pharmacists as well as with pharmacy technicians and other support staff in the hospital pharmacy dispensary but also on the inpatient wards alongside doctors and nurses providing pharmaceutical input into individual patient care. Pharmacists may attend consultant-led ward rounds.

Pharmacists are also involved in ensuring the safe and effective use of medicines across the hospital. For example they will provide training and drug information services to other healthcare professionals, review evidence for new medicines and manage the local prescribing formulary, review and implement NICE guidance and patient safety alerts related to medicines. In 2012 the Royal Pharmaceutical Society published the *Professional Standards for Hospital Pharmacy Services* which was revised in 2014 (RPS, 2014). They also oversee prudent use of antimicrobials (Department of Health and Department for Environment, Food and Rural Affairs, 2013; Tonna et al, 2010). Some larger acute hospitals may also manufacture specialist pharmaceutical products.

Generally, newly qualified and registered pharmacists will start in a basic grade (Agenda for Change pay band 6) pharmacist post where they rotate between different clinical pharmacy areas and complete a certificate followed by a post-graduate diploma in pharmacy practice. There is the possibility for pharmacists to become more specialised within a clinical speciality e.g., oncology, critical care, cardiac or antimicrobials.

Healthcare setting: mental health trusts

Pharmacists working within mental health trusts have often worked in other sectors such as acute hospitals or community pharmacy prior to becoming a mental health pharmacist.

Mental health trusts focus on patients with mental health issues and may have inpatient units, community clinics and community services. They may cover adults, children and learning disabilities. Several mental health trusts may also be responsible for the health care provision to Her Majesty's Prisons (HMPs).

Some of the issues within mental health trusts are similar to those within acute hospitals, except that they are often spread over a large geographical area as opposed to being situated on one or two sites.

Mental health trusts may or may not have their own pharmacy dispensary to supply inpatient and clinics with medicines. Alternatively, they may have contracts in place with acute hospitals or community pharmacies or a combination of both to provide pharmaceutical supplies. Mental health trusts may also have contracts in place with an acute trust or community pharmacy for the provision of pharmacy staff to provide pharmaceutical input.

Mental health pharmacists often belong to the College of Mental Health Pharmacy which is a very active group. It is estimated that they have about 650 pharmacists as members.

Healthcare setting: Community Health Services

Pharmacists working within Community Health Services will often have started their working career within a different sector such as hospital or community pharmacy.

They are involved with providing pharmacy input into inpatient units (e.g., community hospitals or intermediate care bedded units), urgent treatment centres, minor injury units, community clinics such as family planning and dental clinics, supporting community nurses, school nurses, health visitors and community paediatric nurses.

In England Community health services have undergone reorganisation. Community health services used to be part of Primary Care Trusts (PCTs), but had to separate away from PCTs as commissioners could no longer also be providers. From April 2011, NHS community health services were provided via social enterprises, acute hospital trusts, would-be community foundation trusts, mental health trusts and the private sector.

The pharmaceutical supply for community health services has a similar set-up for mental health trusts, with contracts in place with other trusts or community pharmacy for the provision of pharmaceutical supplies and sometimes for pharmacy staff as well. Community health services pharmacists may belong to the Primary Care and Community Pharmacy Network (PCCPN), which has just over 200 members.



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Study Information Sheet: A collective case study of pharmacists' perceptions of their professional roles

Dear Colleague,

Please take time to read through the following information leaflet.

You can discuss this with others if you wish. Ask me if there is anything you would like more information on. Take time to decide if you wish to take part in this research study or not.

I am a pharmacist who is undertaking this research study as part of a professional doctorate in pharmacy with the University of Brighton.

The University of Brighton's ethics committee has approved this study. In addition, local Research Governance approvals have been obtained for NHS organisations.

Thank you very much for taking the time to read this.

Background

The aim of this research study is to explore pharmacists' professional roles in relation to the particular healthcare setting in which they work. This study will include experienced community pharmacists (CP), hospital pharmacists (HP) mental health pharmacists (MHP) and community health services pharmacists (CHS).

There is very little published research available on the professional roles of pharmacists and limited research where the views of pharmacists are expressed.

I hope this research study will add to the knowledge and insight on the professional roles of pharmacists.

What does this research study involve?

This research study will involve:

- You participating in a one-to-one interview lasting about 45 - 60 minutes.
- You completing a simple "five working day reflective diary" ("the diary"), which asks you to record a contribution and a frustration that you have experienced on a particular day. You will need to complete this in 5 working days. This should take 5 – 10 minutes per day to complete.

During the our one-to-one interview I will initially ask some 'closed questions' to obtain some basic background information about your current professional role and then proceed to ask you some open questions which would usually start with "What do you consider...?" or "How do you think...?".

Remember, that it is your view and understanding of your professional role that I am interested in.



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You can ask for clarification about anything during the interview or at any time.

The interview will be voice recorded. This is to ensure the discussions are captured. However, if you do not wish for the interview to be recorded then I will respect this and instead take notes during our interview.

The recorded interview will be anonymously transcribed into written form. If you wish I can email the transcript of your interview to you for you to read. Please let me know.

The voice recordings together with other data collected will be retained for 10 years.

I would like for you to agree for me to be able to contact you after the interview in case I may need any further clarification about the information you provided to me.

I will identify any concepts and themes from analyzing the study data and email or post these to you for your comments, additions or corrections. You do not have to respond to this email if you do not want to.

Do I have to take part?

It is entirely your decision whether or not to take part. If you decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving any reason, although it would be useful to know the reason why.

During the interview you do not have to answer a question if you do not want to.

What are the possible disadvantages and risks of taking part?

It is not considered that there are any disadvantages or risks to you in taking part in this study besides having to give up some of your time.

What are the possible benefits of taking part?

The information you give me will help to produce a research report to inform others about the professional roles of pharmacists. I also hope that I will be able to publish this research and present it at a relevant conferences.

There are no direct benefits to you in participating in this study.

Will my taking part in this study be kept confidential?

It is important that you know that the information that you provide me with will be kept confidential.

The only exception to this is if you provide me with information regarding professional misconduct or information of a criminal nature in which case as a professional myself I cannot ignore this information and will have to act on



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this.

The study data will not include any names. If during the interview or in the “diary” you refer to names or titles of other staff or patients then these will be changed such that the study data maintain their meaning, and such that it will not be possible to identify anyone. Also any direct references that include names of organizations or locations, etc., will be changed in the same way.

When referring to the interview data I will make reference to ‘interviewee CP1 or HP2 or or MHP4 or CHS1 and so forth’. This is to ensure that all the data you provide is kept confidential.

Extracts including verbatim quotes (anonymized) of what is said during the interview or information from the ‘Diary’ may be included in the final research report to help illustrate certain points.

You need to know that I will be sharing the data with my academic supervisors but at that stage the data will already have been anonymized.

What will happen to the results of the research study?

The data produced will be looked at using qualitative data analysis.

You should also be aware that because this is a doctoral study the university will keep the final research study report (dissertation) which will be made available via the website. The plan is for this research to be published in peer reviewed journals.

What if after the interview I decide that I do not want to take part in the research study?

You can decide at any time to withdraw your agreement to participate. If you decide to withdraw then all the information that you have provided will be removed wherever possible.

What if I think of other information during the study that I think would be relevant to the research study?

You can contact me at any time if you feel that there is further information you have thought about and which you feel would help with this research study. However, I will have to ask you specifically if you agree that I can add this additional data to the research study as the initial consent you provided only covers the interview and the ‘five working day reflective diary’.

Is there anything else that I am expected to do?

The consent form does allow for you to agree for me to contact you at later date to clarify particular points or to share with you some of the results. You are free to state that you do not wish to be contacted.

You can contact me at any time.



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Will I receive any reimbursement for my time in helping with the research study?

There will be no reimbursement available.

What if I have a complaint about how this research study has been handled or conducted?

If you are unhappy about the way this research study has been handled or the interview conducted it is hoped that in the first instance you will contact me to discuss this. My contact details are listed below.

However, you can also contact the following directly if you have any complaints:

Dr Nikki Petty, Programme Leader, Professional Doctorate in Health & Social Care, University of Brighton, Tel: 01273 641806, e-mail:

n.i.petty@brighton.ac.uk or

Dr Angela Macadam, Principal Lecturer, School of Pharmacy and Biomolecular Sciences, University of Brighton, Tel: 01273 642097, e-mail:

A.Macadam@brighton.ac.uk

Who is funding and organizing the research?

The research is organized by Clinical Research Centre for Health Professions, University of Brighton.

This study has not received any funding.

Contact for further information

Should you require any further information or want to discuss any aspect of this study, please contact me, Iben Altman, by

Telephone no (work): 01273 265 619

Mobile no: 07792847237

Email address: i.altman@nhs.net

Postal address: Iben Altman, Sussex Community NHS Trust, B-block, Elm Grove, Brighton, East Sussex BN2 3EW

Thank you again for offering to help with this research study.

Page 5 of 5 of the study information sheet was blank





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CONSENT FORM

Research study: A collective case study of pharmacists' perceptions of their professional roles

Consent form:

Please read this consent form. Once you are happy that you have received sufficient information to make the decision to take part in this research study then initial each point below and sign at the end of the document.

1. I voluntarily agree to take part in this research study.
2. I have received sufficient information and explanation about participating in this research study. I have read and understand the information sheet given to me.
3. I have been given the opportunity to ask questions and discuss the study with the researcher.
4. I agree that the interview can be voice recorded. (If not agreed this statement will be crossed out)
5. I understand that the voice recordings and other data provided will be retained securely for 10 years after the completion of this research study.
6. I understand that the interview will be transcribed from the voice recordings and that these transcripts will be anonymized. Any other information provided will also be anonymized.
7. I agree to and authorize the researcher to disclose the results of my participation in the study but not my name or other details that may identify me.
8. It has been explained to me that the data from the study will be analyzed using qualitative data analysis.
9. I understand that the final research report including any publications may include extracts including verbatim quotes (anonymized) from the interview and the "5- working day reflective diary".
10. I understand that extracts from what is said during the interview or information from the 5-day-diary may be included in the research report to help illustrate certain points.



11. I understand that I can contact the researcher at any time to ask for further explanations.

12. I understand that I am free to withdraw from this research study at any time, without given a reason for withdrawing.

13. I understand I can contact the researcher with additional information. I also understand that the researcher will need to ask for my agreement before including this additional information in the study

Initial here if you agree that the researcher can contact you to share some of the data analysis from the research study with you to provide any comments and to seek further clarification on points should this be necessary.

Participant's details:

Name: _____

Address: _____

Contact number: _____ Email address: _____

Signature: _____ Date: _____

I confirm that I have provided an explanation of the research study and what is involved to the above named participant.

Researcher's details:

Name: Iben Altman, Tel:01273 265619, mobile:07792847237, e-mail: i.altman@nhs.net

Signature: _____ Date: _____

The completed form should be given to the participant and one is to be retained by the researcher.

The interview session generally followed the following format:

- Introduction
- Providing a hard copy of the participant information leaflet and consent form.
- Briefly outlining the study.
- Checking if the pharmacist had any further questions.
- Asking the pharmacist if voice recording the interview would be acceptable.
- Signing the consent form.
- The digital voice recorder was started (if agreed).
- A brief introduction was provided. It was explained that this interview was about obtaining the pharmacist's view of their professional role, where they make a difference and what challenges or frustrations they faced. That the interview would start with some closed questions and then move on to using open questions.
- The interview would commence. The interview was concluded with a question like "Are there any questions that you think I should have asked or you would have expected me to ask?" and "Do you have anything further to add?" This provided the participant with an opportunity to add anything that they felt they wanted to add or if they had any concerns during the interview. (Kvale & Brinkmann, 2009, p129).
- Thanking the pharmacist for their time.
- The digital voice recorder was stopped.
- Debriefing. Asking the pharmacist if the interview was acceptable and explaining how to use the five (5) day reflective diary. However, sometimes the diary was provided prior to the interview.

INTERVIEW GUIDE

This interview guide includes examples of questions the study participant will be asked during the interview.

Part A of the interview includes asking study participants some basic background information.

Part B (semi-structured interview) includes examples of open questions that may be modified to allow for unanticipated material to emerge and to be explored during the interviews in relation to the research questions. Study participants may not be asked all the questions below as some could already have been answered in a previous question.

The aim of the interview is for the study participant to do most of the talking. The prompts can be used to clarify questions or to get the study participant to elaborate on an answer.

Name:

Job title:

Male/female

Place of work (name of organization):

Community pharmacists: independent or part of multiple-chain pharmacies/Proprietor or employed or locum/specify

Date:

Time of interview: Start: Finish:

Location of interview:

Community pharmacist (retail)/Clinical Hospital Pharmacist/ Mental Health Pharmacist/Community Health Services Pharmacist (circle relevant group)

Introduction**Interview:**

PART A. Background information:

- **How many years have you been a registered pharmacist for?**

- **How many years or for how long have you worked within your current healthcare setting (acute hospital, community services, mental health or retail pharmacy)?**
- **Do you have any post registration formal qualification(s) (If yes list. If no what are the reasons)?**
- **How many hours per week do you work within your current role (healthcare setting)?**
- **Are you a member of an organization or association or leadership body who are looking after pharmacists' professional interests? (If yes which one(s) and why. If no – why not.)**
- **Are you a member of any sector or special interest groups related to your professional practice as a pharmacist?**

(Prompt: If yes/ Please list those groups by name/ describe the reason for this and how this impact/helps/support your current professional role (within your healthcare sector) If no: Describe the reason for not belonging to a specialist group)?

PART B: Open questions:

- **What contributions do you make to healthcare (in your current professional role)?**
(Prompts: Describe what it is you do? How does this impact on patient care? What benefits do your professional roles deliver and to whom? If your role did not exist what would the risks be?)
- **What aspects of your professional role do you enjoy?**
(Prompt: What contributions do you make? What motivates you in carrying out your professional role?)
- **What are the negative aspects of your professional role?**
(Prompt: What frustrates you? What are the challenges? What improvements would you make to your current professional role?)
- **What professional relationships and interactions do you have with other healthcare professionals?**
(Prompt: How regular/who initiates this interaction? Who are these healthcare professionals? What do the interactions consists of? Would pharmacists lead on any issues? Who benefit from these? Does this interaction work both ways?)

- **How do you think other healthcare professionals may view the professional roles of pharmacists within your healthcare sector?**

(Prompts: Do they value pharmacists? Do you think they understand the role of pharmacists? What are the relationships like?)

- **What does being regarded as a 'professional' mean to you?**

(Prompt: Describe what it is that makes you view yourself as a 'professional')

- **What do you think the future looks like pharmacists within your healthcare sector?**
- **What are your thoughts with regards to the statement "being a pharmacist is a valuable profession" (and why)?**

Are there any questions that you think I should have asked or you would have expected me to ask? If so, what are they?

Conclude interview

Provide the study participant with the "5 working day reflective diary" and explain how to complete this.



FIVE (5) WORKING DAY REFLECTIVE DIARY

Collective case study of pharmacists' perceptions of their professional roles

Instruction on how to complete this 5-day reflective diary

The completion of this record is anonymous if this is what you choose.
It will only identify the healthcare setting in which you work.

- Please keep a daily record over 5 working days.
- Record for each day at least one **positive contribution** you have made and one **frustration** you came across in relation to your professional role.
- This record does not have to be kept over 5 consecutive working days as some pharmacists may work part-time. You can choose to complete the diary over a 3 –week period.
- State the actual date you complete each record for each day.
- Do not state any patients' names or identify others by name. If you need to make a reference to for example another healthcare professional or other pharmacists then use a generic title instead of their name.
- **It is down to you to decide what was a positive contribution or a cause of frustration during your working day.** You can record as many positive contributions and frustrations per day as you wish.
- If you feel that you made no positive contribution or did not come across any frustrations during your working day then please record "none experienced".
- You can complete this record either by handwriting or if you prefer you can receive an electronic copy of this record. An electronic copy can be printed or alternatively it can be e-mailed to me i.altman@nhs.net (note that I may then know who you are)
- Once you have completed this booklet please place it in the envelope provided. Either hand it to me or place in the post.



Examples:

Positive contribution: This can be any contribution that you make either big or small but where you feel this contribution was due to your professional role. It can be an intervention that you made, advice you provided, part of a policy you contributed to, a problem that you resolved or a clinical intervention. A positive contribution is where you feel that your work is worthwhile and where you feel that you made a difference. It is a contribution that motivates you to work as a pharmacist.

Frustration: A frustration is where you feel frustrated or disempowered. A frustration is something that makes you think that pharmacists should be promoting themselves further, expand their professional role or where you think other healthcare professionals ought to have considered input from a pharmacist.

Again, I would like to thank you very much for agreeing for taking the time to complete this record.

THANK YOU FOR COMPLETING THIS. Please place the completed record in the self-addressed envelope provided or e-mail to i.altman@nhs.net



University of Brighton

Sussex Community **NHS**
NHS Trust

<p>Day 2:</p> <p>Date:</p>	<p><u>Positive contributions:</u></p> <p><u>Frustrations:</u></p>
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University of Brighton

Sussex Community **NHS**
NHS Trust

Day 5:	<u>Positive contributions:</u>
Date:	
	<u>Frustrations:</u>



Additional Comments

<p>Please record any further comments that you have or reflections on this exercise:</p>	
--	--

Health and Social Science Research Ethics and Governance Committee - Decision on Manuscript ID 1
 From: onbehalfof+J.Scholes+brighton.ac.uk@manuscriptcentral.com on
 behalf of J.Scholes@brighton.ac.uk
 Sent: 22 December 2011 14:27
 To: iben@altman.org.uk; Altman Iben (SUSSEX COMMUNITY NHS TRUST)
 Subject: Faculty of Health and Social Science Research Ethics and
 Governance Committee - Decision on Manuscript ID FREGC-11-064

22-Dec-2011

Dear Mrs. Altman:

Application ID FREGC-11-064 entitled "A collective case study of pharmacists' perceptions of their professional roles (version 3)" which you submitted to the Faculty of Health and Social Science Research Ethics and Governance Committee, has been reviewed. The comments of the reviewer(s) are included at the bottom of this letter.

The reviewer(s) have recommended that subject to minor revisions to your application, the proposal be approved. Therefore, I invite you to respond to the reviewer(s)' comments and revise your application according to their recommendations. The amendments you make should be listed against each comment made by the reviewer.

To revise your application, log into <http://mc.manuscriptcentral.com/fregc> and enter your Author Centre, where you will find your application title listed under "Manuscripts with Decisions." Under "Actions," click on "Create a Revision." Your manuscript number has been appended to denote a revision.

You will be unable to make your revisions on the originally submitted version of the manuscript. Instead, revise your manuscript using a word processing program and save it on your computer. Please also highlight the changes to your manuscript within the document by using bold or coloured text.

Once the revised application is prepared, you can upload it and submit it through your Author Centre.

When submitting your revised application, you will be able to respond to the comments made by the reviewer(s) in the space provided. You can use this space to document any changes you make to the original manuscript. In order to expedite the processing of the revised manuscript, please be as specific as possible in your response to the reviewer(s).

IMPORTANT: Your original files are available to you when you upload your revised manuscript. Please delete any redundant files before completing the submission.

Because we are trying to facilitate timely approval of applications submitted to the Faculty of Health and Social Science Research Ethics and Governance Committee, your revised application should be uploaded as soon as possible. If it is not possible for you to submit your revision in a reasonable amount of time, we may have to consider your paper as a new submission.

Please note, you may not start your research, or forward your proposal to external agencies until the application has been finally approved by FREGC.

Sincerely,
 Prof. Julie Scholes
 Chair, Faculty of Health and Social Science Research Ethics and Governance
 Committee J.Scholes@brighton.ac.uk

Reviewer(s)' Comments to Author:

Reviewer: 1

Comments to the Applicant

This is a well thought through and written proposal. There were a few minor typos, but I can see minimal ethical problems with this proposal and am happy to clear it to proceed, providing it follows all the usual ethical safeguarding procedures required by the relevant ethics committees

th and Social Science Research Ethics and Governance Committee - Decision on Manuscript ID FRE

Reviewer: 2

Comments to the Applicant

This study is potentially groundbreaking and is worth every effort. Your proposal is in keeping with research governance. However the following points need be addressed.

1. The rationale for not recruiting participants in your own Trust needs to be explicit.
2. For the purpose of clarity and greater fluency keep to the term cases rather than groups.
3. For a detailed theoretical and practical basis of the process of data analysis in Case Study methodology see Merriam(2000) book entitled 'Case Study Research in Education- part three is devoted to data analysis.
3. Because you have superposed the inscription of the word draft on pages15,16,17,18,20,107,109,111 and 113 it has been difficult to read your participant information sheet in these part of the text.

From: J.Scholes@brighton.ac.uk
Date: 10 January 2012 12:14:41 GMT
To: iben@altman.org.uk, i.altman@nhs.net
Subject: **Faculty of Health and Social Science Research Ethics and Governance Committee - Decision on Manuscript ID FREGC-11-064.R1**

10-Jan-2012

Dear Mrs. Altman:

It is a pleasure to accept your application entitled "A collective case study of pharmacists' perceptions of their professional roles (version 4)".

On behalf of the Editors of the Faculty of Health and Social Science Research Ethics and Governance Committee, we wish you well with your research.

Please notify the Committee of any adverse incidents and or any changes to the design of your study. We welcome a final summary of the research once this is completed.

Sincerely,
Prof. Julie Scholes
Chair Faculty of Health and Social Science Research Ethics and Governance Committee
J.Scholes@brighton.ac.uk

Reviewer(s)' Comments to Author:

Thank you for setting out the amendments so clearly. Good luck with your research.

A Collective case study of pharmacists' perceptions of their professional roles
(version 4) Jan 2012 Amendment 1 (8Mar 12)

Research Protocol Amendments

A collective case study of pharmacists' perceptions of their professional roles (version 4) Jan 2012

FREGC -11-064.R1

Amendment 1 (8 Mar 2012)

Page 14. Section 5.4 Recruitment of Study Participants
4th line:

Remove:

Community pharmacists will receive the invitation via the Primary Care Trust, the Local Pharmaceutical Committee or local practice forum

Replace with:

Community pharmacists will receive the invitation via the Local Pharmaceutical Committee or local practice forum

Reason: Community pharmacists will not be receiving invitation from Primary Care Trust partly due to changes within the NHS.

Page 17. Section RESEARCH ETHICS AND GOVERNANCE. 2nd paragraph.

Change from: The voice recordings will be destroyed once the final dissertation has been passed or if this is not going to be the case then they will be destroyed no later than September 2014.

Change to:

Sussex Community NHS Trust will retain the voice recordings, signed consent forms for 10 years following the completion of the study.

Reason: NHS Sussex Research Consortium has requested this as a requirement in MRC Good Research practice guidelines (2005).

STUDY INFORMATION SHEET. Section "What does this study involve?" 6th paragraph. (Appendix 3. Page 32 and separate copy of the study information sheet).

Remove:

Once this research study has been completed these voice recordings will be erased.

A Collective case study of pharmacists' perceptions of their professional roles
(version 4) Jan 2012 Amendment 1 (8Mar 12)

Replace with:

The voice recording together with other data collected will be retained for 10 years.

STUDY CONSENT FORM. Points 4 and 5. (Appendix 4.

Remove:

4. I agree that the interview can be voice recorded. I understand that once the research study report has been fully completed the voice recordings will be erased (if not agreed this statement will be crossed out).
5. I understand that during the research study the voice recordings will be kept securely.

Replace with:

4. I agree the interview can be voice recorded (if not agreed this statement will be crossed out).
5. I understand that the voice recordings and all other data provided will be retained securely for 10 years after the completion of this research study.

Iben Altman
8 Mar 2012

Altman Iben (SUSSEX COMMUNITY NHS TRUST)

From: iben altman [iben@altman.freemove.co.uk]
Sent: 25 March 2012 23:20
To: Altman Iben (SUSSEX COMMUNITY NHS TRUST)
Subject: Fwd: REsearch Protocol Amendment

Begin forwarded message:

From: iben altman <iben@altman.org.uk>
Date: 14 March 2012 22:04:35 GMT
To: Iben Work <l.Altman@nhs.net>
Subject: Fwd: REsearch Protocol Amendment

Begin forwarded message:

From: J.Scholes@brighton.ac.uk
Date: 12 March 2012 09:35:41 GMT
To: "iben@altman.org.uk" <iben@altman.org.uk>
Cc: Flood Glynis <G.B.Flood@brighton.ac.uk>
Subject: REsearch Protocol Amendment

I am happy to approve these changes by Chair's action.

Glynis please can you upload these final changes so we have a record on our files

Many thanks

Julie
Professor Julie Scholes
Chair, Faculty of Health and Social Science Research Ethics and Governance
Committee
University of Brighton

Direct Line: 01273 641085
Administrator: Glynis Flood 01273 644029

This email has been scanned by MessageLabs' Email Security
System on behalf of the University of Brighton.
For more information see <http://www.brighton.ac.uk/is/spam/>

	Length of interview (min)	No of years registered as a pharmacist	Years worked in healthcare setting	Hours worked per week ¹	Post-graduate qualifications ²	Memberships ³	Member of the RPS
HP1	62	6	6	37.5	Dip.in clinical pharmacy	PDA	No
HP2	55	12	12	37.5	Dip. In clinical pharmacy & studying for a MSc in specialist clinical area ⁴	No	Yes
HP3	49	10	7	37.5	Dip. In clinical pharmacy	PDA & UKCPA	No
HP4	51	17	15	32.0	Dip. In clinical pharmacy	PDA & UKCPA	Yes
HP5	50	21	11	37.5	Dip. In clinical pharmacy & Supp prescriber	PDA & UKCPA	No
MH1	53	18	14	37.5	Dip. In clinical pharmacy	Associate member of College of Mental Health & PDA	Yes
MH2	62	33	17 (and more)	30.0	None	Associate member of College of Mental Health & PDA	Yes
MH3	42	33	21	37.5	Dip in psychopharmacology. Dip in management	No (was associate member of College of Mental Health Pharmacist but let membership laps recently. Plan to review.)	No
MH4	36	37	27	37.5	None	Associate member of College of Mental Health Pharmacists. Guild of Healthcare Pharmacists	Yes
MH5	38	32	24	37.5	Dip in clinical pharmacy. Independent prescriber.	Associate member of College of Mental Health Pharmacists	Yes

Cont.

	Length of interview (min)	No of years registered as a pharmacist	Years worked in healthcare setting	Hours worked per week ¹	Post-graduate qualifications ²	Memberships ³	Member of the RPS
CHS1	61*	26	3	37.5	MSc in clinical pharmacy. Independent prescriber	UKCPA, PCCPN, Guild of Healthcare Pharmacists	Yes
CHS2	67	14	5.5	37.5	MSc in clinical pharmacy	PCCPN	Yes
CHS3	42	21	2.5	37.5	MSc in clinical pharmacy. Independent prescriber	PCCPN, UKCPA	Yes
CHS4	61	33	6	24	None	None	Yes
CHS5	36	21	4	30	Cert. in community pharmacy	Two clinical specialists associations ⁴	Yes
CP1	59	28	28	42	No	No	Yes
CP2	47	6	6	42.5	No	No	No
CP3	60	5	5	45	No	No	No
CP4	59	15	15	30	No	No	Yes
CP5	61	24	24	25 - 30	No	PDA	No

¹ Pharmacists reiterated this was their paid hours. Most indicated that they worked more than this.

² Dip. Is the diploma in clinical pharmacy. Supp prescriber = supplementary prescriber qualification.

³ PDA = Pharmacists defence association (provides indemnity insurance and is also registered as a union). UKCPA = UK Clinical Pharmacists Association which has several specialist interest groups usually related to clinical area, PCCPN = Primacy and Community Care Pharmacy Network.

⁴ Details were provided but not included here to preserve anonymity.

* CHSP1 Recording stopped after 33 minutes. We agreed to re-record the interview from where it stopped, which lasted a further 31 minutes.

All NHS employed pharmacists were working at Agenda for Change (AfC) Band 8a or above besides one pharmacist who had work for several years as a band 7 pharmacist. The AfC is the pay scale used by the NHS managed sector for healthcare professionals. Community pharmacists are not graded according to Agenda for Change.