PhD Title: Financial Accountability, Pharmacists and Doctors: Control Issues in a Professional Context.

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PhD

Declaration

I declare that this thesis has been composed by me and is entirely my own work.

Acknowledgement

This work has been a long time in the writing. The completion of this work would not have been possible without the support and guidance of a number of people. Firstly I would like to thank my supervisors, Professors Wendy Loretto and Sue Llewellyn for their unwavering confidence in my ability, and their endless encouragement and support throughout the project. I would also like to thank all of the pharmacists and clinicians who gave up their valuable time to provide me with data for the project. Many other friends and colleagues, too numerous to mention here, have also given me a great amount of support and encouragement over the years. They know who they are and I thank them all.

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Dedication

This thesis is dedicated to the loving memory of my parents, David and Agnes and, my Step Father, Gilbert.

Do not stand at my grave and weep.
I am not there, I do not sleep.

I am a thousand winds that blow.
I am the diamond glints on snow.
I am the sunlight on ripened grain.
I am the gentle autumn rain.

When you awaken in the morning's hush,
I am the swift uplifting rush
Of quiet birds in circled flight.
I am the soft stars that shine at night.

I am the song that will never end.
I am the love of family and friend.
I am the child who comes to rest
In the arms of the Father who knows him best.

When you see the sunset fair
I am the scented evening air.
I am the glow of the setting sun.
I am the joy of a task well done.

Do not stand at my grave and cry.
I am not there, I did not die.

(Author Unknown)

Abstract

The reforming of the UK National Health Service (NHS), in response to pressure on financial resources, has led to the reshaping of healthcare professionals' roles. Within NHS hospitals, clinicians traditionally have held a dominant position in terms of decision making with regard to the use of resources and clinical autonomy. However, the changing environment now faced by hospital clinicians, in the form of increasing financial, legal and regulatory complexities is having an impact on their power base as managerial and accounting control becomes a key element in the changes advocated by healthcare reformers. Some have argued that these changes challenge the power and autonomy of clinicians and their relationships with other healthcare professionals and society; perhaps best exemplified by the increasing role of clinical pharmacists in prescribing decisions. In the past, pharmacy as a health care function has been termed a marginal or quasi-profession due to its apparent inability to promote and control its existence. Traditional professional and jurisdictional boundaries militated against a closer working relationship between pharmacists and clinicians, contributing to this marginalisation.

This thesis investigates the impact that NPM initiatives and increases in financial accountability have had on the pharmacy and the medical professions. It will be shown that, over the last 25 years or so, there have been significant developments in hospital pharmaceutical services which have served to erode the professional boundaries through the emergence of specialist pharmacy services and clinical pharmacists that operate in the clinical setting. The findings demonstrate that, clinical pharmacists, whose specialism is to assist the clinicians in safe, economic and effective use of medicines by optimizing pharmaceutical factors, are increasingly being utilized and regarded as an essential function within the hospital setting. Indeed it has been suggested by both parties that as clinicians increasingly feel the pressure of financial constraints that pharmacy's involvement in clinical decisions and prescribing practice should continue to increase.

This research, therefore, illuminates the erosion of professional boundaries within healthcare as a result of NPM initiatives and increased financial accountability. In particular it focuses upon the changing relationship between pharmacy and the medical profession. The baseline for this study is the period between the Conservatives government reign under the leadership of Margaret Thatcher to the end of New Labour's term in office. The empirical findings generate valuable information that helps to explain and aid our understanding of the professional relationships of clinical pharmacists and clinicians in the current drive towards the rationalisation of prescribing and cost containment procedures. It further, shows how changes in financial accountability have served as a catalyst in the erosion of professional boundaries between the two professions.

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List of Tables, Boxes and Figures

List of Abbreviations

BMA	British Medical Association
CHI	Commission for Health Improvement
CoE	Council of Europe
COSU	Cabinet Office Strategy Unit
CRAG	Clinical Resource Audit Group
CSBS	Clinical Standards Board Scotland
DEP	Drug Evaluation Panel
DoH	Department of Health
DTC	Drug and Therapeutics Committee
DUP	Drug Utilisation Panel
EBM	Evidence Based Medicine
EBP	Evidence Based Practice
EMS	Emergency Medical Service
GP	General Practitioner
JPC	Joint Prescribing Committee
NHS	National Health Service
NICE	National Institute of Clinical Excellence
NPM	New Public Management
NSF	National Service Frameworks
PAF	Performance Assessment Framework
PPR	Pharmacy Practice Research
RPS	Royal Pharmaceutical Society
TUC	Trade Union Congress
SE	Scottish Executive
SG	Scottish Government
SEHD	Scottish Executive Health Department
SHTAC	Scottish Health Technology Assessment Centre
SIGN	Scottish Intercollegiate Guidelines Network
SNP	Scottish National Party
WHO	World Health Organisation

Chapter One: Introduction

> "The National Health Service in Britain could not ensure that doctors....would choose overnight to be 'better doctors; all it could do was to provide that particular framework of social resources within which potentially 'better' medicine might be more easily chosen and practised." (Titmuss 1963:171)

Since its creation, the resourcing of the UK NHS has been a constant issue of debate (Webster, 2002). Indeed the history of the NHS is that of an organisation, noble in conception, but faced with financial crisis on the one hand due to rapid advances in technological innovations and medical knowledge, and on the other, the financial restrictions that inevitably rise from a centrally funded service, changing management dogmas and political beliefs. Within five years of the inception of the NHS the Guillebaud Committee was established to investigate ways in which the provision of adequate healthcare could be achieved without excessive demand on the Treasury (Klein, 2001). Cost, provision and resource allocation of health services therefore have been a major focus of political and public discussions for many years.

A distinctive feature in the UK is the extent to which its health service is state owned and run and the extent to which government pays the costs. Historically, the government and the medical profession operated an implicit pact whereby the government set the budget and the healthcare professionals spent it (Klein, 2001). The management and quality of healthcare service provision was largely left to the professionals (Klein, 2001). Health policy from the inception of the NHS in 1948 to the election of the Conservative government under the leadership of Margaret Thatcher in 1979 was characterised by successive adjustments to the original design of the NHS and fine tuning of its administration (Ham, 1999). The election of the Conservative

government coupled with the emergence of major financial funding pressure led to a powerful critique of healthcare policy, funding, management and in particular the use of resources (Baggott, 2004). By the start of the 1980s the historical management arrangement set out above had started to change and the government through institutional bodies such as the Health Services Supervisory Board adopted an increasingly direct role to improve the quality and performance of healthcare institutions.

Healthcare policy and healthcare provision are of key importance to government for several reasons. The healthcare sector is a major source of employment, every voter is a potential healthcare user, expenditures and financial pressure are high, and there is an imbalance of knowledge between providers and users of healthcare which may result in excessive and unreasonable demand for treatment[1]. As the healthcare system is primarily financed through taxation, the government as the major payer is accountable in a highly visible way, particularly at the ballot box, for expenditure (Dixon, 2006). The funding and provision of healthcare is also highly emotive. As such it is unsurprising that reform of the healthcare sector features highly on any government agenda.

A key feature of the health sector reforms has been the introduction of a number of policy initiatives that have attempted to direct professional activity and spending using '*peer pressure, rewards, regulation or the threat of sanctions to induce changes*' (Moon & North, 2000: 86). Collectively, the introduction of such initiatives signified a loss of confidence in, although not a complete rejection of, the professional model of

[1] As patients become aware through media publications, the internet etc of new treatments they exert demand on clinicians for such treatments but lack the medical and pharmacological knowledge of such treatments compared to what has been offered.

recourse to external regulators and models of financial accountability. This trend not only reflects the government's growing interest in regulating doctors'[2] performance and introducing financial accountability to the state and society, but also the increasing public perception of the fallibility of medicine. The trend of increased regulation and accountability can also be located in the redefining of government's role and encouragement of increased pluralism in healthcare provision (Moon and North, 2000: 86).

As the Conservative government under the leadership of Margaret Thatcher progressed, it became increasingly clear that avoiding confrontation with the medical profession over escalating healthcare costs might outweigh any political costs. It was recognised that, while the emphasis on increasing and strengthening management processes might improve efficiency and allow the NHS to cope with increasing demand within any given budget and that the development of a private sector strand of healthcare provision might provide a safety valve, these strategies in themselves would not necessarily address the inexorable upward surge of cost and demand. This concern provoked reviews and reform initiatives which were primarily designed to push down expenditure, introduce means to optimise the delivery of scarce resources, promote efficiency and productivity and increase financial accountability (Doig, 1999).

Indeed when looking into health policy it is clear that healthcare reform from the Thatcher era right through to the end of New Labour's reign under the leadership of Gordon Brown is characterised by successive adjustments, including managerial and

[2] The government is also interested in regulating other healthcare professionals however; within this thesis the control of doctors is the main focus.

financial initiatives, all aimed at controlling healthcare expenditures and the clinical activities of the medical profession.

Research Area and Problem

Numerous studies concerned with the impact and effectiveness of management and managers within the NHS have been conducted[3]. Several of these studies have focussed on how the introduction of management into the NHS has affected the relationship and balance of power between the medical profession and managers. However, such studies have tended to neglect the inter-professional relationships that exist within the healthcare arena to the extent that that the medical profession is presented as a relatively homogeneous group. Where studies have been conducted they tend to focus on the inter relationship between doctors and nurses[4]. Likewise, historical studies illustrating the differing fortunes of GPs and clinicians before and after the inception of the NHS highlight how health policies have affected on these two groups[5], however, very few studies have been conducted to assess the impact of New Public Management (NPM) strategies and NHS reforms on the inter professional relationship between the medical profession and other healthcare professionals such as pharmacists.

The position of medical and healthcare professionals form the key rudiments of the network of social relationships surrounding the provision and use of therapeutic medicines and can thus be viewed as social constructs[6]. Issues of the social context and the articulation of therapeutic medicines with society situate medicines within the

[3] For a review of such studies see Harrison *et al*, (1992).
[4] Alaszewski, (1995); Dent (1993) looked at the restructuring of the health and welfare professions and the impact of internal markets on the medical, nursing and social professions.
[5] Baeza, (2005) investigated the restructuring of the medical profession and the intra professional relations of GP's and hospital consultants.
[6] This will be covered in chapter 4.

public policy arena (Webster, 2002). One of the paradoxes of the NHS since its creation has been the lack of control exercised by government over those who, in theory, exercise the greatest influence in determining the demand for healthcare services and those responsible for healthcare spending: the doctors (Klein, 2001). Indeed it has been argued that one of the main reasons why Britain is able to spend less than comparable European countries on healthcare provision stems from the unique role in filtering, shaping and controlling demand on healthcare by doctors. It is here that issues of financial accountability and the underlying tensions of NPM are most apparent. For example the medical profession argues for self regulation and accountability and vigorously defends its professional autonomy; however, these arguments have been countered with arguments that such regulation and accountability is limited and subject to an inevitable tendency to oligarchy (Walshe, 1995). It has also been argued that imposing managerial and accountable controls are less likely to be effective than informing the process by which healthcare professionals construct and enact a sense of being accountable (Knights & McCabe, 2000).

The scope to increase NHS spending is limited, thus the need to ensure the efficient utilisation of resources and use of existing budgets has become a central focus of government attempts to reform the NHS. Therefore the main drivers for change within the NHS stem from the government's agenda to rationalise healthcare costs[7]. Greater focus on the quality of clinical care and resource utilisation has put the use of many healthcare functions into sharp focus. One area that has received particular attention in recent years has been the use of therapeutic drugs (medicines) and pharmaceutical services.

[7] This was particularly the case during the Thatcher government era.

In many respects therapeutic drugs, now in virtually universal use, are the personal technology of our times. Medicines play a central role in the delivery of health care as they constitute the principle intervention for many problems presented in both primary and secondary care (Davis, 1997). This arises partly from their painless and convenient method of oral administration and their often highly effective healing qualities. Medicines also represent some of the most remarkable achievements of modern science and provide the foundation for one of the most successful manufacturing industries in the world (Davis, 1997). Medicines are also the keystone to the standing of two important health professions, pharmacy and medicine. The versatility, ubiquity, convenience and potency of therapeutic drugs also give rise to regulatory and policy issues of wide interest and application that go to the heart of the modern welfare state (Panton, 1998). Questions of innovation, quality, safety, efficacy, cost and social impact are important features in the analysis and evaluation of drug treatments (Panton, 1998). However, medicines raise a much wider range of issues that are unique to, and highly representative of, the distinctive way in which the healthcare system functions. While many studies have been conducted on NHS spending, research into the effect of pharmacy profession on the improved use of medicines is rare.

Given that medicines play a central role in the delivery of health care as they constitute the principal intervention for many problems presented in both primary and secondary care, the use of therapeutic drugs and the utilisation and development of pharmaceutical services is an area in which the government specifically hope to contain expenditure (Panton & Chapman, 1998). The provision and management of medicines within the UK in recent decades has changed dramatically. At the centre of this change has been a profound alteration to the control and management of the

medical profession. The impact of such change on the power and influence of the medical profession is however, a matter of debate. The main focus of this study therefore is directed at pharmacy as a healthcare support function and its contribution to medicine resource management and prescribing practices within secondary care.

A major contributing factor to the escalating drugs bill is thought to lie in the prescribing practices of the GPs and hospital clinicians. Every year the NHS drug bill escalates. For example over the last two decades, the NHS drugs budget has been increasing by approximately 13%[8] a year (Abraham, 2009). In the past, there was little incentive for the medical profession to consider the costs of their prescribing which led to wide variations in prescribing habits both in primary and secondary care, resulting in unconstrained growth of the drugs bill (Abraham, 2009). Up until recently, safety and efficacy were considered to be more important than cost in prescribing decisions. However, due to increasing pressure from government bodies to reduce expenditure including the drugs bill, costs are becoming a major issue for prescribers.

Secondary care, in particular has experienced large and rapid changes as a result of the sea of healthcare reforms being initiated within the NHS. These changes have included the introduction of general management practices as recommended in the Griffiths report in 1983, medical audits, resource management transfer of consultant contracts from regional to individual NHS trusts, contracting with the creation of the internal market (now abolished) and the introduction of clinical governance (Ham, 1999). Such changes were developed and driven through by successive governments. These politically driven reforms sought to achieve greater efficiency and value for money

[8] See DoH, 1994a, 1994b, OHE, 2000, 2003, and ISD, 2003.

within the NHS through improving the managerial capacity and reducing the power of the medical profession (McKinlay, 1982).

Within secondary care the government has sought to achieve efficiencies by transferring the responsibility for the drugs budget to the clinical directorate (Barber & Wilson, 1999). This obliges the clinical directorate to make strenuous efforts to control prescribing expenditure and to achieve optimum benefit at least cost. As a result the prescribing practices of clinicians are being guided by control mechanisms such as predetermined care pathways, quality standards, treatment protocols, the imposition of locality formularies and input from clinical pharmacists. Any deviation from these pathways such as the prescribing of new drugs now requires closer attention to the balance of safety and efficacy due to their relatively high cost and must be justified before implementation. This study seeks to explore these issues by examining how pharmacy, as a support service within secondary care, has responded to the changes that have taken place within the NHS in recent years.

The reforming of the NHS has led to the reshaping of healthcare professionals' roles. Within NHS hospitals, clinicians traditionally have held a dominant position in terms of decision making with regard to the use of resources and clinical autonomy. However, the changing environment now faced by hospital clinicians, in the form of increasing financial, legal and regulatory complexities, arguably is having an impact on their power base as managerial and accounting control becomes a key element in the changes advocated by healthcare reformers (Mohan, 1993). Increasingly, clinicians are faced with a shift of emphasis from process accountability to output accountability; with traditional costing and budgeting systems that focused on the control of total

expenditure and provision of information for government purposes being replaced by new systems that delegate financial responsibility and accountability for medical decisions (Moon & North, 2000). Under this new system the clinical autonomy of clinicians is preserved but made more visible through financial calculation and accountability.

However, some[9] have argued that these changes challenge the power and autonomy of clinicians and their relationships with other healthcare professionals and society; perhaps best exemplified by the increasing role of clinical pharmacists in prescribing decisions. In the past, pharmacy as a health care function has been termed a marginal or quasi-profession due to its apparent inability to promote and control its existence (Anderson, 2005). Traditional professional and jurisdictional boundaries militated against a closer working relationship between pharmacists and clinicians, contributing to this marginalisation (Salvage, 1988).

To sum up: the focus of this thesis is an examination of the erosion of professional boundaries within healthcare as a result of NPM initiatives and the drive towards increased financial accountability. In particular, it focuses upon the changing relationship between pharmacy and the medical profession. It aims to explain and aid our understanding of the professional relationships between clinical pharmacists and clinicians in the current drive towards the rationalisation of prescribing and cost containment procedures. It further aims to show, within an interpretive framework, how changes in financial accountability and the imposition of NPM principles have

[9] For example McKinlay, (1982); Harrison, (2001); Allsop, (1995); Cox, (1992).

served as a catalyst in the erosion of professional boundaries between the two professions.

Research Significance

The main research objective of this thesis is to attempt to gain a better understanding of the impact of NPM initiatives and financial accountability on the relationship between two healthcare groups within secondary care, pharmacists and clinicians. Through a case study approach, this research attempts to achieve this objective by providing an examination of pharmacy's involvement in medicine resource management within secondary care in NHS Scotland. The study:

- Focuses on how the discursive nature of NPM techniques and language are implicated in controlling the activities and partisanship of pharmacists and clinicians within secondary care; and
- Considers the power effects of management discourses associated with healthcare reforms and examines how the control of clinical activity through the discursive shaping of clinical subjectivity can occur.
- It further explores the impact of managerial discourses on the negotiated order within the context of the hospital and how such individuals manoeuvre in relation to such discourses.

Connecting Theories, Values and Practice:

The theoretical framework for the research project is based upon the literature of the sociology of the professions[10]. The rationale for this choice hinges on its applicability to the argument of changing professional boundaries as a result of financial accountability being imposed on the medical profession. Historically, the role of the professions within public services has been pivotal to their development. Indeed within the National Health Service (NHS) doctors have played a major role to the extent that a central and prevailing characteristic of the NHS is the dominance of the medical profession. '*Medical authority became synonymous with the service and institutionalised in ways that enabled medical professionals to control management, through presenting definitions of issues that reinforced their own authority*' (Klein, 1989).

Traditional explanatory approaches[11] to the examination of the professions conceptualised that professionals and in particular medical professionals '*can be distinguished from other social groups by their sense of personal service to others and altruism, rather than the desire for economic reward; that they are collectively orientated rather than self orientated*' (Gillespie, 1997: 86). The power of the professions was perceived to be in terms of their ability to achieve social closure, regulate their own education and accountability to each other (Macdonald, 1995). Prevailing concepts of the professionals and professional power within healthcare suffer from the characterisation of the nature of the professions in terms of a trend at a

[10] For example the work of Freidson, (1970); Giddens, (1984); Abbott, (1988); Haug, (1988), Haugaard, (1997).
[11] Such as Klein, (1974); Turner, (1987); Light, (1995); MacDonald, (1995); Elston, (2009).

certain point of time in history (Light, 1995). 'Professional dominance', 'proletarianisation' and 'deprofessionalisation' are examples of this problem.

A recurring theme in the professionalisation and health policy literature during the 1960s and 1970s is the portrayal of medical power and dominance as an entrenched feature of the healthcare system (Alford, 1975). During this period little attention was paid to other healthcare professionals such as pharmacists. If it appeared at all, it was typically as a marginalised or failed profession (Salvage, 1988). Studies of health policy during the same period emphasise the monopoly of legitimacy relative to other healthcare professionals enjoyed by doctors in the development of health policy and their ability to block change at both national and local levels (e.g. Klein, 1974; Haywood and Alaszewski, 1980; Ham, 1981). Indeed there was little suggestion within the literature that medical authority or dominance might be or would become challenged (Elston, 1993).

The recessions of the 1980s and the inexorable rise of healthcare expenditure placed a strain of the relationship between government and healthcare professionals. During this period governments were increasingly viewing the medical profession as a formidable opponent in the development of healthcare policy. The healthcare reforms initiated by the Thatcher government were perceived by many as an attack on the power of the professionals (Fowler, 1991).

Within this study the concept of professions and professional power are therefore introduced. A range of traditional and critical approaches to professional power and the professions are discussed. Prevailing concepts of the profession such as 'professional

dominance', 'proletarianisation', 'deprofessionalisation' and 'countervailing powers' are examined. The ironic consequences of professional dominance, such as the power of the profession to shape its domain in its own image, leads to excesses that prompt counter reactions is of particular importance.

The thrust of the discussion and analysis lies in the introduction of NPM and financial accountability into the NHS and the extent to which the radicalism of 'new managerialism' has successfully contested medical hegemony and aided the development of pharmacy specialisms, with many of the 'traits' of a profession. It is here that inter professional rivalries and a preoccupation with professional rights are most apparent. It is clear that the medical profession has and is continuing to experience one of their most turbulent periods as a result of health policy reforms and changes to the internal dynamics of elaboration and segmentation.

The research approach adopted for this study involved an interpretative[12] and exploratory process which was motivated principally by the intention to cover a broad range of issues and views as was feasible from key actors in medicine resource management. The primary objective was to identify issues and developments that are perceived by the study participants to have specifically affected the relationship and professional status between pharmacists and clinicians.

Structure and Organisation of the Thesis

Chapter two provides a historical background that sets out the changes that have taken place in the development of health policy from Thatcher to Brown. In the process it

[12] The interpretive approach will be elaborated upon within the research methods chapter.

sets out and examines the various influences on healthcare policy making and implementation. The thrust of this chapter, therefore, is an examination of health policy reforms to track the changes that have had the most impact in terms of medicine resource management in the UK and picking up on issues such as crisis of funding, the drive to managing quality and standards, value for money, efficiency etc and debates over how such rationales could/were to be achieved. This leads into one particular outcome of the reforms which is a main focus of the research – the changes in financial responsibility and accountability. Issues of control- macro to micro provide the context.

Chapter three outlines the main objective of this research project and provides an elaboration of the rationale of the research approach, data collection and analysis methods utilised in the execution of this study.

Chapter four provides an overview of sociological perspectives on the professions and highlights its appropriateness to the study of pharmacy and this research. The study is concerned with power, control and issues of discourse. This literature will play an important role in developing an understanding of the changing institutional context of the NHS and the penetration of NPM discourse into medical practice and discursive approaches to organisational analysis.

Chapter five provides an overview of the historical development of pharmacy as a profession. This chapter investigates the meaning and significance of the professions involved in the delivery of healthcare. It seeks to explore the changing nature of

pharmacy as a profession and utilises documentary evidence and information provided by practising hospital pharmacist to describe hospital pharmacy as it stands today.

Chapter six provides an examination of the changing role of clinicians within secondary care. In particular, it presents the perceptions of clinicians to NPM initiatives and their influence with regard to their relationship with pharmacists. It further, shows how changes in financial accountability and the imposition of NPM principles have served as a catalyst in the erosion of professional boundaries between the two professions.

Chapter seven discusses the impact that changes in financial accountability have had on pharmacy and its position as a healthcare profession. The importance of the pharmacist – hospital clinician relationship is also discussed. The chapter focuses on the data collected from a sample of pharmacists across NHS Trusts in Scotland and highlights the impact that NPM initiatives and changes in financial accountability have had on concerns over quality of care and the pharmacist – hospital clinician relationship.

Chapter eight provides a summary discussion of the research findings presented in chapter six and seven to aid the reflection of the data with the sociological theories of the professions which will be made in chapter nine.

Chapter nine reflects on the data produced alongside sociological perspectives of the professions. The chapter is theoretical, analytical and interpretative. It scrutinises the assumptions of underlying NPM and financial accountability initiatives and connects

these to developments within sociological debates on professional status and the management of professional experts.

Chapter ten draws together the disparate strands of the investigation and provides the overall conclusions of the study and suggests avenues for further research.

Chapter Two: Health Policy Reform: the Politics of Technocratic Change

> "Out of ignorance, and a misguided faith in a conception of rationality that is at odds with practice, reformers have failed to recognise the NHS power structure, the capacities of groups to bargain and influence, and the importance of historical legacy for the shape and character of organisational arrangements." (Hunter, 1994, p9)

This chapter will provide an overview of healthcare policy within the UK as the underpinning context of the thesis as a whole. The chapter in particular considers the period between 1979, when the Conservative government under the leadership of Margaret Thatcher took power to the end of New Labour's leadership by Gordon Brown in 2010. It will identify organisational and structural changes as a result of New Public Management (NPM) that are considered to be the most influential in the changing relationship between clinicians and pharmacists. In the process it sets out and examines the various influences on healthcare policy making and implementation. The chapter begins with a discussion of the power of the medical profession and how successive governments have sought to reconcile increasing public expectations, the ever increasing expenditure on healthcare and establish more control and financial accountability within the service.

A Changing NHS

A distinctive feature in the UK is the extent to which its health service is state owned and run and the extent to which government pays the costs. Since its creation, the funding of the NHS has been a constant issue of debate. Indeed, as outlined in the introductory chapter, the history of the NHS is that of an organisation, noble in

conception, but faced with financial crisis (as exemplified by the Guillebaud[13] investigation) on the one hand due to rapid advances in technological innovations and medical knowledge, and on the other, the financial restrictions that inevitably rise from a centrally funded service, changing management dogmas and political beliefs.

The continued popularity of the NHS and the determination of Governments to contain NHS spending in the face of increasing costs have resulted in the National Health Service (NHS) coming under critical scrutiny for the last few decades. In part this can be attributed to the perceptions that there is increasing expenditure in virtually every area of the health care system, resources allocated to health services are not always deployed in an optimal fashion, and that this has put pressure on successive governments seeking to control public spending. At a time when the scope to increase NHS spending is limited, the need to ensure the efficient utilisation of resources and use of existing budgets has become a central focus of government attempts to reform the NHS. Indeed the Conservative governments since 1979 have regarded the management and utilisation of NHS resources as wasteful, inefficient and unresponsive to patients needs. Against this background, policy makers are reviewing the future of the health service and assessing areas of the NHS in which cost efficiencies[14] can be achieved.

Secondary care is a major source of healthcare expenditure which is predominantly driven by clinicians exercising their professional autonomy over resource utilisation and patient treatment regimes. One of the paradoxes of the NHS since its creation has been the lack of control exercised by government over those who, in theory, exercise

[13] HMSO, 1956, Guillebaud Report.
[14] The prevalence of inappropriate long term prescribing for example was major concern. For more detailed information see Buetow *et al*, 1996.

the greatest influence in determining the demand for healthcare services and those responsible for healthcare spending: the doctors (Klein, 2001). Indeed it has been argued that one of the main reasons why Britain is able to spend less than comparable European countries on healthcare provision stems from the unique role in filtering, shaping and controlling demand on healthcare by the medical profession.

In the next section how the medical profession came to hold such power within the NHS will be outlined. It is not the purpose of this thesis to provide a full and detailed history of the power of the medical profession or the creation of the NHS. Rather a brief outline explaining how the profession came to hold such a significant influence is presented in order to frame the direction of the argument that NHS reforms have altered the balance of power of the medical profession.

The Power of the Medical Profession

The consensus that had emerged during the years between the two World wars was that healthcare was inadequate in both quality and availability and that the voluntary hospital system was no longer viable (Klein, 2001, p3). Indeed this period was marked with a series of publications from a variety of sources that shared the same consensus that '*the best means of maintaining health and curing disease should be made available to all citizens*' (MoH, 1920, 693). The inadequacies of the UK healthcare system while already under debate were brought into sharp focus with the vast amount of casualties of the Second World War. The government of the time set up the Emergency Medical Service (EMS) in 1939 as part of the Ministry of Health. While the EMS took control of the hospitals it was the hospital consultants that were actively involved in the day to day running of the service. The introduction of the EMS

emphasised the need for government planning for the provision of healthcare in the eyes of the consultants and state officials.

While there was a general agreement for the need of a better healthcare provision that was more efficient and egalitarian, there were also disputes as the negotiations regarding the details of such a service developed particularly between General Practitioners (GPs) and hospital consultants. One of the main dilemmas was how public accountability and professional participation in decision making could be reconciled (Klein, 2004, p10). The medical profession demanded representation and involvement in the decision making process and formulation of health policy. Aneurin Bevan, the Minister of Health at that time, believed that the hospital sector was vital to the creation of a National Health Service thus a concordat between the Government, Ministry of Health, and medical profession and in particular hospital consultants had to be struck. Bevan exploited the division between the GPs and hospital consultants by seeking and gaining support from the Royal Colleges who were the main representatives of the hospital consultants. In exchange for their support for the development of the NHS, Bevan afforded many concessions to the consultants. This included a high level of autonomy over their appointments, promotions and rewards as well as the retention of their private practice. Consultants that were regarded as meritorious were also granted special financial rewards over and above their basic salaries (Klein, 2004, p16). The structure of the NHS under the influence of the consultants also allowed the medical profession to make resource allocation decisions while the government set the total health budget. Such concessions thus gave a powerful voice to the royal colleges in return for their cooperation.

The level of involvement and participation afforded to the Royal Colleges and consequently the hospital consultants was not extended to other health service workers. Indeed when the possibility of such extended involvement was raised by the Trade Union Congress, Bevan was quick to reject it. In a letter to the TUC's General Secretary Bevan stated,

> 'I attach great importance to the principle that these bodies shall consist of members appointed for their individual suitability and experience, and not as representatives or delegates of particular, and possibly conflicting, interests. This means that members of Regional Boards and Management Committees could not be appointed to 'represent' the health workers, and I could not agree to an alternative suggestion that has been put forward – that a proportion of members of these authorities should be appointed after consultation with the health workers. The difficulty here would be to draw any line which would keep membership of the Boards and Committees down to reasonable members. If the nurses were to be consulted, why not also the hospital domestics? The radiotherapists? The physiotherapists? And so on '(Bevan in Klein, 2004, p17).

The formation of the NHS in 1948 was thus influenced significantly by the desires of Britain's social and economic elite (Baeza, 2005) with the professionals holding a central role in the system of resource allocation. The welfare state thus became a 'professional state' (Alaszewski, 1995, p55).

> 'The nationalisation of the hospitals and the reorganisation of general practice eventuated in a profession-dominated National Health Service which achieved for the medical profession a constitutional position in the realm matched only by the Church and the Law. (Parry & Parry, 1976, p208)

The close relationship that developed between the medical profession and the state in the establishment of the NHS enabled the medical profession to create a monopoly in which they took over the diagnosis of problems and prescriptions for solution and thus redefined individual's need for a service (Culyer, 1976, p14) which resulted in professionals controlling both the supply and demand for welfare services.

Finite Resources, Infinite Demands

Only four months after the launch of the NHS, it became apparent that the estimated costs of the service had been grossly underestimated. In a memorandum to the Cabinet, Bevan warned that the cost of service for 1948-1949 would be in the region of £225 million, £49 million more than had been budgeted (Klein, 2001, p26).

> 'The rush for spectacles, as for dental treatment, has exceeded all expectations....Part of what has happened has been a natural first flush of the new scheme, with the feeling that everything is free now and it does not matter what is charged up to the Exchequer. But there is also, without doubt, a sheer increase due to people getting things they need but could not afford before, and this the scheme intended' (Bevan in Klein, 2001, p26) .

Furthermore, Bevan stressed that the cost of the service in terms of wages and salaries were much higher than originally estimated.

> 'The justification of the cost will depend upon how far we get full value for our money; and that in turn will depend on how successfully my Department administers the service, eradicates abuse – whether by professional people or by the public – and is able to control the inevitable tendency to expand price, which is inherent in so comprehensive and ambitious a scheme as this' (Klein, 2001, p26).

The ability of the state to '*control the inevitable tendency to expand price*' however, did not transpire. The concessions granted to the medical profession in return for their cooperation in the development and implementation of the NHS provided the medical profession with an institutional power base that rendered them a relatively uncontested professional sovereignty that made them insensitive to demands to exercise responsible autonomy in their clinical decision making (Dent, 1995, p89). The problem of exercising management and control within the NHS was thus essentially tied to how best to direct the activities of the consultants and GPs who were intensely individualistic and regarded themselves as only being accountable to their professional

peers. This situation has, since the inception of the NHS, been a major challenge to the government in controlling the cost of healthcare.

> 'The NHS is comprised of very many services rendered daily by physicians, nurses, dentists, pharmacists and others. The content of those services is defined, not by planners, but by essential professional knowledge and skills. Change in method and practice is brought about by intra-professional exchanges; it may be abrupt because of a scientific development such as the advent of a new drug, or it may occur gradually with experience' (Godber in Klein, 2001, p34).

This is further exemplified with the Bradbeer report of 1954 which highlighted conflict between administrators and medical healthcare actors within the NHS (Gillespie, 1997). The Bradbeer report recommended that all senior managers should be accountable to the Chief administrative office. Attempts to tackle such problems and in particular professional power versus bureaucratic power are thus, not a new phenomenon. In many ways, however, the Bradbeer report was a precursor to the Griffiths report of 1984 which will be discussed shortly.

Critics of the welfare state argued that the removal of health services from market provision created collective power. The solution in their minds was the reestablishment of a market for professional services and a return of control and responsibility to individuals. Such critics in terms of the debates surrounding the development and role of professionals within the welfare state remained relatively peripheral and marginal until the 1970s (Lees, 1964, p14).

The Politicians and the Professionals

The Labour government of the 1960's had initiated a series of public sector reviews that included the NHS. The outcome of the reviews, with regard to the NHS, was a restructuring that created administrative units and agencies in both central and local government with the remit to facilitate the introduction of corporate managerial processes into the day to day running of the service and to pull professionals into the management and resource allocation processes. The implementation of the new system came into operation during the fiscal crisis of the 1970s.

The relationship between the state and healthcare professionals during the 1970s experienced significant stress. Due to economic fluctuations public finance was stretched to its limit and the state found it increasingly problematic to control welfare expenditure. This situation was exacerbated by the medical profession taking successful action to increase their salaries and the minimal accountability imposed on them for the use of state funds which created problems of both social justice and efficiency (Alaszewski, 1995, p57). The reorganising of the NHS in 1974 in which the original network of NHS authorities was swept away and replaced with a more narrow and streamlined structure and in which the prestigious teaching hospitals also lost their elite independent status is important for what it reveals about the changing balance of political power within the profession. The 1974 reorganisation, amongst other things, institutionalised the voice of the consumer by giving greater power to Community Health Councils who represented the consumers of health services. The philosophy of 1974 reorganisation was a political attempt to create an NHS capable of rational planning, managerial efficiency and to create a more effective form of accountability and hierarchy for the transmission of national policy.

The financial crisis dogging the NHS rose to a crescendo in the latter part of the 1970s as technological innovations and demographic demands continued to assert themselves. The gap between what could be achieved within the NHS with the financial resources allocated compared to other European nation states widened as virtually no growth in real terms was given to the NHS budget. This contributed to the sense of crisis and disillusionment of the new NHS structure created in 1974. Such disillusionment was reflected in the Royal Commission report on the state of the NHS conducted in 1979. The report reaffirmed the underlying rational and philosophy of the NHS but also indicated the need for a simpler organisational structure.

The Conservative Governments 1979-1997

The Conservative Government under the leadership of Margaret Thatcher in strong contrast to its predecessor of 1970 was not committed to the ideology of rational planning. Rather it was committed to 'rolling back the frontiers of the state' and exposing many areas of the public sector, including the NHS, to the rigours of market forces. '*We will simplify and decentralise the service and cut back bureaucracy*' and thus a further round of reforms was initiated. Initially, this was not focussed on the medical profession *per se* but was rather an attempt to control excessive public expenditure. However, by the Conservative's third term in office the political agenda had shifted from control of public expenditure to the processes of resource allocation and financial control, and was specifically concerned with the role

that professional groups played in the utilisation of public funds. Indeed during this period, The New Right, viewed the NHS as a '*monopoly or monolith which impedes innovation*' and grew increasingly hostile at the level of economic and political privilege that the medical profession held (Bosanquet, 1983, p150).

However, it should also be noted that concern over the power of the medical profession can be traced back as far as the Bevan era. Indeed since the Bevan era, successive governments had attempted to achieve tighter control over service, budgets and spending within the service. This is further exemplified with the Bradbeer report of 1954 which highlighted conflict between administrators and medical healthcare actors within the NHS (Gillespie, 1997). The Bradbeer report recommended that all senior managers should be accountable to the Chief administrative office. Attempts to tackle such problems and in particular professional power versus bureaucratic power are thus, not a new phenomenon. Indeed successive governments have attempted to constrain the power of the medical profession in the form of radical reorganization of the NHS and demands for greater financial control and accountability. In many ways, however, the Bradbeer report was a precursor to the Griffiths report of 1984.

Management and the NHS

By the 1980's the political environment in post war Britain had altered substantially mainly due to the activist model of the state where political intervention was regarded as a necessity to address the failures and deficiencies of the private market which came under attack throughout the 1970s (Clarke, Gewirtz & McLaughlin, 2000). Critics of the activist model argued that such deficiencies could be addressed with the introduction of market mechanisms into the welfare state. The newly elected

Conservative government was sympathetic to the idea of free market principles as a means of addressing the many inefficiencies and failures of the welfare system (Minogue, 2000, Baeza, 2005).

The NHS reforms that were initiated during the 1970s were targeted towards achieving reductions in public services and improving efficiency. The reforms of the early 1980's saw the introduction of the internal market and contracting out of non-core services. The previously passive public administration of welfare services was no longer sufficient within this new focus. Thus a new form of management consisting of professional managers with considerable discretion was introduced into the welfare delivery.

> 'A system dominated by central government departments, local authorities and the NHS, and based upon the values and practices of public administration...is being replaced by a new set of practices and values, based upon a new language of welfare delivery which emphasises efficiency and value for money, competition and markets, consumerism and customer care (Butcher, 1995, p.161).

The first step towards this achieving this new rationale came after the Griffiths Report[15] in 1983 in which the prevailing consensus management approach that dominated the service was severely criticized. The report recommended the replacement of consensus management with general management at all levels thus moving the previous preoccupation of reforming the organisational structures of the NHS towards organisational dynamics. Griffith's diagnosis of the state of the NHS was that it was suffering from institutional stagnation (DHSS, 1983). Policy thus came to be preoccupied and driven by cost efficiency and productivity imperatives.

[15] The Griffiths Report was an investigation into the manpower of the NHS conducted by Roy Griffiths (later to become Sir Roy Griffiths) managing director of Sainsbury's. The report marked the beginning of the managerial revolution within the NHS.

NPM, Budgeting and Accountability

The pursuit of achieving broad cost efficiencies resulted in the introduction of an internal market (now abolished) in the NHS and increased emphasis being placed on devolved financial accountability (Jones, 1999, p164). A common feature of the drive to achieve these new efficiencies was the attempt to replace provider-driven services with managerial-driven services which are geared more towards consumer preferences and value for money (Hunter, 1991, p441). The reforms also included a review of the financial management of NHS services.

Prior to 1974, financial management in the NHS was limited to the control of costs on a subjective basis with the focus being on what the money was spent rather than on for whom, where, why etc. Budgeting was at its most basic, with simple roll-over historical budgets and no clear definition of lines of financial management or responsibility. The reorganisation of the NHS in 1974 was the first step towards placing an emphasis on the organisation, management and accountability of where the money was being spent. The 1982 reorganisation pushed the authority and accountability for resource consumption decisions to unit level (Mellett *et al,* 1993, p9). However, those responsible for the day to day organisational decisions that determined the patterns and volume of resource consumption were not responsible or accountable for the management of the budgets that the costs were allocated to. This presented Ministers with a dilemma. To increase efficiency and accountability meant introducing management and control measures which would potentially be perceived as threatening by the medical profession. Previously such considerations were unquestioned as medical professionals were trusted to deliver appropriate medical care to their patients and to adhere to their professional code of conduct. However, concerns

with efficiency and financial accountability introduced a new language and focus into the management of NHS services which was coined as New Public Management (NPM) by Hood, 1991. The core of NPM hinges on managerial processes with the general manager as a single authority figure (Lapsley, 2008) and thus brought the previously established arrangements and relationships under scrutiny (Exworthy & Halford, 2002).

Critics of NPM regard it as a market based ideology that invades public sector organisations (Laughlin, 1991), while others view it as a management hybrid that retains the core public sector ethos (Ferlie et al, 1996). The initial introduction of new management approaches within the NHS however, did not succeed in achieving the cultural change that it sought. It was clear by the end of the 1980's that due to the complexity and subtleties of the organisational context of the NHS that the management principles of the private sector could not be imported into an organisation staffed by powerful professional groups. Up until this point the reforms had concentrated its efforts on the organisational environment within which the medical profession operated. However, by the end of the decade the reforms started to take a turn and were more directed at tackling the profession head on. Thus a further round of reorganisation with distinct roles of accountability and management being established with the aim of achieving cost efficiencies which would come to engulf the medical profession were initiated (Harrison & Pollitt, 1994).

The most influential papers in this next round of reform were the department of Health white papers, *Working for Patients* (DoH, 1989a) and *Caring for People* (DoH,

1989b)[16]. These papers were the foundations of the 1990 reforms and Community Care Act which introduced further changes that covered NHS secondary care, disengaging them financially and managerially from their district health authorities. NHS trusts were also established (Levitt *et al*, 1999, p53). The boards managing the NHS trusts are similar to that of the health authorities, but a fundamental difference is that the executive and non executive members are corporately responsible for financial decisions (Le Grand & Bartlett, 1993).

Clinical directorates were also established within the NHS in response to two major initiatives: the *Resource Management initiative* which was designed to involve clinicians in the management of information and resources and the government White Paper *'Working for Patients'*. The report *Working for Patients* stressed that clinicians should be properly accountable for the consequences of their clinical decisions and that they could no longer display little regard to the financial and other resource consequences of their clinical decisions (Barber & Wilson, 1999, p11). Within secondary care the government[17] sought to achieve efficiencies for example by transferring the responsibility for the drugs budget to the clinical directorate. This obliges the clinical directorate to make strenuous efforts to control prescribing expenditure and to achieve optimum benefit at least cost. As a result the prescribing practices of clinicians are being guided by control mechanisms such as predetermined care pathways, the imposition of locality formularies and input from clinical pharmacists. Any deviation from these pathways such as the prescribing of modern drugs now requires closer attention to the balance of safety and efficacy due to their relatively high cost and must be justified before implementation. The intention was that

[16] The emphasis on patients was continued after John Major replaced Margaret Thatcher as leader of the conservative party.
[17] The government under the leadership of Margaret Thatcher.

clinicians would be obliged to behave in a more cost conscious manner and become key actors in the management of health care resources.

This change however, also presented the clinicians with a shift of emphasis from process accountability to output accountability; with traditional costing and budgeting systems that focused on the control of total expenditure and provision of information for government purposes being replaced by new systems that delegate financial responsibility and accountability for medical decisions. Under this new system clinical autonomy is preserved but made more visible through financial calculation and accountability.

The Politics of Value for Money

Since its creation the lack of control over those who yield the greatest influence within the service, the doctors, has been a major issue for health ministers. Indeed, as noted in chapter one, it has been argued that one of the main reasons why Britain is able to spend less than comparable European countries on healthcare provision stems from the unique role in filtering, shaping and controlling demand on healthcare by doctors. During the 1980's, at a time when the scope to increase NHS spending was limited, the need to ensure the efficient utilisation of resources and use of existing budgets became a central focus of government attempts to reform the NHS. A major contributing factor to the escalating costs of the service was thought to lie in the level of autonomy over resource utilisation held by the doctors and the prescribing practices of the GPs and hospital clinicians.

For a government striving to tackle excessive healthcare expenditure, the open ended budget for the provision of medicines was an obvious target. Evidence based medicine and value for money became important concepts in health care and were promoted by the government in the attempt to reduce the overall cost of NHS services and are demonstrable as one of the Governments first attempts to achieve financial control and at political risk.

Controlling the prescribing practices of doctors, particularly in primary care, had been floating around for some time. Successive Governments, had avoided a head on conflict with the British Medical Association (BMA) in this regard hence the announcement of the imposition of a 'limited list'[18] for the provision of medicines in primary care in November 1984 caught everyone by surprise (Newton & Burt, 1989). This heralded one of the biggest changes to the provision of NHS services since its introduction. Both the BMA and the pharmaceutical industry with the support of the Labour ministers vigorously campaigned against its introduction. The battled ended in compromise with the list being extended marginally and agreement that the medical profession would be consulted regarding its precise composition. An Advisory Committee was also established to review and consider proposals for the addition or deletion of drugs to the list. The success of imposition of the 'limited list' also challenged the level of clinical autonomy held by the medical profession and indicated that the profession was not exempt from limits and scrutiny in the use of NHS resources and proved to Ministers that it was possible to achieve efficiency by using tools of bureaucratic control.

[18] The limited list was a list of 30 of the most commonly used drugs for specific health related conditions. This was later extended to 100 items.

This brings us to another element of reforms of the NHS which established commissioning authorities covering both primary and secondary care to address prescribing issues (Panton, 1998, p49). In comparison to primary care a vast range of drugs are utilised within the hospital setting. Secondary care also has the advantage of achieving economies of scale through its ability to bulk buy and negotiate discounts directly from the pharmaceutical companies (Upton *et al*, 1989). Prescribing at the interface between primary and secondary care has always been problematic and hindered by poor communication and coordination. Clinicians in the hospital setting also had little appreciation of the cost of medicines within primary care and the effects of their prescribing decisions that would accompany the patients into primary care. In an attempt to resolve this situation the implementation of a 'joint formulary'[19][20] that spans across this interface was put forward (AC, 1994). Moves to integrate primary and secondary care drug budgets were also being undertaken.

It was hoped that this would increase the clinician's awareness in secondary care of the implications of their prescribing patterns on the primary care sector and encourage more cost effective prescribing that can be continued in primary care. Although during this process the government compromised on some of the policy details, its main substance remained intact thus impinging further on the closely guarded clinical autonomy of the medical profession (Beaza, 2005). Changes were also made over the control of budgets with Managed Care Units and Directorates taking control over the financial accountability of their own areas. The government during this period was thus

[19] The joint formulary is a list of permitted drugs on the NHS that can be prescribed in both primary and secondary care.
[20] Examples of the first official formularies see Jackson, 1989,Joshi *et al*, 1993, Basu, 1999 also drug cost containment strategies such as those discussed by Kutch-Lojenga, 1989 and Levy, 1993.

continually pressing its agents to utilise government funds more efficiently and to demonstrate that they are providing 'value for money' in the services that they offer.

The focus of such initiatives was maintained after John Major replaced Margaret Thatcher as leader of the conservative party. The corollary of the successive round of reforms imposed by the Conservative governments, and the success of the government to overcome resistance to their policies, resulted in the established rules of conduct of the BMA being suspended (albeit temporarily) and replaced with a political ideology modified with managerial pragmatisim. While the BMA and pressure groups were closely involved in policy issues and implementation and continued to exert some influence, the most striking observation that can be made during this time period is the success of government to drive through significant changes within the healthcare system in the face of powerful opposition.

The NHS and the 'Third Way'

The new Labour Government implemented further reforms with the aim of transforming the NHS into an efficient and value for money organisation. It also promoted a commitment to 'abolish the internal market' which was to be replaced with service agreements within its 1997 Labour manifesto. GP fund-holding was also dispensed with and was replaced with larger Primary Care Groups. This did not mean however, that a return to the old centralised control and command structure would occur. Rather what was proposed was a '*Third Way*', a new model that sought local responsibility;

partnership; efficiency; excellence; and a regain of public confidence. A greater emphasis was also placed on achieving improvements in the population's general health and the quality of care provided. A statutory duty of collaboration and co-operation was imposed on health authorities and Trusts to contribute to Health Improvement programmes. Local Authorities and Health Boards were also required to work collaboratively on issues of such as social care and investment plans (Ham, 2004).

In addition to improvements in the co-ordination and planning of NHS services, New Labour also sought to improve the standard of care and achieve equity of access to high-quality services an issue that had largely been ignored by the Conservative governments. In order to facilitate these objectives New Labour turned to regulation announcing the creation of two new regulatory bodies in its first White Paper *The New NHS, Modern, Dependable* (DoH, 1997), a commission for Health Improvement and a National Institute for Clinical Excellence (Walshe, 2003a).

The Commission for Health Improvement (CHI) and the National Institute for Clinical Excellence (NICE) were created in response to the perceived crisis of equity and quality of care within NHS services. The regulatory function of the CHI is generally compliance orientated, with a strong commitment to quality improvement. It specifically investigates service failures, undertakes clinical governance reviews, conducts NHS reviews and provides clinical governance advice and guidance to medical professionals. NICE is a specialist authority whose chair and non executive director are appointed by the NHS Appointments Commission (HCHC, 2002). NICE[21]

[21] The specific function of NICE is outlined in chapter 4. For a detailed overview see NICE, 1999.

was established to address the controversial issue of postcode prescribing and to bring rationality and national direction to the use of existing and new health technologies and clinical practice (NICE, 1999).

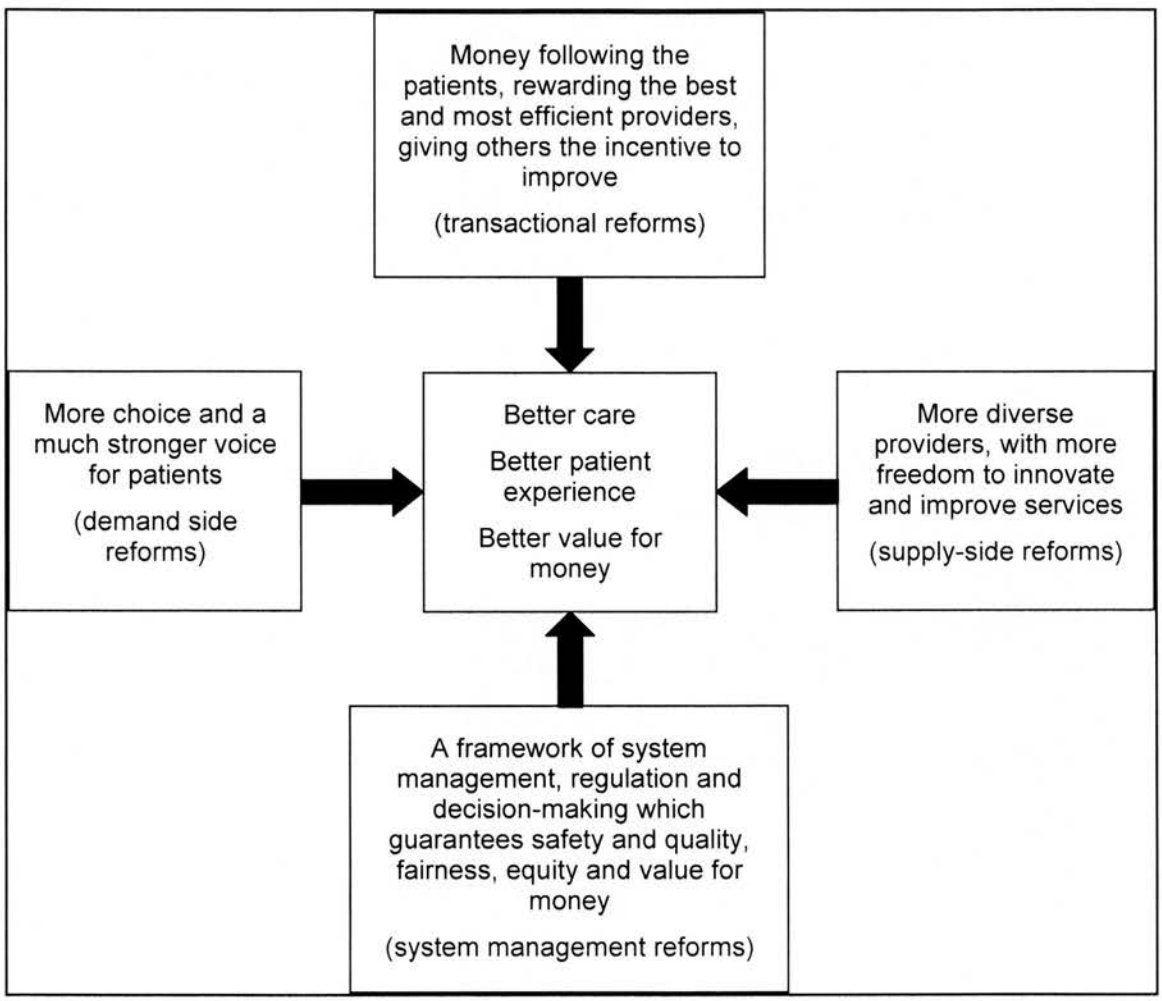

Figure 2.1: Framework of the Health Reforms
(Source, DoH, 2005)

During New Labour's second term an ambitious plan (*The NHS Plana*) for additional funding and expansion of the NHS to bring it closer to European levels of healthcare expenditure was produced. *The NHS Plan, 2000*, outlined a range of initiatives, targets, performance management system and tighter regulation. Local authorities were also promised greater powers of scrutiny. Three further regulatory bodies, the National

Clinical Assessment Agency to deal with specific areas of poor clinical performance, the National Patient Safety Agency to deal with adverse event reporting and the Modernisation Agency with the broad remit to support any NHS organisation to deliver the ambitious targets were set out in the NHS Plan (DoH, 2000b). The main focus of the health policies initiated by New Labour was tackling the economic, social and environmental factors in ill health. The NHS Plan also initiated further reorganisation of NHS with NHS regions being reduced and Health Authorities reconstituted as Strategic Health Authorities.

Establishing a more efficient and effective service was thus a prime objective of New Labour. Issues of quality, safety and efficacy have featured highly in the NHS reforms as can be seen in many of reports issued by the Department Of Health. For example, The National Patient Safety Agency was established in 2001 to promote patient safety throughout the NHS. A specific remit of this body is to identify and provide solutions to patient safety issues. This report was followed by *Building a Safer NHS for Patients* (DoH, 2001), *A Spoonful of Sugar*, (AC, 2001), *Design for Patient Safety* (DoH, 2004), *Safety First: a Report for Patients, Clinicians and Healthcare Managers* (DoH, 2006), and *Coding for Success* (DoH, 2007) with the key theme, patient safety being embedded within all of these reports and thus coming to dominate healthcare services. Such initiatives arguably[22], affected the level of autonomy of key healthcare professionals, the doctors, and their relationship with other healthcare operatives.

[22] Derber 1982, Derber & Schwartz, 1991, Dent, 1995, and Courpasson, 2000, for example argues that increased controls and standardisation are managerial strategies of domination and a form of soft bureaucracy that can potentially lead to the proletarianization of the professional.

Gordon Brown and NHS Reform

The election of Gordon Brown to head the New Labour government in June 2007 gave rise to speculation over the direction that the new leader would take with NHS reform. Speculation over whether the market based principles followed by his predecessor, Tony Blair, would continue were of particular interest. In the first major speech of the new Prime Minister at the beginning of 2008, it became clear that the new leader was adding points of emphasis to existing policies rather than departing from them. In particular increased significance was placed on preventative medicine, medical innovations and the need for these to be made available to the NHS, long term illness and support services required to care for the long term sick, patient's responsibility for their health, patient's rights, and establishing '*the best insurance system for the long term*' (Ham, 2008a, p53).

Following the election of Gordon Brown an extensive review of the NHS was also commission; *The NHS Next Stage Review*. This review was headed by Lord Darzi and was aimed to be published in the 60th year of the NHS. The report emphasised a set of new priorities which would build on earlier progress within the service, improving primary care services and a continuing drive towards establishing a world class health service (Ham, 2009). Such priorities were further reflected in the report, *High Quality Care for All,* which focused on patient safety, quality of care and the need for strengthening staff engagement and leadership within the service (COSU, 2008). While

this paper did not endorse or reject the market based principles of the party's predecessor, it, along with other public sector reform initiatives, signalled that the Brown government was not enthusiastic about such principles.

During the Next Stage Review, the government also announced the results of the 2007 spending review which had been initiated due to concern within both the government and the media that the NHS was unable to balance its books even with the large financial resource injections given by the former party leader. This marked the end of a rapid growth period that had started at the beginning of the decade in NHS resourcing. Debates over NHS funding and rationing, while not a new phenomenon, increased in intensity during the Blair and Brown years of Office. Indeed its ability to continue to provide a universal and comprehensive service was of particular concern.

The King's Fund review headed by Derek Wanless drew attention to existing deficits in approximately one third of NHS organisations. The report concluded that the successive structural changes to the service had brought little benefit in terms of its efficiency and productivity (Wanless *et al*, 2007). Such failure was attributed to the ideological divide between supporters of devolution within the healthcare system and those that favoured central control; a predisposition for continual structural reorganization that negatively affected staff morale; ineffective coordination of care; lack of data to track quality and productivity improvements and territorialism (Leatherman & Sutherland, 2008; Ham 2009).

To address these challenges a National Quality Programme was initiated which focused specifically on patient choice, payment by results, the establishment of

Foundation Trusts[23], increased utilisation of private services and commissioning in order to establish a coherent and integrated approach to healthcare delivery (Ham 2009).

While there was political differences, health policy under both the Blair and Brown governments incorporated important elements that were initiated under the Thatcher and Major governments. A central feature of the Blair and Brown reforms, however, was the pragmatic approach taken, 'what counts is what works' and the increased focus on providing better services for patients, greater accountability for resource utilisation, performance and quality control and a more standardised approach to patient care.

NHS Scotland

While similar in content, the traditions of independent Scottish health policy were reflected in the 1947 Act and NHS organisation. Within Scotland, the Scottish Secretary and Scottish Office held the administrative control rather than the local authorities (Jenkinson in Nottingham, 2000). The NHS in Scotland was administered through four structures, the Executive Council, Regional Health Boards, Boards of Management and Local Health Authorities. The establishment of Hospital Management Boards which held greater power than their English and Welsh counterparts was distinctive feature of the Scottish legislation. This arrangement remained in place until 1967, when the Secretary of State for Scotland called for a reorganising of the Scottish Health Service which led to the National Health Service (Scotland) Act 1972 which brought structural and managerial changes of the service in the form of Planning Councils, Consultative Committees, Health Education Groups,

[23] See also Walshe, 2003b.

Common Services Group and ultimately a Health Service Policy Board being set up in 1985 (Mackie, 2005).

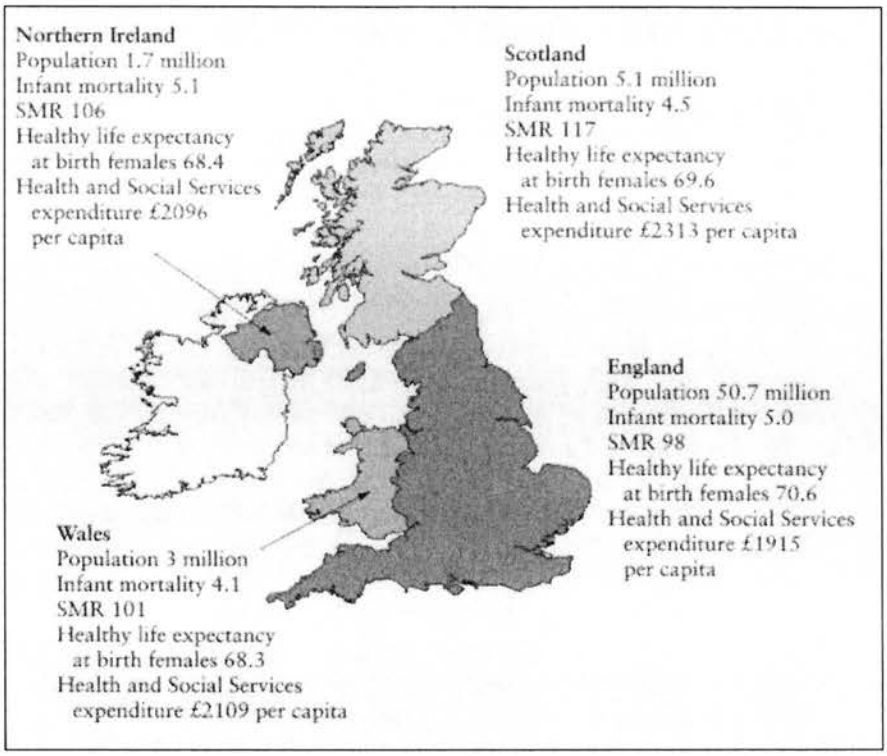

Figure 2.2: Health and Health Care in the UK
(Source: ONS, 2008)

By the end of the 1980's the management and structural changes that came about as a result of the 1972 Act were no longer adequate to cope with the requirements of New Public Management regimes being rolled out by Central Government. In response to National Initiates the Chief Executive of NHS Scotland promoted the concept of managed competition and public choice in the policy document *Framework for Action* (Scottish Office, 1991) in which NHS Trusts and GP Fund-holding were proposed. This system remained in place until 1997 and the publication of the governmental White Paper, *Designed to Care*.

Within NHS Scotland the contemporary mandates that contributed to its current structure are contained within the post- 1997 White Papers and Acts of the Scottish Parliament (Mackie, 2005). The 1997 Secretary of State, Donald Dewar, took immediate action to the management of the NHS in Scotland following the election of New Labour. The 1997 White Paper, *Designed to Care- Renewing the National Health Service in Scotland* ended the internal market. GP fund-holding and contracting for services was also abolished. NHS Trusts were retained initially with the remit of improving quality of service by drawing clinicians more into the hospital management. Ultimately the number of Trusts was to be reduced and would be split into two branches; Acute Hospital Trusts and Primary Care Trusts.

A significant change that came out of the Blair government was the devolution of power and establishment of the Scottish Parliament. While control over the constitution, defence, economy and other major areas was retained in Westminster, devolution gave the Scottish government control over health and social care (Ham, 2009). Complementary to the objectives of the national NHS Plan, the DoH, 1999 White Paper, *Towards a Healthier Scotland*, was directed towards improving health and addressing health inequalities. This was quickly followed by the White Paper, *Our National Health: A Plan for Action, A Plan for Change* (SE, 2000) which introduced unified NHS Boards that held more responsibility for the long term organisational direction and which are accountable to the Scottish Executive Health Department (SEHD)[24]. The SEHD Chief Executive heads the Management Executive which overseas the 15 regional Health Boards, 40 Community Health Partnerships that provide a range of NHS allied services and directs NHS management and is

[24] The Scottish Executive Health Department (SEHD) is the responsible body for the administration of NHS Scotland and health policy.

accountable for the efficiency and performance of NHS Scotland to ministers (see table 3.2 below). In February 2003, the Scottish White Paper, *Partnership for Care,* abolished all Trusts in Scotland and replaced them with Operating Divisions within Unified NHS Boards and Community Health Partnerships (RCGP, No 8, 2002).

	Central Management	Regional Structure	Health Authorities	NHS Trusts	Primary Care
Scotland	Scottish Health Executive Department	Special Health Boards NHS Unified Boards Operating Divisions	15 Health Boards	–	c.40 Community Health Partnerships
Northern Ireland	The Department of Health, Social Services and Public Safety	Regional Health and Social Care Board Regional Agency for Public Health and Social Well-Being	–	5 Health and Social Services Trusts	5 Local Commissioning Groups
England	Department of Health	Public health teams are located in the government offices of the regions	10 Strategic Health Authorities	c.125 NHS Trusts c.115 NHS Foundation Trusts	c.150 Primary Care Trusts
Wales	NHS Directorate in the Welsh Assembly Government; National Advisory Board, and National Delivery Group	3 Regional Office of the NHS Directorate (under review)	7 Health Boards	Welsh Ambulance Service NHS Trust and Velindre NHS Trust	Locality Networks

Table 2.1: Differences in the NHS in the UK in 2009
(Ham, 2009)

The unified boards were required to produce a single health plan for their area which became a key tool in the Performance Assessment Framework (PAF) which the Scottish Executive utilises to monitor planned performance against performance achieved. In order to meet the required targets set out within the plan the unified health

boards are required take on a more managerial role in the provision of services within their area. Once approved, the implementation of the health plan is directed through systems of resource allocation and monitored through the PAF framework (Audit Scotland, 2004).

In addition to the national strategies to improve efficiency and effectiveness of service delivery local agencies that work in conjunction with national agencies such as NICE were formed. The Scottish Intercollegiate Guidelines Network (SIGN) is one such example. SIGN is primarily concerned that knowledge from research and reviews presented through NICE is quickly disseminated and adopted (Millard, 1999). Compliance with national strategies is also supported through The Clinical Standards Board (CSDS) for Scotland and the Scottish Health Technology Assessment Centre who work closely with SIGN in developing good codes of practice and guidelines for clinical care (SIGN, 1999).

The National Health Service Reform (Scotland) Act 2004 also promoted increased regional planning of health services by placing responsibility on Health Boards to co-operate with each other. Ministerial powers were also extended to permit ministerial intervention to secure the quality of health services and economic, efficient and effective utilisation of resources. NHS Board Accountability Reviews, NHS Quality Improvement Scotland, the Clinical Governance and Patient Safety Support Group and Audit Scotland all contribute to the overarching framework that ensures that the government drive for value for money, efficiency, effectiveness, clinical quality and continuous improvement of NHS services, in Scotland are achieved.

Healthcare policy development in general started to gather momentum after 2004 as politicians within devolved governments started to put their own stamp on NHS reform. In Scotland this resulted in a report *Building a Health Service Fit for the Future: The Kerr Report* (SE, 2005) which drew attention to the overall poor health of the nation and widening inequalities within the healthcare service. The report identified the need to develop primary care service, and to establish increased integration between primary and secondary care (Ham, 2009). This report was rapidly followed by a paper which endorsed the need to respond to such concerns and laid out specific areas that required action. These included reducing inequalities in service provision by providing wider access to healthcare services in rural communities, and for the disabled, mental health sufferers and those at most risk of hospital admission (SE, 2005). To aid and monitor progress of the initiatives set out the Kerr report a Delivery Group within the SEHD was set up to strengthen the management process.

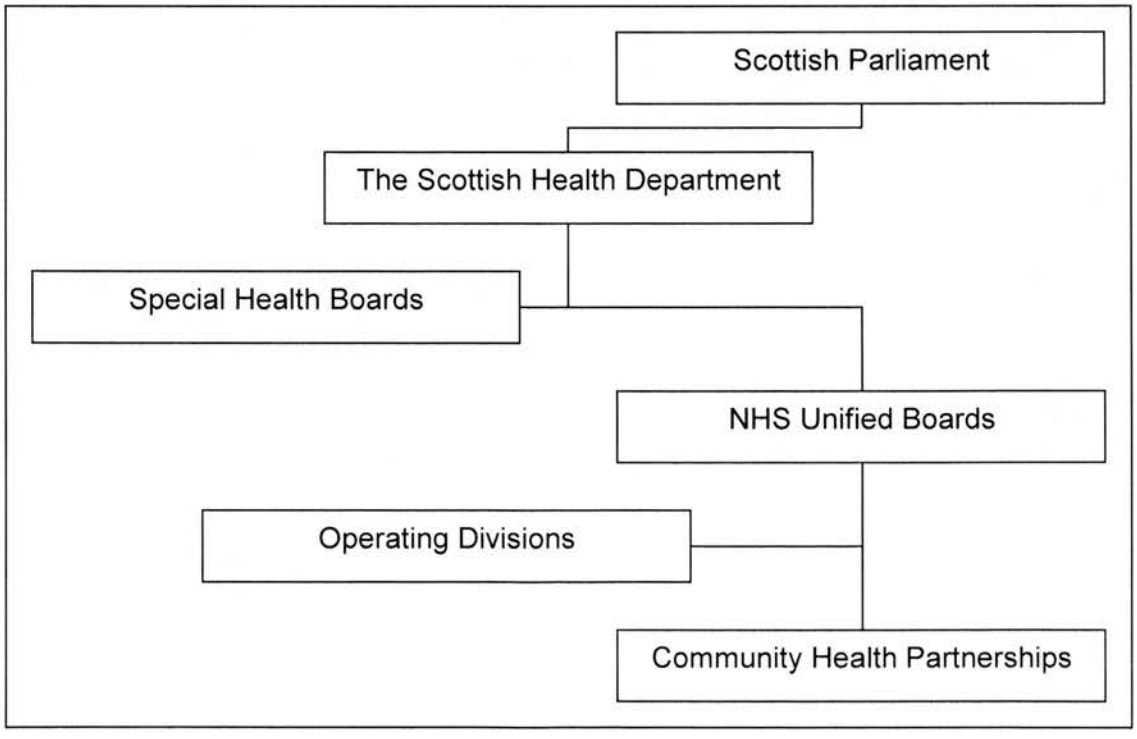

Figure 2.3: The Structure of the NHS in Scotland (Source, RCGP, No8, 2002)

The Scottish Nationalist Party (SNP) gained ground after the 2007 election. The future of healthcare set out by the SNP, was published in a report, *Better Health, Better Care* (SG, 2007). The main objectives of the report built on previous policies and emphasised reducing healthcare inequalities, health improvement programmes and preventative care. A significant feature of the report was the phrase 'mutual NHS' denoting a partnership approach that included staff, patients, stakeholders and an increased emphasis being placed on patient involvement and responsibility for their own health. The report further signified a departure from the market based principles set out by the Blair government and the development of a Scottish based healthcare agenda built on cooperation and collaboration (Ham, 2009).

What has been demonstrated so far is that the organisation of the NHS was reformed in the pursuit for improved efficiency, value for money and improvements in performance. Taken together, such changes to the organisation and management of NHS services are viewed among social scientists as challenges to the level of power and clinical autonomy of the medical profession (Boyne et al, 2003)[25].

[25] See also Lawton & Rose, 1994, 1999, Hoggett, 1996a, 1996b, and North, 1997.

Reform Effects on Hospital Pharmacy

The effects of the reforms were not only felt by the medical profession but also by other healthcare professionals including the pharmacy profession[26]. Within hospital pharmacy, these reforms have meant that accountability for budgets has experienced a change of ownership. In the hospital, the drugs budget was once the responsibility of the pharmacy managers who had considerable autonomy over resources, which services to provide, how they should be provided and to whom (Cotter *et al,* 1997, p7). As ownership passed from pharmacy managers to clinical directors a considerable strain was place on this autonomy as control over the usage of resources was been removed, leaving pharmacy as a basic procurement function. Some perceived that the reality of this change would result in somewhat downgraded role for pharmacy departments and indeed is evident in some of the suggestions for improved pharmacy management, appearing in the literature (Smith, 2002).

Within this new system, pharmacy departments are now expected to *"Cost their services to individual clinicians or directorates with whom there is a service agreement"* (Hunt & Stainton, 1991, p47). Staff costs and overheads, as well as drug expenditure, are contained within these pharmacy costs. Clinical budgeting and the need to allocate drug costs to the individual clinician had significant implications for the pharmaceutical service (Miller & Ashford, 1988). As a result of these changes, pharmacy managers came under pressure to demonstrate their effectiveness, efficiency

[26] Community Pharmacies for example, now work much more closely with GP practices to provide a triage service to patients. The effects of NPM and healthcare reforms on community pharmacy however, are out with the scope of this thesis. Thus generalisation over the extent of such initiatives on the whole of the pharmacy profession cannot be made within this thesis.

and contribution to reducing the drugs bill, even though they no longer had control over, or responsibility for drugs budgets. Arguably, despite the disadvantage that it gave to pharmacy managers for the management and control of the drugs spend, the budgetary changes were made to place responsibility for drugs cost firmly in the hands of the clinicians. As clinicians are the main drivers of drug usage within the hospital setting, they were given control over the drugs budget, in order to make them more aware of the cost of the treatments that they were prescribing[27]. A full exploration of the impact of NPM and financial responsibility changes on pharmacy as a profession will be discussed further in chapter 4.

Research on NPM in healthcare

Since the expression New Public Management was first coined in 1991 by Hood it has been a major focus in public sector accounting, administration and management literature. The core of NPM hinges on managerial processes with the general manager as a single authority figure (Lapsley, 2008). However, as noted earlier in this chapter prior to the expression NPM the general management principle was in place within the NHS as a result of the Griffiths Report of 1983 which recommended the creation of a general management spine with managers at all levels. Numerous studies concerned with the impact and effectiveness of management and managers within the NHS have been conducted. Much of this has focussed on concern over how issues of quality, safety and efficacy are measured and used as a mechanism for regulating clinical practice. A main concern that features regularly is that of patient safety data such as

[27] Up until this point clinicians were relatively ignorant of the cost of medicines for example see Hoey *et al*, 1982, Long *et al*, 1983, Narayan *et al* (1996).

medical error reporting which may give a spurious appearance of objectivity and obscure more prevalent underlying service problems (Buetow *et al*, 1996).

Studies critical of NPM in healthcare suggest that it ignores social relations and behaviour (Metawie & Gilman, 2005) and thus categorises people inappropriately (Llewellyn & Northcott, 2005). NPM also assumes an element of managerial discursive thinking will take place on the part of the employee (Linneberg et al, 2007). However, not all employees will receive managerial training as evidenced in the work of Jacobs (2005) which highlights a distinct lack of managerial and financial training for doctors despite the fact that they are increasingly being given a greater managerial and financial responsibility role. Additionally, NPM does not integrate the fact that individuals can (and sometimes do) act powerfully and intentionally or unintentionally whichever the case may be (Walters & Williams, 2003) which in turn can lead to conflicts with implementation. An example of this is the medical profession.

A notable feature which appears within the UK healthcare reforms is the perceived lack of accountability for resource utilisation and an over emphasis being placed on professional needs (Blakeman, 2003). The challenge of introducing the concept of accountability into the healthcare sector has a number of strands. On the surface, the concept of accountability appears deceptively simple. However, closer examination reveals that accountability 'exists in many forms and is sustained and given extra dimensions of meaning by its context' (Sinclair, 1995:1). Accountability is thus subjectively constructed and can be regarded as a complex, fragmented and evolving concept within the British state (Jones, 1999). Previous attempts to directly manage

healthcare professionals proved to be problematic it was thus considered more effective to recreate such professionals as managers (Maile, 1995).

Incorporating professionals into a managerial position was therefore a distinct strategy within the healthcare reforms to generate some control over professional activity through the discourse of competition (Hoggett, 1996b). The introduction of the internal market and GP fundholding into the healthcare arena was an important policy development. In the Scottish context, Llewellyn and Grant, (1996) in their investigation into the impact of fundholding on primary healthcare found that the market was more muted and the development of the fundholding scheme was not unidimensional. This is further exemplified by Fischbacher and Francis (1998), in their study of purchaser provider relationships and innovation which noted that within GP practices in Glasgow while improved efficiencies in terms of prescribing had been achieved the success of the GP fundholding scheme was not unequivocal.

Healthcare professionals continually strive to provide high quality of service to their patients. The language of 'commercialised professionalism' (Hanlon, 1998) such as empowerment, innovation, autonomy, is instinctively attractive to healthcare professionals. It was assumed that managerial newspeak would provide a powerful form of normative control with which healthcare professionals would identify and consider themselves in terms of management (duGay, 1996; Maile, 1995). Such assumptions, however, are overly simplistic and underestimate the complex negotiated order and organisational life within the NHS (Bolton, 2005).

Fundamental to reforming healthcare has been the process of redefining the workforce which duGay (1996) argues likens NPM to an identity project. Given the vocational orientation and selfless public service ethic ethos that healthcare professions hold this is particularly pertinent for healthcare professionals as their identity and status is closely linked to their role within the organisation (Flynn, 1990). Integrating managerial and clinical roles has been shown to be problematic[28]. Indeed, Thorn (1997) found that clinical managers firmly rooted their identity within the medical profession despite having to adopt a managerial mindset. However, investigation into the clinician-manager and the negotiated order with other healthcare professionals has been generally under researched.

Several studies have focussed on how the introduction of management into the NHS has affected the relationship and balance of power between the medical profession and managers. However, such studies have tended to neglect the intra professional relationships that exist within the healthcare arena to the extent that that the medical profession is presented as a relatively homogeneous group. Historical studies illustrating the differing fortunes of GPs and clinicians[29] before and after the inception of the NHS highlight how health policies have impacted on these two groups, however, very few studies have been conducted to assess the impact of healthcare policies and NHS reforms on the intra professional relationship between the medical profession and other healthcare professionals such as pharmacists. This thesis aims to contribute towards bridging this gap.

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[28] Studies conducted by Fitzgerald (1994); Fitzgerald & Dufour (1997); Kitchener, (2000); Hoff (1999) and Doolin, (2001) for example found that the clinician-manager experience difficulties with colleagues over both professional and managerial matters with legitimacy being a particular issue.

[29] For example see Baeza's work on the restructuring of the medical profession.

Chapter Summary

What has been demonstrated so far is that since its creation, the funding of the NHS has been a constant issue of debate. Indeed the history of the NHS is that of an organisation, noble in conception, but faced with financial crisis on the one hand due to rapid advances in technological innovations and medical knowledge, and on the other, the financial restrictions that inevitably rise from a centrally funded service, changing management dogmas and political beliefs. Cost, provision and resource allocation of health services therefore have been a major focus of political and public discussions for many years.

Health policy from the inception of the NHS in 1948 to the election of the Conservative government under the leadership of Margaret Thatcher in 1979 was characterised by successive adjustments to the original design of the NHS and fine tuning of its administration (Ham, 1999). The election of the Conservative government coupled with the emergence of major financial funding pressure led to a powerful critique of healthcare policy, funding, management and in particular the use of resources (Baggott, 2004).

As the Conservative government under the leadership of Margaret Thatcher progressed, it became increasingly clear that avoiding confrontation with the medical profession over escalating healthcare costs might outweigh any political costs. It was recognised that, while the emphasis on increasing and strengthening management processes might improve efficiency and allow the NHS to cope with increasing demand within any given budget and that the development of a private sector strand of healthcare provision might provide a safety valve, these strategies in themselves would

not necessarily address the inexorable upward surge of cost and demand. This concern provoked reviews and reform initiatives which were primarily designed to push down expenditure, introduce means to optimise the delivery of scarce resources, promote efficiency and productivity and increase financial accountability (Doig, 1999).

A distinctive feature in the UK is the extent to which its health service is state owned and run and the extent to which government pays the costs. Historically, the government and the medical profession operated an implicit pact whereby the government set the budget and the healthcare professionals spent it. The management and quality of healthcare service provision was largely left to the professionals provided each did not challenge the other (Klein, 2000). By the start of the 1980's the historical management arrangement set out above had started to change and the government through institutional bodies adopted an increasingly direct role to improve the quality and performance of healthcare institutions.

While the reforms initially were not targeted at challenging the power of the medical profession, by the end of the Thatcher era this had taken a turn. By the end of the 1980's many clinicians had become involved in the management process through the introduction of clinical directorates thus imposing a requirement of financial accountability on the profession. Under this new system clinical autonomy is preserved but made more visible through financial calculation and accountability. The introduction of clinical governance, medical audits and performance programmes and the continuing swathe of NHS reforms by successive governments served to further challenge the power of the medical profession. The successful introduction of the

limited list was one of the first indicators of a fundamental shift in the balance of power between the Government and the medical profession.

A key feature of the NHS reforms has been the introduction of a number of policy initiatives that have attempted to direct professional activity and spending using 'peer pressure, rewards, regulation or the threat of sanctions to induce changes' (Moon & North, 2000: 86). Collectively, the introduction of such initiatives signified a loss of confidence in, although not a complete rejection of, the professional model of recourse to external regulators and models of financial accountability. This trend not only reflects the government's growing interest in regulating doctors' performance and financial accountability to state and society, but also the public perception of the fallibility of medicine. The trend of increased regulation and accountability can also be located in the redefining of government's role and encouragement of increased pluralism in healthcare provision (Moon and North, 2000: 86).

It is clear that the NHS while noble in its conception has been beset with problems in terms of its structure, availability of funding, excessive demand, difficulties in exercising and maintaining control and the entrenched position of the medical profession. Concerns over efficiency, effectiveness, and financial accountability have been common concerns for successive government. The successive rounds of NHS reform sought to address these issues. Within the Scottish context, while similar in content, the principles of NPM initiatives appear in a more attenuated and muted form. Nevertheless, the introduction of NPM principles directed towards achieving efficiency, value for money and increased accountability had a dramatic effect on the underlying ideology and vocabulary of healthcare organisation.

The organisation and effects of NPM on healthcare and the inter-professional relationships however, has been relatively neglected within the sociological literature (Cox, 1992). The principle aims of this study considers the power effects of management discourses associated with healthcare reforms and discusses how the control of clinical activity through the discursive shaping of clinical subjectivity can occur. It further explores the impact of managerial discourses on the negotiated order within the context of the hospital and how such individuals manoeuvre in relation to such discourses. The theoretical framework that underpins the argument that the professional boundaries of the medical profession have changed as a result of NHS reforms and increased financial accountability will be presented in the following chapter.

Chapter Three: Elaboration of the Research Strategy

Regarding the theoretical framework for this study the chosen approach is based upon the literature of the sociology of the professions and critical interpretivism. The rationale for this choice hinges on its applicability to the argument of changing professional boundaries as a result of New Public Management (NPM) discourses and financial accountability being imposed on the medical profession. The purpose of this chapter is to demonstrate the relevance of this approach to the research project. The chapter provides an exploration of the ways in which social theory has been applied to healthcare and addresses the question why social theory can be a useful tool in the study of professional boundaries in pharmacy and medicine. Following this, attention is drawn to key aspects of the nature of sociological thinking and their relevance to this study. The chapter hereafter provides an outline of the research method, case study approach and data collection method. The chapter concludes with a statement of the study's contribution to research in this area and an overview of the research approach.

Research Methodology

According to Taylor & Bogden methodology '*refers to the way in which we approach problems and seek answers...and applies to how one conducts research*' (Taylor & Bogden, 1984, p1). In approaching research it is necessary for researchers to make clear and deliberate choices with regard to the nature of the research project and how they view the issue being researched (Laughlin, 1995). Such choices involve making assumptions with regard to what constitutes knowledge and how this relates to the investigation (epistemology) and the 'nature and reality' of the social world (ontology)

(Laughlin, 1995, p66). Epistemology is concerned with 'what is the nature of the relationship between the knower or would-be knower and what can be known?' (Hopper & Powell, 1985) and precedes research methodology (Burrell& Morgan, 1979; Gill and Johnson, 1997). The epistemological and ontological assumptions of the researcher influence and shape the methodological approach adopted for the study (Hopper & Powell, 1985). Thus, determining a suitable theoretical framework is based on the researcher's beliefs of the nature of the social world and society (Burrell & Morgan (1979).

Sociology Defined

There is an abundance of sociological perspectives which makes defining sociology problematic. Sociology in the simplest term can be viewed as the science of society. The word sociology is a hybrid derived from the Latin *socius* (companion, associate) and the Greek λογος (that by which the inward thought is expressed), i.e. the expression of thoughts about *socii*, one's peers. It is concerned with the nature of social structure, historical developments of society and the relationship between self and society. As such it seeks to examine, explain and understand both the individual's contribution to and interpretation of society and society's effect on individuals.

Defining the boundaries of sociology as a discipline is also problematic as it overlaps with many other social science disciplines including, economics, psychology, political science, cultural studies, anthropology to name a few. As a discipline that relates to the study of society, considerable boundary encroachment and cross fertilisation with social science and the humanities occurs (Cuff et al, 1998). The drawing on and importing of ideas, concepts and importantly everyday discourse thus makes it difficult

to pin down and renders it somewhat amorphous. Sociology deals with real world issues and discourses which are ongoing, transient and affected by popular culture and current political debate and thus exposes its subject matter to academic disputes.

Sociologists aim to identify and frame problems rather than producing facts, certainty or objectivity in their research findings. This is the result of the fact that there is no one overarching sociological theory, a point which has resulted in sustained criticisms of the discipline. Rather it consists of a set of highly differentiated and contested theoretical perspectives regarding the social world. These include functionalism, symbolic interactionism, ethnomethodology, Marxism, post-structuralism, post-modernism, structuration theory, feminism and critical theory. The fact that it embraces competing paradigms does not render it intellectually frail but rather reflects its intellectual vibrancy. It does however; pose difficulties in determining the most appropriate way to cut a path through the competing theoretical approaches.

One road forward is to consider how theories conceptualise key issues, for example the relationship between 'structure' and 'agency'. Social structure can be defined as 'any recurring pattern of social behaviour or the ordered interrelationships between different elements of a social system or society. For example, 'different kinship, religious, economic, political and other institutions of a society may be said to constitute a social structure' (Marshall, 1995). From this perspective sociologists are interested in addressing issues such as: what is the structure of this particular society as a whole? In contrast, agency is concerned with the power of actors (individuals) to operate independently regardless of the constraints of social structures. The fundamental concern of the structure – agency divide is how the wider society influences

individual's thoughts, behaviour and actions and further how such thoughts, behaviours and actions actively shape society.

In order to understand ourselves as individuals, Mills (1995), argued that an appreciation and understanding of our involvement in the historical development of social institutions and structures is necessary. Halford and Leonard (2006, p657) suggest; '*Human identities are constructed from a range of positions;... each of us is subject to diverse and sometimes competing discourses which constitute our identity in multiple and fractured ways*'. Furthermore in order to understand and fully comprehend the nature of institutions and structures an appreciation of how they are sustained through individual action and behaviour is required. This is exemplified by Giddens (2000) who argues that it is the business of sociology to analyse social orders which constrain our behaviour, but at the same time to acknowledge that we actively make our own history.

Sociology in Healthcare

In the early days of sociology, social scientists and sociologists were considered to be handmaidens to medicine and insufficiently critical in as much as they researched issues that for example, helped to shed light on patient compliance or health promotion but failed to illuminate the underpinning assumptions and values of much medical practice (Annandale, 1998), thus adopting the perspective and assumptions of the doctors rather than a critique of their practices. This major shortcoming was the result of the belief that the technical and (supposedly) subjective nature of medicine was beyond the remit of sociologists.

Increasing awareness on the part of individuals of the limitations of medicine, the medical profession and the extent to which medicine has been regarded as the underpinnings and reinforcing power of wider relations within society have resulted in this view becoming superseded. Indeed the 1970s and 1980's witnessed an alternative social model of illness, health and healthcare which sought to subject healthcare to a thorough sociological critique. This period marked out a new found confidence that challenged the conservatism of Parsonian theory[30] and the general acceptance of medical definitions (Gabe et al, 1993, p3). Furthermore, at a macro level a more critical perspective of the power of the medical profession which questioned the legitimacy and benign form of social control that arose due to the medical professions claim to expertise and power also started to emerge (e.g. Navarro, 1976; Johnson, 1977).

Sociologically based research within healthcare is not solely concerned with supporting and reinforcing the practices of clinicians, pharmacists and other healthcare occupational groups. Rather it is explicitly concerned with power. In particular it is concerned with the nature of power, for example, where it is held and by who, how it is dispersed through the healthcare system, how power operates and preserves order, how it shapes individual behaviour and how individuals resist the actions of powerful groups. Applying social theory to the research of such questions can result in responses that do not simply address questions posed by policy makers but can be critical of existing health care policy and practices thus as Giddens argues, social theory is a critical discipline which has a subversive quality to it (Giddens, 2000).

[30] Parsons used health and healthcare as examples of the general working of the social system. Within this context health became sociologically defined as being central to the (life) value system and medicine to the pattern of social control (Gabe et al, 1993, p2).

In relation to this study, the questions that the application of social theory raises include how clinical decisions regarding drug therapeutic regimes are determined, and how they are challenged, circumvented or accepted. Additionally, what do the answers to these questions tell us about the exercise of power and the maintenance of the social order within the healthcare system? It was envisaged that the application of social theory to these types of research questions would uncover uncomfortable issues that go beyond policy makers' ability to respond appropriately. It was also envisaged that this approach would shed light on the contours and dynamics of the power relationship and thus provide a deeper and richer understanding of the contested nature of expert systems such as medicine and pharmacy.

Healthcare Professionals

As discussed in chapter 2 the recessions of the 1980's and the inexorable rise of healthcare expenditure placed a strain of the relationship between government and healthcare professionals. During this period the government were increasingly viewing the medical profession as a formidable opponent in the development of healthcare policy. The healthcare reforms initiated by the Thatcher government were perceived by many as an attack on the power of the professionals (Fowler, 1991). It is for this reason that the responses of clinicians to the healthcare reforms is of interest.

While the research is grounded in a desire to gain a better understanding of the impact of NPM discourses[31] and financial accountability on the relationship between hospital

[31] A discourse is a structured set of text and practices which are formed, dispersed and assimilated by actors in a way which constructs objects and subjects in the social world (Fairclough, 1992)[31]. Managerial discourses can be located in a variety of forms such as policy documents, individual narratives, government modernisation programmes and so on.

pharmacists and clinicians, it does not do so without considering the power relations that form the organisational process. Organisational structures such as the National Health Service (NHS) are constructed, changed and reproduced within historical and spatially defined conditions of possibility (Knights & Willmott, 1989).

Historically, the role of the professions within public services has been pivotal to their development. Indeed within the NHS doctors have played a major role to the extent that a central and prevailing characteristic of the NHS is the dominance of the medical profession. 'Medical authority became synonymous with the service and institutionalised in ways that enabled medical professionals to control management, through presenting definitions of issues that reinforced their own authority' (Klein, 1989).

Traditional explanatory approaches to the examination of the professions conceptualised that professionals and in particular medical professionals '*can be distinguished from other social groups by their sense of personal service to others and altruism, rather than the desire for economic reward; that they are collectively orientated rather than self orientated*' (Gillespie, 1997: 86). The power of the professions was perceived to be in terms of their ability to achieve social closure, regulate their own education and accountability to each other (Macdonald, 1995). Prevailing concepts of the professionals and professional power within healthcare suffer from the characterisation of the nature of the professions in terms of a trend at a certain point of time in history (Light, 1995). 'Professional dominance', 'proletarianisation', 'deprofessionalisation' are examples of this problem.

A recurring theme in the professionalisation and health policy literature during the 1960's and 1970s is the portrayal of medical power and dominance as an entrenched feature of the healthcare system (Alford, 1975). During this period little attention was paid to other healthcare professionals such as pharmacists. If it appeared at all, it was typically as a marginalised or failed profession (Salvage, 1988). Studies of health policy during the same period emphasise the monopoly of legitimacy relative to other healthcare professionals enjoyed by doctors in the development of health policy and their ability to block change at both national and local levels (e.g. Klein, 1974; Haywood and Alaszewski, 1980; Ham, 1981). Indeed there was little suggestion within the literature that medical authority or dominance might be or would become challenged (Elston, 1993).

NPM Discourses

As discussed in chapter 2, healthcare reform involved the corporatisation and contractualisation of social relations. Within the reforms, attempts were made to make clinicians in the hospital setting more accountable for their clinical decisions and resources consumed by integrating them into some system of organisational control. Management focus towards an increasingly rational organisational culture through quantitative and economic analysis resulted in NPM discourses, budgeting and financial accountability becoming an integral part of the organisational process.

Organisations are socially constructed environments from networks of dialogues and discourses. Discourse[32] is the mobilisation of 'language by talking, listening and

[32] Fairclough, (2000) states that, 'discourses include representations of how things are and have been, as well as imaginaries – representations of how things might or could or should be'.

constructing meaning' and is considered here not only as 'a process in an organisation, but organisation itself' (Rhodes, 2000, p217). Organisations, however, are not discursively monolithic; rather they are polyphonic and pluralistic entities in which 'ambiguity within discourses is common-place and where resulting incoherence is normal' (Mueller, 2004, p76). As such, it is unsurprising that management and accounting are drawn into the reform agenda and that this course of action entails the rhetorical construction of issues and seemingly uses of rational augmentation (Shapiro, 1998).

Managerial discourses and financial accountability are regarded as being important components in the shaping of shared meanings, beliefs, values and distribution of power within organisations (Preston, 1995, p273). Indeed Covaleski and Dirsmith argue that 'accounting serves as a myth or symbol that is complicit in the construction of a fluid, social reality' (Covaleski & Dirsmith, 1990, p 545). In this respect, managerial discourses, budgets, financial accountability and information are symbolic representations of reality and carry meaning which may be communicated to other organisational actors (Preston, 1995, p281). The way, in which rudiments of the organisational process, as symbols, are supplicated, range from internal, manifest symbols to external latent symbols. For example, Wildavsky (1964, 1975, & 1979) argues that budgets and systems of financial accountability achieve many purposes beyond realising control, that they are sources of power and provide political advocacy to both budgetees and financial controllers in the financial resource allocation process[33].

[33] See also March & Simon, 1958; Pfeffer & Salancik, 1974; Hackman, 1985; and Jonsson, 1982.

According to Parker, discourse of NPM, can be considered as a '*generalised technology of control*' and further as a '*hegemonic model of organisation*' (Parker, 2002, p184) that results in such discourses assuming a degree of hegemonic totality (Spicer & Bohm, 2007, p10). Managerial discourses therefore can be considered as counter-hegemonic movements (Hindness, 1996). Despite the apparent extensive reach of NPM discourses into the NHS, a growing body of research demonstrates that such discourses remain open to hegemonic struggles and are subject to resistance and contestation (Rosenthal, 2001). For example, Foucauldian studies[34] of the workplace illustrate how managerial discourses are contested and resisted. Within such studies contestation and resistance are shown to occur as actors who are subject to managerial discourses attempt to challenge and circumvent their unity by seeking to '*articulate and develop chains of equivalence amongst diverse struggles*' (Willmott, 2005, p772). It is for this reason that the responses of the medical profession to the imposition of NPM discourses into their working practices and resultant effects on their status and relationship with other allied healthcare professionals, namely pharmacists, is of interest.

Critical Interpretivism

The research approach adopted for this study is based on the sociology of the professions and critical interpretivism. From an interpretive perspective, human actions are considered to be the outcome of external influences (Smith, 2004, p4). Such actions have both intentions and reflections which occur within a system of rules that bind the actors. Gill and Johnson, argue that the interpretative approach aims to '*understand how people make sense of their worlds, with human action being conceived as*

[34] E.g. Knights & MacCabe 2000, Ackroyd & Thomson, 1999, Knights & Willmott, 1989).

purposive and meaningful' (Gill and Johnson, 1997, p126) Interpretive social science therefore seeks to ascertain why actors behave in certain ways by unearthing the largely tacit, mutual knowledge, symbolic meanings, motives and rules which govern their behaviour (Blaikie, 2000, p115). Burrell and Morgan (1979) define the interpretative approach thus:

> 'Its subjective approach to the analysis of the social world makes its links with this sociology often implicit rather than explicit. The interpretive paradigm is informed by a concern to understand the world as it is, to understand the fundamental nature of the social world at the level of subjective experience. It seeks explanation within the realm of individual consciousness and subjectivity', (Burrell & Morgan, 1979, p28).

Underpinning the critical interpretative approach is the belief that knowledge acquired and transmitted should also be understood from the actor's point of view. Critical interpretivism is thus an approach that '*appreciates social phenomena from the standpoint of actors who are engaged in routine construction and reproduction of social worlds*' (Hopper & Storey, 1987, p438). Critical interpretivism assumes that multiple realities, which are made problematic through distorted communications, exist. Meanings are found in language and social behaviour which go before logic and fact. Interpretivism thus depends on language, common sense and the actors' reflexivity in understanding a social context (Covaleski & Dirsmith, 1990, p552).

Critical interpretivism enables a focus on organisational processes such as NPM and financial accountability and how the reality of such processes are produced and reproduced by organisational actors (Colville, 1981). Such an approach thus offers the possibility to generate an understanding of management and accounting in practice from the actors' perspective, and facilitates analysis of how this is woven into a wider social framework (Chua, 1986b).

Managerial processes and financial accountability are not natural phenomena; rather they are socially constructed and thus can be altered by social actors (Chua, 1986a). It is necessary therefore to consider the relationship between various aspects of social arrangement and day to day social action (Ryan *et al*, 1992, p63). To study the effects of managerialism and financial accountability from this perspective it is necessary to locate current policy in its economic, social, organisational, as well as its historical, contexts. A holistic orientation, in which managerialism and financial accountability are considered part of a unified social system, is therefore required.

The core ontological assumption of this research is to view reality as a realm of symbolic discourse, wherein managerial discourses and financial accountability are utilised as a symbol and as a social construction which are actively deployed to express conformity to both societal and organisational expectations. The critical interpretive approach thus permits investigation of the phenomena of interest. It is concerned with investigating and strengthening the conditions of social life. From a management perspective this could involve a better understanding of why NPM discourses, budgets and financial accountability are linked so closely to the drive for economic efficiency and why financial control is regarded as a technical activity rather than a social process (Ryan *et al*, 1992, p64). Further, it should facilitate clearer understanding that the altruism of organisational actors is to a large extent a consequence of existing forms of organisational control, as a situation which necessitates the need for control. In the following sections the research approach for this research project and the rationale for its adoption will be presented.

Research Method and Design

This study is focused on the changing professional boundaries of pharmacists and clinicians within secondary care. The study is an exploratory and interpretative process which was motivated principally by the intention to cover as much of a broad range of issues and views as was feasible from key actors in medicine resource management. To gain an in-depth understanding of the effects of NPM discourses and financial accountability on the relationship between these two groups of healthcare professionals a qualitative approach has been adopted. The qualitative paradigm has been adopted as it permits researchers to observe actors behaviours and actions in their day to day activities (Schutz, 1967) and enables understanding of events in terms of how and why they occur (Cassel & Symon, 1994). As discussed in the previous section the interpretative approach attempts to '*understand how people make sense of their worlds, with human action being conceived as purposive and meaningful*' (Gill & Johnson, 1997, p126). Strauss and Corbin (1998) stress the importance of theoretical sensitivity of the phenomena under investigation within this approach. The theoretical framework adopted for this study provides basic propositions that enable a focus on relevant data collection methods which will be discussed next.

Why a Case Study?

> 'Case study research is remarkably hard, even, though case studies have traditionally been considered to be 'soft' research. Paradoxically, the 'softer' a research technique, the harder it is to do' (Yin, 1984, p26).

The adoption of a case study was chosen for this investigation for the following reasons. Firstly, case study research is a well recognised method of investigation which facilitates the study of phenomena in more depth and is amenable to the study of public

sector organisations such as the NHS (Kaplan 1986). In studying NPM discourses and financial accountability within professional relationships the interactions are complex. Langfield-Smith concluded that in such circumstances, in-depth (case based) research offered the best possibility of gaining understanding and insight into the complex nature of these relationships (Langfield-Smith, 1987, p228). Also, the strengths of case study research are that it permits the detailed study of all aspects of an individual case as opposed to being focused on measuring a few characteristics (Malim & Birch, 1997). In addition it is proposed that the in-depth data collection methods can give a perspective that may otherwise have been missed by other methods. As the data are gathered from a variety of sources, the results are more likely to be grounded in reality and guard against observer bias (Eisenhardt, 1989). Case study research also has the advantage of bringing to the fore the research questions that need to be addressed and emphasises the relationship between these questions and the conceptual framework of the study (Robson, 1998, p146-166).

In examining contemporary events within public sector research the case study method is preferred when the relevant behaviours cannot be manipulated (Yin, 1994, p8). While case study research relies on many of the same techniques as those used in other social science subjects it also adds two sources of evidence: direct observation and systematic interviewing (Yin, 1994, p8). This allows the observation of practices and procedures in operation and to assess their appropriateness and effectiveness. The use of systematic interviews can also be used in a variety of contexts and situations that puts the researcher face to face with the participant thus reducing any misinterpretation of the question.

Finally, the case study method was also chosen for its unique strength and its ability to deal with a variety of evidence beyond that which may be available in the conventional research setting, and because it is especially well suited to small scale research projects (Platt, 1988, p1-23). The fluidity and flexibility of case study design are also major advantages. The fact that it takes place within a natural setting such as a public sector organisation gives the work reality which is often absent from other similar types of investigation. The case study considers the whole situation enabling the researcher to assess the inter-relations of the organisation as they occur and provides evidence to show how both the rule and its exceptions operate (Stoecker, 1991, p89-112).

With regard to this study the case study method was therefore chosen as it permits the collection of data from study participants in their organisational environment and provides the flexibility to explore issues related to the phenomena under study from their perspective.

The case study setting is NHS Scotland. For reasons of confidentiality the name of individual hospital sites will not be stated. The hospital sites were located within lowland Scotland. Four of the sites were Acute General Hospitals, one psychiatric and one children's hospital. A pharmacy department was present at each of the hospital sites. The study seeks to examine the effects of NPM discourses and financial accountability on the professional boundaries of pharmacists and clinicians within secondary care. For this reason, the study focused on hospital pharmacy personnel and clinicians for data gathering.

Study Aims and Objectives

The particular areas that the study addressed are as follows; investigation into NHS reforms and NPM initiatives directed at controlling the activities of clinicians; the nature and power of the hospital clinicians, and the role and influence of clinical pharmacists on clinicians prescribing behaviour.

The study focuses on how the discursive nature of NPM techniques and language are implicated in controlling the activities and partisanship of pharmacists and clinicians within secondary care; and considers the power effects of management discourses associated with healthcare reforms and discusses how the control of clinical activity through the discursive shaping of clinical subjectivity can occur. It further explores the impact of managerial discourses on the negotiated order within the context of the hospital and how such individuals manoeuvre in relation to such discourses.

The principal aims of this study can be summarised as follows:

- To assess the effect of NPM and financial accountability initiatives on pharmacy as a healthcare profession and their effects on hospital clinicians;
- Explore the role of the clinical pharmacists and their influence in the prescribing decisions of clinicians;
- And to assess the impact of NPM initiatives and financial accountability on the status of hospital clinicians and their relationship with pharmacists.

In order to achieve these aims the following research questions were utilised to define the scope and focus of the investigation:

- How, and in what ways, will present trends in healthcare policy impact the occupational status of pharmacists?

- Are there boundary disputes between pharmacy and other medical professionals?
- To what extent do boundary disputes with other medical professionals impinge on pharmacy's ability to take on new roles and responsibilities?
- Do occupational boundary disputes limit the pharmacists' scope to recommend alternative treatments?

Study Motivations

The conception and research motivations of this study arose out of the researcher's previous working experience within the pharmacy profession in retail, which was followed by a spell in pharmaceutical research before entering into hospital pharmacy within the Edinburgh region at the beginning of the 1980's. The role held by the researcher at this time took her on a regular basis' to five hospitals within the region to perform a number of activities which included ward rounds and contact with the clinicians. Within the period 1980 to 1990, significant changes within hospital pharmacy were taking place and were witnessed by the researcher. This period was particularly exciting for pharmacy as it was during this time that it became freed from the constraints of budget responsibility and opportunities for professional advancements became available. Indeed, the Chief Regional Pharmacist, at the time actively pushed the development of hospital pharmacy with the support of senior pharmacy managers within the region. The researcher during this time witnessed debates and conflicts both within the pharmacy profession and between senior pharmacy personnel and the hospital clinicians. Due to this experience the researcher was motivated and interested to investigate how hospital pharmacy, as a healthcare

profession, had responded to NHS reforms and continued with its professional development. Such previous experience also added richness to the data analysis[35].

Research Method

Addressing these aims required a longitudinal study which was conducted over the period 2003-2008. Examination of the discursive practice and subjectivities enables access to the processes of wider organisational and external discourses (Ball & Wilson, 2000). It is envisaged that such an approach will facilitate an understanding of the organisation, power and subjectivity that may be meaningful beyond the confines of one location. This approach should further provide an explanation of professional identities, as being continually constituted and reconstituted through managerial discourses.

A discourse is a structured set of text and practices which are formed, dispersed and assimilated by actors in a way which constructs objects and subjects in the social world (Fairclough, 1992)[36]. Managerial discourses can be located in a variety of forms such as policy documents, individual narratives, government modernisation programmes and so on. Hence in seeking to achieve the aims of this study information was gathered through investigation into available reports, studies and government White Papers concerned with NHS reforms and UK health policy. A literature review was undertaken to establish the key actors in medicine resource management and to identify the political and environmental pressures that have determined the existing policies and practices. The role and influence of clinical pharmacists in medicine

[35] Caution however, was exercised to ensure that bias was not introduced into the interviews and data analysis by allowing the interviewees to direct the conversation and where possible to confirm the researchers interpretation of the conversation.
[36] See also Fairclough 2000.

resource management and their contribution to current practice was also assessed through an examination of available literature. An investigation into the processes involved in medicine resource management and the interactions and involvement of clinicians and pharmacy within these processes was also conducted. Other aspects that were considered include pharmacy's role in establishing national drug formularies, guidelines, protocols and evaluation of medicine usage, pharmaceutical needs assessments and the use of newly prescribed medicines.

An important factor in determining the method of data collection and analysis is the nature of the research. The methods employed within this study to examine the relationship between clinical pharmacists and clinicians followed Denzin's (1978) tripartite research methodology. Denzin argues that '*no single method is free from flaws – no single method will adequately handle all the problems ...and no single method will yield all the data necessary*' (Denzin, 1970, p3). This study is thus based on evidence gathered information from three sources:

- Interviews with clinical pharmacists;
- Interviews with clinicians (particularly those in control of the budget); and
- By the use of available literature and documentary evidence.

Although case study research and interview methods have been criticised on a number of fronts which include validity; reliability; forms of bias; and generalisability, Hopwood, 1983; Otley, 1984; Scapens, 1990 and Hopper & Powell, 1985 argue that qualitative methods such as these can make substantial contributions to NPM and accounting research.

With regard to issues of validity, Yin, 1994, devised four design tests to address validity concerns. These include tests to ensure:

- Construct validity; by establishing correct operational measures for concepts under study,
- Internal validity[37]; by ascertaining causal relationships, whereby certain conditions are revealed as leading to other conditions,
- External validity; identifying the domain to which the research findings can be generalised, and
- Reliability through demonstrating that the data collection procedures can be repeated with the same results.

Interview bias can come from three sources;

- The interviewer through a misinterpretation of the interviewee's responses;
- The interviewee who may give response that he thinks the interviewer wishes or expects to hear; and
- The situation[38]: circumstances whereby the interviewee does not feel at ease and comfortable in answering the interview questions and as a result may give answers that are lacking in detail or are inaccurate (Sekaran, 1992).

As this study involved the use of interviews an attempt was made to avoid issues of interview bias by making the participant aware of the objectives of the study; establishing trust by ensuring participants were aware that their responses would be confidential and not communicated to other study participants; allowing participants to respond freely and openly; and conducting the interviews at a time and place that suited the participant.

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[37] Applies to explanatory or causal studies only.
[38] Situation bias can result from the interviewee feeling exposed and compromised if the interview is taking place within ear distance of other people.

With regard to the issue of generalisation, within case study research generalisation is not the main objective of the researchers. Indeed Otley and Berry argue that '*it is fair to note that generalisation is not the prime concern of researchers using this approach*' (Otley & Berry, 1994, p50). Within this research the objective of utilising the case study approach is not to locate a universal truth that explains NHS reforms and the drive for financial accountability but rather to gain an in-depth understanding of the effects of NPM discourses and financial accountability on the relationship between pharmacists and clinicians.

Whilst each method of investigation was undertaken with normal academic care, not all were utilised as extensively as they would have been if they were the sole method of investigation. The reason for this being a constraint of time and resources. More significantly, the use of these methods were intended to produce an overview of the issues surrounding medicine resource management and to ascertain the general views, attitudes, experiences and observations of all the key actors to the changes that have taken place in medicine resource management and their perceptions of the effects on the inter-professional relationship between clinicians and hospital pharmacists. This includes discussions with members[39] of the National Institute for Health & Clinical Excellence, the National Prescribing Centre and the Drug and Therapeutic Committee.

Data Collection Methods

The study sought to investigate the everyday reality of the management of medicines with secondary care. Hence the research method selected was documentary and interview based. Documentary data was chosen in order to identify health care reform

[39] Such committees have clinical pharmacists and clinicians as members.

initiatives that had the potential to affect the power and autonomy of clinicians and their relationship with pharmacists. Yin, 1994, argues that documentary evidence is likely to be relevant to every case study project and is important in order to add information and corroborate evidence from other sources and thereby increases validity. With regard to this study the documentary sources provide two elements; background to the study and also empirical evidence in terms of the nature, evolution and position of pharmacy as a healthcare profession today.

The interviews were focused on the key actors who take part or have an interest in the management of the drugs budget. Data was collected through interviews with the key actors within pharmacy and the medical profession and organisations identified for the study. An interview can be likened to a conversation, albeit a conversation with a specific purpose (Kahn & Cannell, 1957). Cohen and Manion describe interviews as conversations '*initiated by the interviewer for the specific purpose of obtaining research-relevant information and focused by him on content specified by research objectives of systematic description, prediction or explanation*' (Cohen & Manion, 1994, p307).

The use of interviews, partly because of their relatively straightforward and non-problematic approach, is a common investigative method. As a flexible and adaptive approach the interview has an advantage over postal and questionnaire based methods as it offers the possibility to modifying the line of enquiry such as following up on interesting responses and investigation underlying motives in a way that the other methods cannot. Non verbal cues witnessed during the interview process may also aid understanding of the verbal response possible altering meaning or in extreme cases,

causing a reversal (Robson, 1998, p229). Interviews are often regarded as being the most appropriate method of gathering information as they can deal with more complex and wide ranging issues and enables the researcher to capture deeper thoughts, problems, insights and opinion which is not always possible with other data methods (Yin, 1994). Indeed, Burgess (1982, p107), noted the importance of interviews in his statement 'an interview is the opportunity for the researcher to probe deeply to uncover new clues, open up new dimensions of a problem and to secure vivid, accurate inclusive accounts that are based on personal experience'.

The design and construction of the interview questions were developed by drawing upon the issues identified by the literature review. The questions were devised with the objective of eliciting the views of the key actors and to track the dynamics of any cost containment and control efforts that may be in place. The questions formed the basis of the discussions held with the clinical pharmacists and clinicians and were divided into three main sections that dealt with matters concerning regulatory policy, prescribing practice and the issue of professional boundaries.

The interviews were conducted on field visits to the hospitals within NHS Scotland with participants identified for the study. The initial selection of both pharmacist and clinician participants was determined primarily by the Chief Regional Pharmacist and the Clinical Director who granted access to the sites. Once on site however, the participants readily directed the author to other colleagues who were willing to participate in the study. In total 38 interviews were conducted. The participants included 3 clinical directors, 6 senior clinicians and 7 junior clinicians, 3 directorate (clinical) pharmacists, 3 pharmacy managers, 8 clinical pharmacists, 6 pharmacist and

2 retired pharmacists. The participant type, interview timeline, and key labels used in the empirical chapters, 6 and 7 are summarised in the table 3.1 below.

Participant Type	Number	Key
Clinical Directors	3	CD
Senior Clinician	6	SC
Junior Clinician	7	JC
Directorate Clinical Pharmacist	3	DCP
Clinical Pharmacist	8	CP
Pharmacist	6	P
Pharmacy Manager	3	PM
Retired Pharmacist	2	RP

Table 3.1: Summary and Key of Study Participants

The majority of clinical pharmacists and clinicians, past [40]and present, proved extremely cooperative and readily agreed to participate in a short questionnaire based interview. The interviews were conducted individually and lasted from 1-2 hours. While the questions formed the basis of the interview, during these sessions both the clinical pharmacists and the clinicians directed the course of the discussion. The reflections of both groups yielded a wide variety of comments on their attitudes towards budgetary and prescribing practice and the management of medicines. There were several principal findings from the interviews which will be discussed in the following empirical chapters. Following the interview, the discussions were transcribed and summarized. Feedback on the transcribed interviews was sought from the participants, giving them opportunity to confirm the interview results. All interviews and replies were treated as confidential and non attributable. For this reason all

[40] Retired pharmacists were included as it was envisaged that they could provide information as to the professional relations between clinicians and pharmacists at the time when the control of the budget changed hands and the efforts of pharmacy to enhance its position as a healthcare profession.

interviewees are referred to as male[41]. Documentary reviews were used to supplement the interviews.

The author reviewed the empirical data several times to become both familiar with and to identify the emergent themes inductively. In order to conceptualise the interview data a simple coding procedure has been applied. Initial categories from the ideas and language used by the research participants have been developed. Data groups, patterns and comparisons to generate common properties and dimensions are then applied. Different themes within the empirical data will then be interpreted on several levels in an iterative process of interrelating theory with the data.

The interviews produced a large volume of qualitative data, from which clinical pharmacists and clinicians responses are analysed to reveal key issues. It was anticipated that the responses would reveal areas of convergence and divergence of opinions with regards to some of the policy changes that have taken place. In comparing the responses, differences of opinion on specific issues and controversies were illuminated. These findings add richness to our understanding of the management of medicines and the regulatory pressures which are not evident from the literature.

Considering the interpretative stance of the research, the objective during the analysis stage of the research process, is to crystallise the relationship between clinicians and pharmacists. The underlying philosophy of the study therefore mandates an iterative process of data analysis (Eisenhardt, 1989). The data analysis follows a four step

[41] The majority of pharmacist participants were female while the majority of clinician participants were male thus it is possible to interpret pharmacy as being a predominantly female gendered occupation. Gender however, is not the focus of this study. It does however; open up the possibility for further (future) research in this area.

'intentional analysis' procedure (Lacity & Janson, 1994, p146). Within step one, the facts[42] of the phenomenon are described. Step two of the process involves the determination of how the study participants attribute meaning to their separate realities. In step three, the key themes that emerged from the research are identified. These are then used to develop common interpretations. In step four, the researcher abstracts the distinctive elements (essences[43]) from the data. The validity of the interpretation is checked through methodological triangulation by cross checking the field notes, documentary sources and statements and feedback from the study participants. Finally, the research findings are presented in a narrative form to provide an overview of the perceptions of the clinical pharmacists and clinicians experiences in managing the costs of medicines by describing, analysing and interpreting the literature and interview results.

Study Limitations

The conception of this study as an exploratory and interpretative process was motivated principally by the intention to cover as much of a broad range of issues and views as was feasible from key actors in medicine resource management. The primary objective was to obtain a significant breadth of coverage of the issues relating to medicines resource management. This study therefore, does not have the precise and unique focus that would appear in a report of a single, well developed hypothesis. Rather, its principal object is to present a coherent interpretation of the findings of the investigation. These caveats arose from decisions over the structure and form of the study and the pattern of issues and views that emerged as it developed.

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[42] Facts are the socially shared realities shared by the study participants.
[43] 'Essences are wholly subjective gestalts of what is learned from studying the phenomenon, and requires creativity, intuition and reflection' (Kelliher, 2005, p128).

Study Contributions

The main purpose of the research is to understand and explain the views and practices of the key players in medicine resource management within the NHS, how they have responded to policy changes and government pressure and the resultant impact on their professional status. The empirical findings, the research method and design employed will be used to generate valuable information to explain and understand the perceptions of clinical pharmacists and clinicians in the drive towards rationalising prescribing and costs containment procedures. It is envisaged that the data will illuminate some professional and political tensions that may be hindering progress. This study will produce an overview of the changes that have taken place within medicine resource management and provide coverage of a number of related issues. The study also aims to close a gap in public sector research in the area of the professional relationships between the clinicians and clinical pharmacists in the management of medicines.

The study will be informed by a body of research contained within the sociology of the professions concerned with power, control and issues of discourse. This literature will play an important role in developing an understanding of the changing institutional context of the NHS and the penetration of NPM discourse into medical practice and discursive approaches to organisational analysis. The study thus can be usefully located within a body of research that considers the changing nature of professional roles and identities under the influence of NPM.

Chapter Summary

This chapter has presented the main objective of this research project: to examine the effects of NPM discourses and financial accountability on the professional boundaries of pharmacists and clinicians within secondary care. The research approach adopted for this study is based on the sociology of the professions and critical interpretivism. The rationale for this choice hinges on its applicability to the argument of changing professional boundaries as a result of NPM discourses and financial accountability being imposed on the medical profession. The study sought to investigate the everyday reality of the management of medicines with secondary care. Hence the research method selected was documentary and interview based. A case study method was adopted as it permits the collection of data from study participants in their organisational environment and provides the flexibility to explore issues related to the phenomena under study from their perspective.

These methods of investigation were employed for a number of reasons. Firstly, investigation into the literature was required to track any changes that may have occurred in the management of medicines and professional structures and to establish current practice. Secondly, the exploratory nature of the project counselled the use of interviews in order for wider matters to be explored. It was also envisaged that through such interviews new and unexpected issues may be unearthed. It was also considered that interviews were required to uncover attitudes towards cost containment measures from both the pharmacist and the clinician's point of view. Thirdly, there is the caveat that clinicians and clinical pharmacists as managers may have the perception that their actions are subjective which may distort the actual effectiveness of cost containment measures. With this in mind, triangulation was

sought by exploring the views of the separate constituencies involved in the management of medicines. For the purposes of this case study, the key ideas are presented in an accessible fashion rather than the production of an exhaustive account of this literature. Finally, this method was chosen as it was envisaged that one source of evidence to some extent would corroborate another (Stake, 1995). In the next chapter a brief discussion of the sociological perspectives of the professions as the underpinning of the study will be discussed.

Chapter Four: Sociological Perspectives on the Professions

The study of the professions has a long tradition and in particular can be found in the works of one of sociology's founding fathers, Emile Durkheim, in his discussion of professional ethics and the role and function of professions in society. However, early works on the study of the professions tended to be uncritical with regard to the way the professions operated to the extent that little systematic thinking of the concept of a profession took place until after the Second World War and the expansion of sociology as a discipline. This chapter seeks to highlight the contribution which sociological perspectives of the professions can make to our understanding of issues affecting pharmacy as a profession and its relationship with the medical profession. To facilitate this task, three broad phases of sociological activity will be distinguished. The first phase covers the time period from the end of the World War 2 through to the beginning of the 1960's. It was during this period that sociology as a discipline developed its distinctive base. The second phase is concerned with the period covering the late 1960's and through the 1970s, a period which witnessed new currents appearing within the discipline. The third phase continues from there picking up the context of sociological activity and debate through to present day. This is then followed with a focus on the pharmacy profession.

Post-war Sociology & the Functional System of Expertise

Sociology during this period was predominantly preoccupied with two main stands of investigations. The first strand concerned class based inequalities which underpinned poverty and impacted on community life. The second strand focussed on policy

oriented studies concerned with the equitable distribution, access to and uptake of welfare and health care services (Gabe et al, 1993). During this period the sociology of medicine existed in an embryonic form. Indeed sociologists of this period concerned with health and healthcare focussed on consolidating the health service and largely worked within the Fabian tradition of social reform (Stacey & Homans, 1978).

Research problems during this period tended to be defined directly by medically dominated funding agencies or public health specialists within the medical profession (Illsley, 1975) resulting in medical definitions of health and health care being taken for granted. Additionally, such research was also not regarded as mainstream to the sociological discipline (Johnson, 1975) and viewed as 'curiously uncurious' about the assumptions on which healthcare was based (Jeffreys, 1980). As a result medical sociology in Britain came under heavy criticism much of which came from their American counterparts who were paying much more attention to fundamental issues such as power and conflict within health care (Rex, 1961). During this period, medical sociology was thus struggling to establish an independent and firm intellectual footing to health and policy issues.

Talcott Parsons, was one of the first researchers to systematically study the professions and put forward the view that professions were 'the most important single component in the structure of modern societies' (Buxton, 1985). Parsons argued that the professions exercised a key social function in holding society together by applying scientific and rational knowledge to particular cases (Parsons, 1954). With respect to medicine Parsons did not focus on the technical proficiency of physicians, rather his attention was drawn more to their functionally specific role and specifically the social

role of the patient and the physician, a relationship which, according to Parsons, is consequently determine and maintained by the 'established structure and functional requirements of the social system' (Buxton, 1985). This approach permits the study of a social object that does not interfere with the study of medicine - a natural object.

Writers within this tradition identify altruism and community rather than self-orientation as significant professional functional traits for their role in society. Known as the 'traits analysis' this approach was highly popular during the 1960's. This approach regarded the role of the sociological researcher as listing the characteristics or traits of an ideal profession (Goode, 1957). On a more positivistic stratum, others developed a Guttman scale of professionalism (Hickson & Thomas, 1973).

Although highly compatible with functionalism, trait analysis was heavily criticised on a number of grounds. Such criticisms include the taking for granted the views of the professions themselves, the assumption that the client accepts the professionals view and ignores the potential for disagreement and conflict (O'Donnell, 1992). Further it is criticised on theoretical grounds as no two authorities agree exactly on what the characteristic or traits of a profession are (Dingwall & Wilson, 1995). Following this period more critical theories started to emerge.

Development of Critical Sociology & the Power Approach

From the late 1960's and through the 1970s rapid developments within sociological discipline took place. This process was aided by student unrest and the economic and cultural youth of the time. This period in particular marks the development of theoretical approaches e.g. the Frankfurt school of 'critical theory', phenomenology

and symbolic interactionism that began to challenge the dominance of structural functionalism that prevailed in British sociology and the beginnings of a more 'critical' sociology with specialists research areas such as medical and healthcare related projects appearing which could challenge the previously accepted medical definitions and the conservatism of Parsonian theory. Indeed, Phenomenology at the microsociological level for example, proved to be most influential within medical and healthcare research with much work focussing on the doctor-patient interaction (Gerhardt, 1989).

A more critical perspective at the macro level also emerged during this period. For example, Marxist analysis of medical power fuelled medical sociologists to reconsider the legitimacy of the medical profession's claim to expertise, power and benign form of social control (e.g. Navarro, 1976; Johnson, 1977). Adopters of the power approach argued that the professions reinforced the class system and limited opportunity for others and therefore represented unjustified elitism. Thus it was during this period that growing interest in how professionals and occupational groups managed to achieve and maintain a privileged position within society developed.

Friedson (1970), in particular, developed a wide ranging critique of the monopoly of medical profession over the definition and treatment of illness. Freidson attributed two interrelated dimensions to physicians' power: autonomy and dominance: '*Together are such as to give the professions a splendid isolation, indeed the opportunity to develop a protected insularity without peer among occupations lacking the same privileges*' (Freidson, 1988, p17). In the case of the medical profession, Freidson also argued that organised autonomy is '*also the freedom to regulate other occupations....By its*

position in the division of labour we can designate it as a dominate profession' (Freidson, 1988. p18).

The power approach, as a critique of functionalism, questions the degree to which the professional fulfils Parsons' criteria of altruism and rationality. As such it focuses on social interactions that constitute the systems of authority and power (Friedson, 1970, 1994). In particular, the strategies and tactics utilised by professionals to gain state support for self regulation and market control for their services are emphasised (Gabe et al, 2004). Friedson, in his critical explanation of professional power, focuses on the relationship between knowledge and power and views the professional as the central agent (Friedson, 1986). Knowledge is regarded as '*unfamiliar to and impenetrable by many and discussed by techniques of discourse that are opaque to outsiders*' and thus, in Freidsons view, inherently undemocratic and oppressive (Freidson, 1988). From either standpoint (in the case of Freidson, or Marxist such as Navarro), the power of the medical profession was regarded as requiring more accountability and if necessary regulation by the state.

Regulation and the Medical Profession

Freidson in his classic analysis of the rise of the medical profession used the term '*profession*' to denote both '*a special kind of occupation*' and '*an avowal or promise...of extraordinary trustworthiness of its members*' (Freidson, 1970, p17). Such a promise implied that professionals could be trusted to determine and deliver the best treatment for their patients without external control. Such a position also implies acceptance of occupational autonomy, self regulation and professionally controlled licensing (Freidson, 1970, p18).

Turner, (1987) suggests that the specialized and esoteric knowledge of medicine made it possible for the medical profession to make demands for self regulation and autonomy from the state arguing that the profession's knowledge must '*have a distinctive mystique which suggests that there is a certain professional attitude and competence which cannot be reduced merely to systematic and routinized knowledge*' (Turner, 1987, p.136). Indeed the state regularly used such an argument to justify the level of autonomy afforded to the medical profession.

Within bureaucratic organizations there is an expectation that subordinates will respond to and comply with the directions and instruction of officials. Within healthcare however, this expectation does not hold true with regard to the medical profession and NHS officials. Medical professionals '*expect to be autonomous and self-directing, subject only to the constraints of competent knowledge and skill related to their task. They can accept advice, perhaps even orders, if it stems from someone of competence, but it is only competence, not official position as an administrative superior that is accepted as the source of effective authority over work*' (Freidson, 1986, p159). Although this may be a somewhat over exaggerated view of level of dominance of the medical profession by Freidson, it is nevertheless true to say that the medical profession has successfully secured a powerful niche within most healthcare systems.

The work of Freidson on the medical profession however, raised questions over the rationality of the acceptance of this position and whether the nature of the medical professions work justified their power, status and self regulation. Freidson's work thus ushered in a new wave of sociological analyses of the profession in the form of

Weberian and Marxists studies that, rather than focusing on the nature of work, considered the acquisition of professional privilege as being contingent on social and political processes (e.g. Starr 1982; Waddington, 1984). Within much of this critical literature, the professions claims of the need for occupational autonomy, self regulation and professionally controlled licensing are viewed in ideological terms that served to give weight to the professions strategy to gain and maintain authority and status (Gabe *et al.* 1994). It is evident within chapter 6 that many medical professionals still perceive that their medical expertise and altruistic nature of their service provides justification for the maintenance of self regulation and autonomy.

Within such literature it is further recognized that the level of autonomy and self regulation held by the medical profession is not absolute, but dependent on the government and thus can be subjected to change. Strauss *et al*, (1964), for example, argue that social and negotiated orders are present both within and outside of the organisation. In subsequent work, Strauss, (1978), observed that 'organisational rules and procedures have temporary limits and will be reviewed, revised, revoked, or renewed over time' (Rahaman & Lawrence, 2001, p150), thus demonstrating that social orders and negotiations within organisations are continuous events and subject to change.

Self regulation of the medical profession previously was achieved through the professions economic and political power and government sponsorship. Economic and political changes, however, have the potential to affect the level of autonomy and self regulation held by the medical profession (Slater, 1998). Thus it is not the medical profession alone that decides whether it will maintain its privileged position. Indeed

recent debates over medical autonomy and self regulation illustrate this as a potential vulnerability of the profession (Smith, 1998; Gray & Harrison, 2004). Such debates indicate that the professions autonomy is not unquestionable but rather requires justification and defending (Slater, 1998).

This shift in emphasis led to criticism of medical sociology itself with the claim that it was searching, focusing on and exaggerating negative aspects of medical practice to enhance its own professional purpose and thus had become imperialistic (Strong, 1979). Nevertheless, the potency of critically examining the power of the medical profession prevailed with many sociologists applying structural analysis or ethnographic field work to this area rather than researching policy development or enactment (Gabe et al, 1993). Indeed this period also witnessed a protracted debate on contemporary status of the medical profession with theories of proletarianisation and deprofessionalisation which contested Freidson's theory of professional dominance appearing (Annadale, 1988).

Proletarianisation and Deprofessionalisation

The concept of proletarianisation emerged from Marxist theory of the labour process. Marxists writers argue that the medical profession is succumbing to the logic of capitalism, resulting in a transformation of the labour process equivalent to that put forward by Marx. Recent sociology[44] views proletarianisation as a process by which the labour of middle class workers becomes comparable to that of manual workers. For example, with regard to medicine in the USA, McKinlay (1977) argues that the incorporation of physicians into healthcare institutions means that physicians no longer

[44] For example see Knights & Willmott, 1989, Gabe et al, 2004, and Harrison & Checkland, 2009.

operate altruistically but rather, like any other worker, are employees of the institution and have thus been proletarianised. McKinley also agues that transformations in organisational structures has resulted in medicine becoming increasingly subjected to a process of rationalisation as evidenced in the transfer of many technical aspects to less qualified occupations groups such as nursing. This it is argued coupled with the development of new complex treatments and technologies that are regulated through agencies such as NICE, has altered the independence and level of control and autonomy of physicians (McKinlay & Stoeckle, 1988).

> 'The process by which an occupational category is divested of control over certain prerogatives relating to the location, content and essentiality of its task activities, thereby subordinating it to the broader requirements of production under advanced capitalism' (McKinlay and Stoeckle, 1988).

While it is recognised that there has been a shift towards employee status within medicine, critics of the proletarianisation thesis argue that proletarian workers do not have the same level of knowledge, control over others or marketable skills as physicians. Further more, physicians in contrast to genuine proletarians, have the ability to determine and shape their own future and therefore does not necessarily mean that the medical profession has become proletarianised (Annandale, 1998).

In contrast to the proletarianisation thesis, deprofessionalisation theory within the medical profession is not drawn specifically from general theories of social change but is rather based on the critical attitudes of the public to professional paternalism as a result of trends towards the rationalisation and codification of expert knowledge. Deprofessionalisation theory is mainly associated with Haug and the alleged waning of professional sovereignty (Haug, 1973). With regard to the decline in professional powers, Haug (1973) developed a hypothesis on the status of medicine in which she

argued increased egalitarianism and the narrowing of the knowledge gap as a result of improved educational levels within the general public made it possible for clients to question the authority of medicine.

Haug's interest lay in the reaction of the medical profession to the 'revolt of the client' and threats to its authority and medical power. Haug regarded deprofessionalisation as: '*A loss to professional occupations of their unique qualities, particularly their monopoly over knowledge, public belief in their service ethos and expectations of work autonomy and authority over clients*' (Haug, 1973). The response of the medical profession to such threats, according to Haug, has been to develop specialisms within the profession whereby physicians essentially 'divide up the expertise pie so that each would master slices in depth' and thus maintain their professional monopoly (Haug, 1973).

Deprofessionalisation theory has limitations similar to that of proletarianisation in as much as the evidence proffered is limited and hard to test due to its lack of specificity thus the significance of changes reported tend to be inferred rather than demonstrated (Elston, 1993). Attempts to challenge the authority and power of the medical profession are often promoted in terms of consumerism. In relation to the UK experience, patients have little opportunity to exercise choice with regard to health care access therefore when considering the deprofessionalisation thesis circumspection needs to be applied. However, despite such limitations, Weiss and Fitzpatrick's (1997) work in which they explored proletarianisation and deprofessionalisation in relation to prescribing concluded that deprofessionalisation was a key influence in the prescribing behaviour of doctors.

Medical Dominance and the Power of Medicine

Friedson argues that while the concepts of proletarianisation and deprofessionalisation raise some interesting issues, they raise more questions than they answer (Friedson, 1994). Notwithstanding a significant theme of medical sociology by the 1990's was investigation of the decline of medical dominance and autonomy and the developing view that physicians work was becoming more rationalised as a result of more complex organizational structures such as the development of National Service Frameworks, the works of the National Institute for Clinical Excellence and the Scottish Intercolleigate Guidelines Network for the treatment of common diseases all of which arguably challenged their autonomy and dominance (McKinlay, 1977; Friedson, 1970, 1988, & Haug, (1973). Furthermore, changes to organisational and occupational structures have enabled other professional groups such as prescribing pharmacists and nurses to take up tasks that were formally held within the sole domain of the medical profession. Why such changes are occurring and what they mean for the future of the professions is where such researchers disagree.

The nature of professional dominance and autonomy has also come under debate. With regard to autonomy, Elston (1993) suggests that it has three forms: political, economic and clinical. Following the expansion of research in this area, Friedson (1994) has modified his original account of the professions. While he accepts that significant changes have occurred within medical practice and healthcare, particularly in the area of surveillance and accountability, that this has not impacted greatly on the power of

individual physicians or medicine as a collective group, as demonstrated by the fact that they have retained the control over the credentialising[45] of the profession.

Despite the increase in surveillance and accountability, Friedson (1994) maintains his argument that the medical profession has more autonomy and control over their activities than other proletariat and regards the concept of proletarianisation and deprofessionalisation as too sweeping and over generalised. Friedson applied the term 'countervailing pressures' as a means to demonstrate that medical profession has been, and continues to be, subjected to change some of which will reinforce their dominance while others will undermine their medical power. Rather than making grandiose claims of proletarianisation, deprofessionalisation and dominance, Friedson advocates grounding research in terms of the activities of professional groups.

Retrenchment

Since the late 1970s, sociology within the UK has been situated in a political climate that has been predominately Conservative. Within this political climate sociological research was viewed with suspicion and hostility by politicians who regarded proponents of the discipline as 'folk devils responsible for inducing moral panic' (Halsey, 1989). Further development of the discipline during this period slowed significantly as a result of political negativity and meagre governmental support and cuts in funding.

[45] While the government has imposed greater control over the medical profession, the BMA still retains control over medical education and training programmes.

Faced with such uncertainty, sociologists recovered their interest in classical theoretical traditions, quantitative methods and secondary analysis. The sociology of illness and health during this period reflects this change. For example, applying different theoretical paradigms to the study of health, disease and medicine and quantitative methods to secondary analysis of health data contained within the Office of Population Censuses and Surveys (Arber & Gilbert, 1989). Advancement of this approach was taken further under the influence of the writings of Foucault and led to renewed theoretical debates within healthcare and medicine (Armstrong, 1983; Bury, 1986).

Unlike its parent discipline, medical sociology due to its historical relationship with epidemiology and social medicine, has been sheltered from the worst effects of retrenchment. However, as Illsley (1975) predicated, this came at the price of surrendering selection of research topics to civil servants and physicians, for example, the large scale government funding for AIDS research and illustrates the return of medical sociologists accepting medical diagnostic categories and policy led research (Scambler, 1987). While such investigations are highly desirable, such a context limits the opportunities to subject health policy issues to rigorous sociological analysis.

Profession's Theory and Pharmacy

Within academic writing on the professions and many areas of healthcare research social theory has been utilised. However, within pharmacy research, explicit engagement with theory has not been a central endeavour of the research process. Indeed it rarely appears within the specialist pharmacy practice research journals (PPR). That this should be the case is interesting given the distinct social role

(historical and contemporary[46]) that pharmacy plays within healthcare delivery. Mays (1994), put forward the case that greater utilisation of theory would enhance PPR and increase its explanatory capacity and sophistication. The lack of engagement with theory perhaps can be explained by the historical trajectory of Pharmacy Practice Research (PPR) towards more technical aspects. Intriguingly, Turner suggests that 'pharmacy leaves little scope for hermeneutics' (Turner, 1995). This demonstrates little appreciation of the crucial social role that pharmacy plays in campaigns such as health promotion, medicines management, compliance and the many other services which it provides.

As pharmacy plays an important social role (albeit marginalised) within the healthcare arena, it is appropriate to subject it to sociological investigation. Indeed the following quote by Nettleton (1995) provides compelling reasons as to the appropriateness of theory to PPR.

> 'Our birth may be mediated by technology and controlled by health professionals. The beliefs about health and illness held by our peers and by those with whom we will live shape our experiences of illness and understandings. Our contact with health professionals (dentists, doctors, pharmacists, opticians, health promoters, practice nurses and so on) is likely to be a routine fact of our lives. Our self identity may be shaped by our experiences of illness and our interactions with both formal and informal institutions of healthcare. Our attitudes towards our bodies will be influenced by the discourses of health promotion and consumer culture. Our experiences of death will be influenced by our socio-cultural context. We may come into contact with new technologies of healthcare, either through our own illness or through having children. We may have to face the ethical and moral dilemmas central to the blurring of the beginning and ending of life' (Nettleton, 1995, p22).

The quotation above highlights that illness and health, as well as being biological, are a social phenomena. Being ill affects (to varying degrees) our lives, relationships, ability

[46] Historically pharmacists were the 'poor mans' doctor. In contemporary healthcare pharmacy is involved in health promotion, medicines management, and enhancing compliance and concordance.

to undertake everyday tasks, our identity and how we construct our sense of self (Marmot & Wilkinson, 1999). For example, in managing illness we interact with healthcare professionals for advice, diagnosis and treatment. At work we need to explain or account for being ill which can affect how we present ourselves and are viewed by others. Being ill can also require that we take some form of treatment including medicines, which can affect our sense of self and identity (Blaxton & Britten, 1995). In short it exemplifies that healthcare is mediated through social interaction, relationships and structures. It is on these that social theory attempts to shed light.

When considering the case of pharmacy and the professions debate it is important to bear in mind its historical background as outlined at the beginning of this chapter. When assessing the criteria of a profession as outlined within trait theory, it is evident that pharmacy posses a number of those characteristics. In terms of a monopoly of practice, entry to the register of Pharmacists in the UK is restricted by the Pharmacy Act. The Professional conduct of pharmacists is also regulated through their own statutory committee the Royal Pharmaceutical Society of Great Britain. It holds monopoly over the sale of 'pharmacy medicines'[47] in the UK and the dispensing and compounding of prescription medicines. Pharmacy also provides a service orientation as evident through the range of pharmaceutical services, treatment of minor ailments and health advice that it provides. Application of trait theory would indeed suggest that pharmacy can be classed as a profession. However, this view has been contested by several authors.

[47] 'Pharmacy medicines' is a class of drugs only available for sale over the counter by a registered pharmacist.

Denzin and Mettlin, (1968) argued that pharmacy had not succeeded in evolving into a true profession. The basis for their argument held two elements. The first concerned the lack of control over the social object of its practice, medicines, held by pharmacists while the second claimed the commercial (retail) orientation of pharmacy conflicted with the altruism of professions. With respect to pharmacy in the USA, Knapp and Knapp, (1968) examined community pharmacy and concluded that pharmacy had been unsuccessful in defining their professional role and functions and that medicines, were still under the control of the medical profession. Furthermore, the commercial orientation of community pharmacy was also regarded as being in conflict with professionalisation. In the late 1980's the professional status of pharmacists in Sweden was investigated by Claesson (1989. This research demonstrated that pharmacy, prior to 1900, had maintained a high status. However, throughout the 20th century pharmacy in Sweden was subjected to a period of deprofessionalisation which was attributed to pharmacy's subordinate position relative to physicians and control over medicines.

These examples demonstrate that there have been different perspectives of the status of pharmacy as a profession. Almost 30 years later, Dingwall and Wilson (1995) revisited such works and argued that a central task of pharmacists was the transformation of pharmaceutical compounds into a social object in the form of medicines. Additionally, they suggested the problem was not necessarily attributable to incompatibility between commercial interests and professional services but rather to the sociology of the professions itself which had developed primarily on empirical studies of the medical profession. Dingwall and Wilson further argued that rather than debating the status of pharmacy as a profession that more focus should be placed on the nature of pharmacy's daily tasks.

Such a task was taken up by Harding and Taylor, (1997) in their study of changing roles in community pharmacy in the UK the results of which complement the work of Dingwall and Wilson (1995). Harding and Taylor argue that the knowledge required and opportunity for the symbolic transformation of pharmaceutical compounds in social objects (medicines) was possible within community pharmacy. However, they also argued that introducing new services such as diagnostic testing into their daily tasks diverts their attention from their social object – medicines to activities for which they have little training, and thus could have the effect of deprofessionalising pharmacy as a profession rather than a professionalising one. Harding and Taylor concluded that for pharmacy to maintain its position as profession medicines had to remain a core element of the pharmacist's activity.

Professional Implications

Pharmacy as a discipline has traditionally been situated within natural sciences, with its main focus being on the technical skills for the transformation of pharmaceutical compounds into the social object of medicine. Educationally pharmacy has not always kept pace with the demands of the labour market. Indeed in the last 60 years, the profession's technical paradigm has lost three (drug procurement, compounding and storage) of the four core foundations of the profession to industry (Bissell and Traulsen, 2005). The remaining element, dispensing, in the narrowest term can be viewed as marketing and sales.

In contrast, the broader view recognises the active contribution that pharmacists can make to healthcare teams. Within clinical pharmacy and pharmaceutical care, for

example, pharmacists contribute their knowledge and expertise to healthcare teams and patients seeking resolutions to specific health related problems. Such activity does not fit within the technical paradigm but rather belongs to a paradigm that emphasises a disease and patient orientated approach within pharmaceutical decision making. Recent research conducted by Almarsdottir and Morgall (1999), demonstrates that when legislation imposes new demands on pharmaceutical services that the skills required to satisfy these demands are not always the skills contained within the pharmacy educational programme. Investigation of the pharmacy profession therefore requires an appreciation of how it has developed over time. Attention to how it is affected by and responds to external influences as well as internal conflicts is also required to fully appreciate its professional position today. This is discussed in the following chapter.

External Influences

The pharmacy profession as with other healthcare professions has been subjected to many external influences at local, national and international level that have resulted in changes to professional practice. For example, the Council of Europe has been particularly proactive in developing and advancing the role of pharmacists in managing health risks through relevant publications and seminars (CoE, 2004). The World Health Organisation (WHO) has also been active with regard to addressing the needs of the new independent member states for the distribution of medicines and development of pharmaceutical services. Indeed, the EuroPharmForum (2004), initiated by the WHO, concentrated on developing policy for the future of pharmacy and the profession.

All health professionals are subjected to constant scrutiny by external agencies. In recent years policy changes, such as the introduction of evidence based medicine, have

been shaping legislation and regulation of the pharmacy profession at all levels. Professional decisions based on expertise alone are no longer acceptable; rather they must be grounded in scientific assessment of effectiveness. The European Union in its efforts to harmonise the production, distribution and pharmacy education has had particular influence in the shaping and development of the pharmacy profession through the development and implementation of legislation, regulation and guidelines (Abraham and Lewis, 2000).

Within the UK, the National Institute for Clinical Excellence (NICE)[48] was established in April 1999, with the specific remit of appraising the efficiency and efficacy of new and existing therapeutic treatments including medicines (Kay, 2001). NICE is responsible for promoting clinical excellence and the effective use of available NHS resources through the development of guidelines for managing certain diseases, auditing of methodologies and appraisal of the appropriate use of specific health technologies including pharmaceuticals (Taylor, 2001). It has replaced the system whereby individual authorities made their own decisions on the funding of new drugs and technologies (Kay, 2001). In the case of pharmaceuticals, NICE collates complex evidence on the effectiveness and cost of drug treatments and reaches *`a judgment as to whether, on balance, the intervention can be recommended as a cost effective use of NHS resources*' (Sculpher *et al*, 2001, p943).

At a local level, the Scottish Intercollegiate Guidelines Network (SIGN), the Scottish equivalent to NICE, is primarily concerned that knowledge from research and reviews presented through NICE is quickly disseminated and adopted (Millard, 1999). The

[48] Now the National Institute of Health and Clinical Excellence.

Clinical Standards Board for Scotland and the Scottish Health Technology Assessment Centre work closely with SIGN in developing good codes of practice and guidelines for clinical care. Information from these groups is also feed into Drug Therapeutic Committees, Joint Prescribing Committees and Drug Evaluation Panels.

In addition to NICE, the desire to improve the efficiency of prescribing practice has seen the introduction of Joint Prescribing Committees (JPCs). The primary aim of the JPC is to improve the cost effectiveness of prescribing across the primary and secondary interface (Wakeman & Leach, 1997, p52). This has engaged with the proposed greater integration of primary and secondary care and has necessitated the use of cross-boundary drug budgets in some areas with the purpose of establishing efficient medicine management across this interface (Duerden & Walley, 1999, p437). In establishing a shared care protocol, financial responsibilities are defined both for hospitals and GPs with the view to reducing drug costs. Thus, the main focus of JPC is on the appropriateness of hospital-led prescribing and the development of policies for the managed entry of new drugs into the NHS. The main mechanism for this, within both primary and secondary care, has been through the use of drug budgets and joint formularies to encourage the delivery of more cost conscious health care (Walker, 2000).

Such changes have had a contentious effect on the pharmacy profession and its relationship with physicians. The most influential relationship that pharmacy has is with the medical profession. In the UK, as with most countries, pharmacists and other healthcare professionals are subordinate in some form or another to that of physicians with their professional role being controlled or at least limited by the dominance of the

medical profession (Turner, 1995). Another development within healthcare, that will potentially influence pharmacists' professional status, is their involvement in primary and secondary care teams and in which they conduct regular drug therapy reviews. Within this role the pharmacist also has the ability to prescribe a range of medicines for specific illnesses.

One of the many interprofessional conflicts between pharmacists and physicians concerns dispensing physicians. Such practice occurs in some thinly populated areas within Europe, many developing countries (including the national capital of most developing countries) and some remote parts of Scotland and (Trap *et al*, 2002). While this is more of a problem in developing countries allowing the same profession to prescribe and sell medicines leads to concerns over an inherent conflict of interest. Debates regarding the abolition of this practice are ongoing. Physicians involved with this practice, contest its abolition on the grounds that it is fair compensation for providing their services within less lucrative areas. However, this argument is weakened by the extent of the practice in heavily populated areas.

The relationship between pharmacists and pharmacy technicians is another area of importance to the pharmacy profession. Pharmacy technicians been traditionally been situated below pharmacists. In many countries, as a result of political and economic changes, the occupation of pharmacy technicians has become increasingly regulated and upgraded with technicians taking over roles that were previously performed by pharmacists. While some low skill tasks can be perceived as deskilling for one workforce it can be considered as upgrading for another. The concept of 'deskilling' is prevalent within the literature on theories of professions. The division between

pharmacists and technicians provides a good example. The education and training programme for pharmacy technicians varies from country to country, some countries requiring technicians to have very little while others such as Denmark have a three year state approved programme (Morgall & Almarsdottir, 1999). The education and training of pharmacy technicians within the UK has also developed considerably over the last decade to the extent that technicians now carry out many of the traditional functions of the pharmacists and senior technicians taking over many management functions.

Increasing professional and governmental awareness of the spiralling costs of medicines highlighted the importance and need for more rigorous medicines management within both the community and hospital setting. This led to initiatives such as 'concordance' and the Expert Patient Programme being introduced into the pharmaceutical sphere. Several policy documents outlining a detailed profile of pharmacy within primary and secondary care followed the NHS Plan of 2000 (DoH, 2000a). These include *Pharmacy in the Future* (England)[49], *The Right Medicine* (Scotland)[50] and *Remedies for Success* (Wales). A common theme of these documents is greater collaboration and communication within healthcare teams in order to improve quality of care, efficiency and effectiveness. Key measures designed to give patients more access to modern pharmaceuticals and pharmaceutical care were summarised in the 2003 policy documents *A Vision for Pharmacy in the New NHS* (DoH, 2003). The recommendations contained within these documents facilitated programmes, such as the Medicines Partnership and Medicines Management Collaborative (SE, 2003), in which pharmacists play a key role.

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[49] DoH, 2000b
[50] SE, 2001,

Chapter Summary

Although questions regarding the relevance of studying the professions in modern society are raised by some researchers, with regard to pharmacy, one thing is certain: there can be no one single description of the pharmacy profession. Rather it is embedded in the culture and laws of the land where it is practised. The study of pharmacy as a profession and the future of the profession can be usefully studied with the application of sociological theories of the professions. It is clear that the development and status of pharmacy as a profession is not static.

As a result of increasing political interest in managing healthcare costs, the provision, distribution and cost of medicines, as well as the role and contribution of pharmacy to medicines management, are of major interest. Incentives, as well as pressure, for continued professional development within pharmacy are exerted both internally and externally. The implications of such policy documents and the development of the pharmacy profession will be discussed in the next chapter.

Chapter Five: The Professionalisation of Pharmacy

When considering issues around professionalisation and pharmacy it is important to keep in mind the historical development of pharmacy. A central feature of a profession is its struggle to attain and maintain control and autonomy within a specific field and to achieve a monopoly of practice which is usually granted and enforced by government (Elston, 1993). Achieving the status of a profession is also identified as being dependent on a number of factors one of which was the ability to have access to and control over a unique and specialised body of knowledge such as medicine (Abbott, 1988). Once achieved it was argued that the profession usually adopts strategies of exclusion and usurpation to maintain its monopolistic position (Abbott, 1990).

When considering the status of pharmacy as a profession, what is interesting here is that pharmacy is one of the oldest healing professions and was once held in high regard. Indeed the history of pharmacy and the making of medicines can be traced back over 4000 years (Court 2005), during which great shifts in medicine and professional boundaries have taken place (Anderson 2005). When reviewing the early history of medicine and pharmacy the two professions are practically inseparable with Apothecaries not only dispensing medicines but also prescribing them (Trease, 1964) a situation which persisted in many parts of the world and the UK in particular until the end of the 17th century (Homan, 2005). To fully understand the changing nature of

pharmacy as a healthcare profession and its contribution to medicines management today an investigation into its historical context is required. This chapter therefore provides a brief overview of the history of pharmacy and identifies important themes in its development. In particular the relationship between pharmacy and medicine and how the boundaries between these two professional groups came to be negotiated and defined are presented.

Pharmacy: A Brief Historical Overview

Investigation into the history of pharmacy portrays the historical relationship between Apothecaries and Physicians as one of ongoing conflict and competition as a result of the skills and service overlap of the two professions (Barrett, 1905; Poynter, 1965). Apothecaries prescribing in particular led to conflicts with both physicians and Chemists & Druggists. An important theme therefore in the history of pharmacy lies in the area of professional boundaries between these professions and how these came to be negotiated and defined. The social, economic and political contexts in which pharmacy has existed have largely developed and shaped the role and practice of pharmacy as it is known today (Anderson 2005).

Important events that shaped the evolution of the pharmacy profession include the Foundation of the Society of Apothecaries, a Royal Charter granted by James I in 1617 which separated the apothecaries from grocers including the Chemists & Druggists in London. The granting of this Charter shaped what was to become the pharmacy profession and introduced rules of practice, training standards and inspection. The Charter also provided a valuable monopoly as it restricted apothecary shops to apothecaries (Trease, 1964).

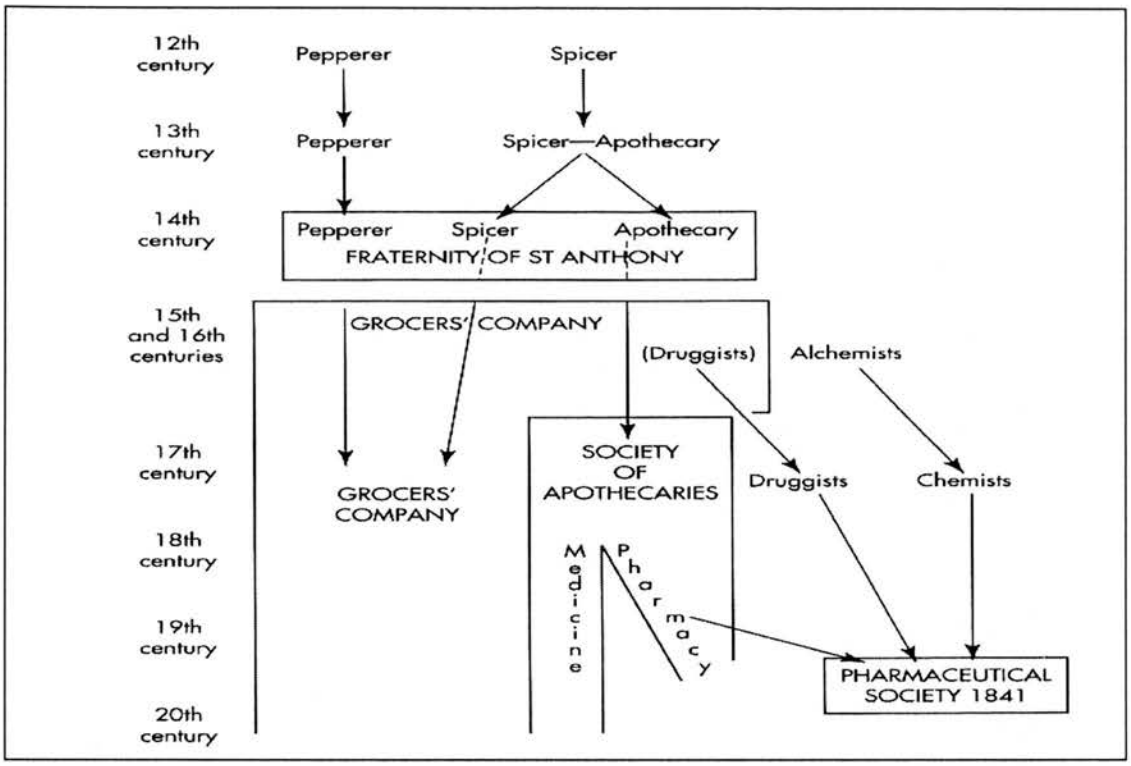


Figure 5.1: The Evolution of Pharmacy
(Anderson, 2005: p12)

As far back as this period Pharmacy enjoyed a status comparable to medicine through its understanding and control over an exclusive field of specialised knowledge concerning the compounding and dispensing of medicines. It also had control over remuneration for its services another feature which is attributed to the status of profession. Whilst the establishment of the Society of Apothecaries had smoothed the relationship between the apothecaries and physicians, apothecaries had to contend with competition from chemists and druggists who were largely unregulated, a situation which continued to aggravate professional boundaries. This situation continued into the middle of the 19th century (Savage, 1994). By 1820, practically anyone who entered the field of medicine could open a chemist and druggist shop without any training. The Chemist & Druggist of this time believed in free trade and did not agree with being

governed by the guild systems that controlled the Apothecaries (Homan, 2005). This petty bourgeois image of retail and the ability of laymen with inadequate professional education and apprenticeship training to set themselves up in business to supply drugs and chemicals constrained the profesionalisation of pharmacy.

Many Bills and court actions were taken throughout this period in a bid to resolve this situation. It was not until 1841 that the proposal to form the Pharmaceutical Society of Great Britain was agreed. The establishment of this society marked a significant change in the regulation, control, and development of pharmacy while the granting of the Royal Charter of Incorporation in 1841, laid the foundations of a professional body (Bell & Redwood, 1880). The Pharmacy Act of 1852 gave the Pharmaceutical Society more powers and made it illegal for non registered persons to practice as a Pharmaceutical Chemist or Chemist & Druggist thus separating pharmacists from other members of the medical profession (Matthews, 1962; Homan, 2005).

Figure 5.2: Travelling medicine seller
(Anderson, 2005: p225)

The establishment of the Pharmaceutical Society in 1841 represents the beginnings of modern pharmacy in the UK. Despite the formation of the society skirmishes continued and professional boundaries remained vague and ill defined (Hunt, 2005). Patients requiring medical treatment had a confusing choice, they could consult a physician whose advice was costly but may provide cheaper medicines, or they could take a prescription from a physician and have it dispensed by an apothecary or chemist and druggist for a lesser fee. Alternatively they could consult an apothecary for free advice but pay high prices for the medicines or purchase a propriety product or a 'nostrum[51]' from a chemist and druggist (Hunt, 2005). This situation persisted until the introduction of the National Insurance Bill in 1911 and the rise of the welfare state which had a profound effect on pharmacy and the practice of medicine in the UK (Hunt & Jones, 1994). The introduction of National Insurance Bill was a significant event in the development of pharmacy as, for the first time, the need to 'separate the drugs from the doctors' was given state recognition during the Chancellor's parliamentary speech (Anderson, 2005, p).

The separation of drugs from doctors was not as straight forward as had been hoped. Within the bill 'Friendly Societies'[52] were to play a major role in the administration of the scheme. This feature of the bill generated a great deal of protests particularly from the physicians who stood to lose a considerable loss of earnings from the dispensing of medicines. As far as pharmacy was concerned the proposed separation opened up an unprecedented opportunity to take over the physicians dispensing activities, an arrangement that did not go uncontested by the physicians. However, by 1913 the

[51] Any secret, quack, patented medicine or favourite remedy.
[52] Friendly Societies were comprised of national societies and small local groups.

resistance of the BMA collapsed and the National Insurance Scheme commenced which was an important watershed for pharmacy in the UK. As stated in the Pharmaceutical Journal on Wednesday 15th of January 1913 '*the business of pharmacy entered a new era*' (Editorial, 1913, 90:90). The Pharmaceutical Society had successfully secured the exclusive right of pharmacists to dispense physicians prescriptions for patients covered under the new scheme (Holloway, 1987). However, the compounding and dispensing of medicines could still be undertaken by anyone, physician or layman, provided that the sale did not include items covered under the Poisons and Pharmacy Act of 1908 or payment from the National Insurance Fund (Holloway, 1991). This arrangement remained largely unchanged throughout the inter-war years with only minor modifications being introduced before and after the inception of the NHS in 1948. Indeed the arrangements put in place for the provision of pharmaceutical services at the beginning of the 20th Century remained largely intact at its end.

Another important landmark in development of the pharmacy profession lies in the area of education, training and regulation. Whilst Chemists & Druggists[53] initiated apprenticeship training and education this was far shorter and less rigorous that that of the Apothecaries. Early declarations concerning the role of Apothecaries emphasised a lengthy apprenticeship and training. Entry into the Apothecary profession was strictly regulated and controlled after the establishment of the Society of Apothecaries in 1617. Further reforms to the pharmaceutical education system followed with statutory qualifications being imposed and reinforced through the Pharmacy Education Act 1868. Expansion of formal education continued with degree qualification appearing in

[53] Formal education of Chemist & Druggist became a legal requirement as part of the updated Pharmacy Act in 1868.

the UK in 1924. By 1948 a three year honours degree had been introduced in the University of London. Thus laying the foundations of the formal pharmacy education system that is in place today. The three term Chemist and Druggist course was abolished and a formal register of Pharmaceutical Chemists was introduced.

Whilst the transformation that had taken place up until now had been mostly positive in terms of the development of pharmacy as a profession, the traditional role as compounder of medicines was rapidly being undermined with the growth of the pharmaceutical manufacturing industry. As the availability of propriety drugs expanded and lower prices became available, pharmacy's role in production gradually became redundant. As a consequence of technological and economic advances they found themselves being viewed as over trained and qualified for their role and labelled as a quasi or marginal occupation (Eaton & Webb, 1979). These technological and economic changes also contributed to the structural fragmentation of the occupational group with two principal sectors emerging, private business (retail) and medical (hospital) (Turner, 1995) which in turn are fragmented both vertically and horizontally in the form of hospital pharmacists, administrators, industrial chemists and retail pharmacists. Such fragmentation makes the development of a common professional code of practice difficult to achieve and sustain.

The chapter discussion from this point will be on the development of hospital pharmacy as it relates specifically to the focus of the PhD.

The Development of Hospital Pharmacy

The development of hospital pharmacy can be broken down into four chronological periods. The first can be traced back from the introduction of the National Insurance Health Scheme in 1911 to the Roman military hospitals, or Valetudinaria. By the medieval period a wide variety of establishments for the collective care of sick were in existence. Early monasteries were amongst the few establishments offering collective care of the sick. Each monastery had their own infirmarian[54] for diagnosis of the condition and the prescribing and preparation of medicines (Whittet, 1965). The dissolution of the monasteries between 1537 and 1547 by Henry VIII caused the loss of hospitals. After petitioning the King by the Mayor of London three hospitals were restored, St Bartholomew, Bedlam and St Thomas each of which employed an apothecary instead of an infirmarian (Ellis, 2005).

The formation of institutions for the collective care of the sick expanded rapidly during the 18th century with the backing of philanthropists who provided financing for the building of hospitals. Within these new institutions one of the first departments to appear was that of the elaboratory or apothecary shop. However, the Apothecaries Act of 1815 effectively blocked the development of hospital pharmacy through demanding a much more medically driven qualification and later (from 1841) the requirement to hold membership of the Pharmaceutical Society (Granshaw, 1989).

[54] An officer in charge of the infirmary and responsible for finding '*whatever may be necessary in the way of medicines and comforts for the sick....*'

Hospital Pharmacy 1911 to 1948

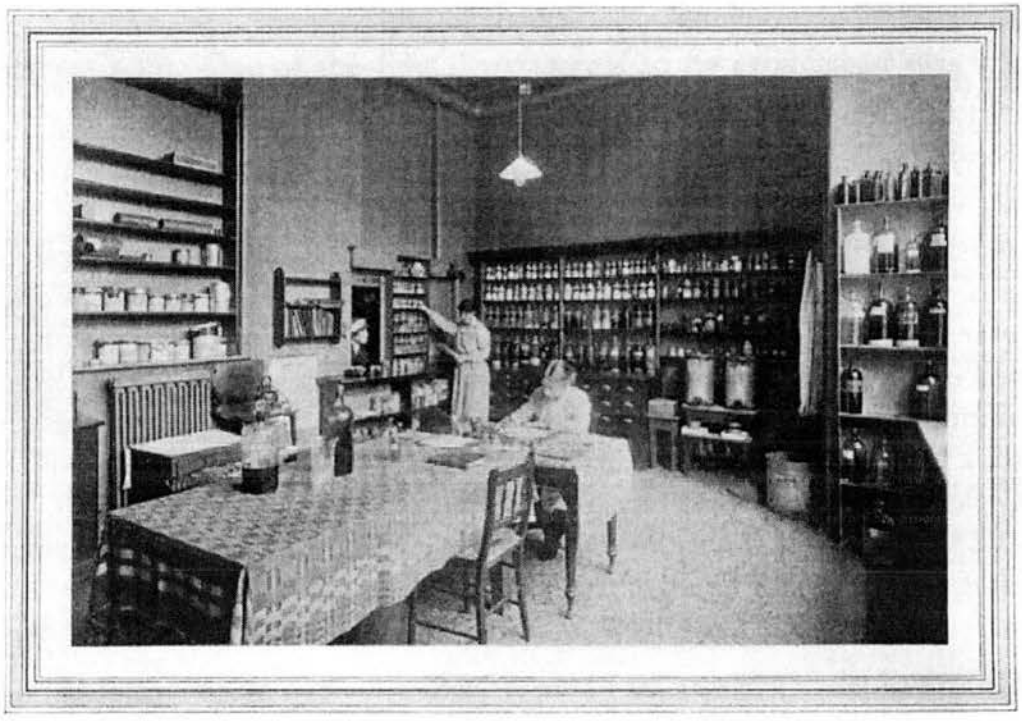
The second period runs from 1911 up until the introduction of the NHS in 1948. During this period hospital pharmacies were still undertaking the large scale production of many compounds, elixirs, galencicals[55] and so on (Anderson, 2001). The Pharmacy and Poisons Act of 1933 saw the reintroduction of ward pharmacy into the hospitals, a function which the apothecaries had allowed to lapse. The dramatic increase in therapeutic interventions after the Second World War led to hospital pharmacists innovating pharmaceutical equipment to reduce the level of medication errors and bacterial contamination (Crooks & Calder, 1966).

The responsibilities of a pharmacy department include:

- providing, drugs, medicinal preparations, dressings, chemicals and pharmaceutical sundries, and ensuring the nature and quality thereof;
- ensuring their correct storage;
- dispensing prescriptions for in-patients and out-patients;
- preparing pharmaceuticals, including devising formulae for special needs;
- investigating pharmaceutical problems;
- assisting with the development of new treatment;
- promoting economy of use of medical supplies;
- assisting efficient prescribing through advice to prescribers;
- instructing users of medicines; and
- training pharmacy students.

Box 5.1: Responsibilities of a pharmacy department
(Linstead Report p11).

[55] Therapeutic medicines made from the pharmacists own theories and methods.



DISPENSARY, NEW HOSPITAL FOR WOMEN.

Figure 5.3: Dispensary of the New Hospital for Women, London, c.1916.

1948 to 1980

The inception of the NHS in 1948 was eagerly awaited by hospital pharmacists in the hope that Pharmaceutical Whitley Council would negotiate better career and remuneration structures. This issue remained unaddressed until the Linstead report of 1953 which for the first time recognised the wide ranging activities of the hospital pharmacist (HMSO, 1955). The report encouraged greater involvement and recommended increased participation in medical decisions. The subsequent Aitken Report called for hospital pharmacists to become more involved in the safe handling of medicines within the whole institution and not just within their department. In response multidisciplinary teams were established to identify prescribing causes of errors. Within a decade ward pharmacy increased dramatically and a systemised system of prescribing introduced.

By 1970, hospital pharmacy did not differ greatly from the mid fifties. However, following the Medicines Act of 1968, pharmacy's responsibilities extended to include the supervision of medical gases. Changes to the manufacturing of intravenous fluids with complex aseptic dispensing being introduced also occurred. Following Noel Hall's report within which a recommendation was to make better use of facilities and expertise, further changes to hospital manufacturing occurred with the introduction of a specialist Pharmacy Advisory Committee for quality assurance, Drug Information Centres to support ward staff, a computerised pharmaceutical information bank (Pharmline) and specialist information centres for psychiatry, maternity and oncology being introduced (HMSO, 1970) Following the Hall report pharmacists also took over the responsibility for the preparation of radiochemicals that had traditionally been prepared within the radiotherapy departments by physic technicians (McCarthy & Steane, 1980).

Figure 5.4 The Dispensary, St Bartholomew's Hospital, 1959.

1980 to 1990

The period from 1980 to 1990 saw further changes in the activities of pharmacy and its management. In particular ward pharmacy was moving away from a stock control and supply function into a more clinical orientation. The Nuffield Report of 1986 labelled pharmacy as a 'clinical pharmacy service' (Nuffield, 1986). This report was a philosophical milestone in the development of pharmaceutical services and the pharmacy profession. The report recognised the crucial role of pharmacy in terms of achieving high quality cost effective treatments and provided considerable support for continued professional development.

Hospital pharmacists took full advantage of the reports recommendations and actively developed clinical and information services which would take them out of the dispensary and increasingly empower them as essential practitioners in prescribing and medicines management within the hospital setting (Anderson, 2005). However, the development of clinical pharmacy was not uniform across the hospital service and was constrained by unit size and resources. Further rationalisation to in-house manufacturing and in particular the manufacture of products that were available commercially also occurred during this period. The full impact of this was not felt until the NHS lost its Crown immunity and a licence to manufacture medicines was imposed by the Medicines Control Agency in 1990 (3M,1986). However, during this period pharmacists' involvement in clinical trials, development of prescribing guidelines and formularies and aseptic dispensing increased (DoH, 1997). By the end of 1990, a multidisciplinary Drug and Therapeutics Committee was established in 97% of hospitals for the control and implementation of formularies and prescribing policies (Fitzpatrick, 2003).

Activities undertaken in all pharmacies:

- establishing and maintaining safe systems of work for each section of the service;
- procuring pharmaceuticals, undertaking medicines utilisation review and maintaining stock control;
- distributing medicines;
- providing ward pharmacy, in-patient prescription monitoring, and clinical services where possible;
- manufacturing and assembling medicines;
- applying appropriate quality assurance for the level and type of activity undertaken;
- establishing and maintaining a local formulary and participating in the Drug and Therapeutics Committee;
- providing drug information services and monitoring the occurrence of adverse reactions.

Activities determined by clinical need or local circumstances:

- patient counselling and medication history services;
- therapeutic drug level monitoring services;
- intravenous additive and parenteral nutrition services;
- aseptic dispensing services;
- cytotoxic preparation and reconstitution services;
- radio-pharmaceutical services;
- participation in clinical trials.

Box 5.2: Responsibilities of a hospital pharmaceutical service 1980-1990

1990 – Present day

As a result of the many healthcare reforms, economic pressure and changes to educational programmes hospital pharmacy has moved towards a more patient orientated service. Traditional duties of supply and procurement, stock control and dispensing are now largely carried out by pharmacy technicians. Pharmacists now spend a greater amount of their time outside of the pharmacy and are increasing engaged in clinical duties and interactions with medical staff (Remington, 1993). In the next section details of the services and activities of pharmacists (as outline by the interviewees) within the participating hospitals investigated are presented.

Pharmacy Services

Within the hospital setting two broad levels of service were encountered. At the first level, pharmacy services are provided on a hospital wide basis. At this level, the pharmacy service appears to be little more than procurement and distribution with no separate arrangements with specialist units or other hospital groups being in operation. In a few wards/units an informal arrangement whereby the pharmacy provides a 'ward top-up service' was in operation. This involves a visit to the ward by a junior pharmacist or pharmacy technician who scans the patient drug cards and the drug cupboard and arranges an appropriate supply of drugs to be stored in the ward. Any in discrepancies found in prescribing are reported to a clinical pharmacist who then alerts the clinician. However, given that this is an informal arrangement that does not span across the whole hospital the influence that pharmacy has with such wards/units is reported to be limited.[56]

At the second level there are directorate services which involve an arrangement between the pharmacy and individual clinical directorates, such as surgery, general medicine or geriatric care, within which the nature and level of pharmaceutical service is agreed. The detailed organisation of the service varies according to the need of the ward/unit but, in each case, a specific directorate (clinical) pharmacist is assigned as a point of contact and is responsible for the provision of pharmaceutical services to that particular clinical directorate.

[56] This information was provided by senior pharmacists within Lothian and Glasgow Healthcare Trust

Services common to all hospitals:

- prescription;
- providing prescribing advice to medical and nursing staff;
- detection and prevention of medication errors and detection and reporting of adverse drug reactions (CSM yellow card scheme);
- patient education and counselling;
- taking medical histories;
- establishing links with primary care on patient discharge;
- advising on pharmacokinetics and therapeutic drug level monitoring;
- clinical and professional audit.

Specialised services provided according to clinical need or local demand:

- anticoagulant services;
- pain management and palliative care;
- geriatric and paediatric services, including development of appropriate regimens;
- nutrition, selection, formulation, and preparation of nutrients;
- oncology, prescribing regimens and side-effect control;
- mental health, including monitoring and community support;
- renal services, development of treatment guidelines;
- HIV/AIDS services, including patient education and counselling.

Box 5.3: Components of a clinical pharmacy service.

The role of the directorate pharmacists can be defined as having four key elements. Firstly, being a clinical specialist with knowledge of the literature relevant to their particular directorate and having a working knowledge of current practice and protocols. Secondly the directorate pharmacist supports the directorate by providing input into clinical audits, new drug evaluations, protocol preparation, drug security, training for other directorate staff and drug budget support. Thirdly, the monitoring of drug expenditure is also facilitated through input from the directorate pharmacists by the provision of regular information and interpretation of drug expenditure and advice on how to efficiently manage expenditure[57]. Predictions and advice on any changes with regard to drug treatments is also offered. Lastly, the director pharmacists also

[57] For an example of this see Beard *et al*, 1998 who have developed systems and strategies for the management of the drugs budget in Glasgow hospitals. See also Morris, 2000.

performs a supporting role to the pharmacy by advising pharmacy of any directorate service plans and acting as an ambassador for all pharmacy services. The directorate service is superimposed on the first level of service as provided across the whole hospital.

Chapter summary

What has been demonstrated so far is the changing role of pharmacy from its origins through to present day. The pharmacist, in essence is society's expert with regard to medicines, providing and ensuring their safe and effective use through their information and advice. In broad terms the responsibilities and duties of hospital pharmacists today compared to the early apothecaries are not significantly different. Indeed it would appear to have gone full circle from prescribing and dispensing for complete patient care through a period of restriction to preparation, distribution and procurement back to a clinical function in the form of clinical pharmacy which also includes a prescribing role within defined areas. Such activity echoes the historic function of the apothecary.

The Nuffield Report proved particularly influential in terms of the development of pharmaceutical advisory services for the support of the medical profession. The Pharmaceutical Society and the Government accepted the reports recommendations which led to further policy documents on the future development of pharmacy including, Pharmacy in a New Age, (RPSGB, 1986), Medicines Partnership and Medicines Management Collaborative in which pharmacists play a key role being produced. Such documents continue to drive the new pharmacy practice agenda forward today.

In the following chapter the perceptions of clinicians of NPM and financial accountability initiatives and their relationship with pharmacists will be presented. The extent and effect of the changes presented within this chapter on the pharmacy profession and its relationship with clinicians will be discussed in chapter seven. This will then be followed with a summary discussion of both sets of data in chapter eight.

Chapter Six: The Clinician's Perspective

This chapter is concerned with the clinicians' perceptions of the impact of NPM initiatives and increased financial accountability on their role and status within the NHS and their relationship with hospital pharmacists. The particular areas that this chapter addresses are the identification of NHS reforms and NPM initiatives which clinicians perceive as being, directed at controlling their activities. It focuses on how the discursive nature of NPM techniques and language are implicated in controlling the activities and partisanship of pharmacists and clinicians within secondary care; and considers the power effects of management discourses associated with healthcare reforms. It further discusses how the control of clinical activity through the discursive shaping of clinical subjectivity can occur. The role and influence of clinical pharmacists on clinicians prescribing behaviour from the clinician's point of view is presented. It further explores the impact of managerial discourses on the negotiated order within the context of the hospital and how such individuals manoeuvre in relation to such discourses. The chapter is informed through data gathered from interviews held with clinicians operating within NHS Boards in Scotland. One of the first issues raised by the clinical director was the effects of managerial roles on clinical activity. The discussion within this chapter therefore begins with NPM and clinical activity.

NPM and Clinician Activity

As discussed in chapter 2, the cost of healthcare services within the UK has been rising for some time. Many of NHS reforms were an attempt to stem the rising costs of healthcare provision and to achieve cost efficiencies in medical care. However, the discourses of government and financial responsibility have traditionally been viewed differently by medicine and management. A central feature of NPM discourses is the promotion of professional and managerial subjectivities through core managerial and leadership capabilities. Management on its own was regarded as insufficient to deal with the reform agenda. The establishment of clinical directorates was deemed to be a mechanism by which management could be achieved from the inside through putting some medical professionals into an authority position over their colleague's decisions.

Indeed it was recognised that the medical profession has an important role to play in achieving a more effective use of resources by improving cost efficiencies in clinical practice. This however, presumes that clinicians have some knowledge, interest and concern of medical costs, and the financial implications of their clinical decisions. An underlying premise of putting clinicians into a management position with a degree of autonomy over how their units are managed is that clinicians within their unit are more likely to accept and respond to managerial aspects put forward by medical rather than non medical managers[58]. The establishment of clinical directorates with semi autonomous clinician managers also imposed a level of financial responsibility on to the clinician manager and thus redefines dominant views about financing and the delivery of healthcare services.

[58]See also Llewellyn (2001) who demonstrates that the physician manager has access to management ideas which are then interpreted and channelled as they deem fit to other clinicians.

The clinical director in his role as 'executive' acknowledges the financial pressures as highlighted within NPM but, at the same time emphasises the importance of his clinical role. *'Imposing financial accountability is reasonable after all its public money but we have to make sure that we can still treat our patients in the best possible way for them but I have reservations with all this increasing visibility and financial accountability it limits how you can treat your patients'* (CD1). Thus the dominate focus on financial aspects is regarded as being a distraction from the core activity of clinical service and highlight the difficult that clinicians have when trying to reconcile managerial initiatives with their core clinical function.

Two of the core elements of NPM are aimed at utilising private sector styles of management and placing more stress on financial control and parsimony in resource consumption. The latter premise also indicates a move away from placing emphasis on organisational continuity, maintenance of volume of service and policy development towards the continual search for alternative less costly service delivery systems[59]. Typical justifications for the imposition of NPM include the need to cut direct costs, more stringent financial and labour discipline and the need to achieve more for less. Clinical directors are acutely aware of the political and organisationally sensitive nature of these managerial directives.

> 'As far back as the mid 1980's politically there has been a drive to close down units. Look at the psychiatric division for example we have a hospital within this Trust that is still open but half the wards have been shut down...The reality is we have to cope day-in day-out with politically driven decisions that don't always make sense to us. Closing facilities obviously has a knock on effect to us and the patients. The problem is that often such decisions are not fully thought through with short term gains driving the agenda. It right to rationalise this kind of service if the right kind of support is available in primary care but it many circumstances this is just not the case so we end up with the same patient coming back through the system several times before they're stabilised enough to cope outside so this obviously puts a drain on our resources' (CD2).

[59] For more information see Hood (1995).

The above quote neatly illustrates that there are cross boundaries between management and medical tasks and conflicts with professional values. Indeed it exemplifies an antithesis between the ethos of quality of care and NHS cutbacks. Cutting services and shortening hospital stays are thus regarded as being inappropriate and too focussed on financial considerations that are short sighted.

The majority of clinician interviewees indicated that many of the initiatives and targets set within the system and their ability to achieve such targets had resource implications that were just not recognised.

> 'When it comes to service provision finance takes up about 85% of the focus of the board meeting rather than elements of its core obligations- providing a high quality of service to its patients...Financing is always a source of tension. The finance director has to control the money but we have to treat the patients and get them through the system with the best quality of care and meet our output targets so the finances need to match these targets. As far as we're concerned it's not just about accounting for money it's also about measuring the delivery and quality of service. The most important thing is to treat the patient right...What's important is to get quality higher on the agenda rather than just looking at the numbers. Unfortunately much of the management within the system is focussed entirely on the finances. Financial considerations often get in the way of clinical excellence but what can you do? We have lists of patients waiting on treatment and not enough money to treat them the way we want... Linking performance to efficiency and effectiveness in financial terms in my opinion isn't relevant what would be more useful is linking quality to quantity and the amount of resources consumed'. (CD1).

The above quote neatly illustrates some of the frustration that clinicians feel when trying to serve their patients needs not only within tight financial constraints but also clinical guidelines and standards. However, it should also be recognised that such constraints provided professional development opportunities for pharmacy as a profession as outlined in chapter 5.

> 'I was rather negative about taking over the responsibility for the budget, I didn't view it as something that we should be doing, it's just another administrative task that effectively impinges on the time we have available for patients...I think generally it was felt that it

> was inevitable given the financial constraints and rationalisation policies being driven in...Most of us took this on reluctantly....there was a fair amount of resistance because of additional administrative workload and the fact that it eats up time that would be better spent with the patients' (CD1).

It is evident from the above comments that clinical directors are resistant to excessive managerial control of their medical practice and are thus concerned with ensuring the maintenance and protection over their level of clinical autonomy. Indeed, the above comments are indicative of a strong mind set towards professional autonomy and the pursuit of clinical quality and excellence which are to be guarded against the potentially detrimental effects of managerialism.

Despite the perceived impingement on their clinical autonomy, clinician interviewees indicated that the inevitability of increased financial constraints and accountability has drawn their attention to closer examination of their clinical practice and how they work with other healthcare professionals.

> 'The reality is we don't have an bottomless pot of money so we have to be creative with how these resources are used unfortunately inequalities exist but the quality standards, clinical protocols, prescribing guidelines and other initiatives which help to control spending will hopefully reduce these inequalities... Taking on more financial responsibility inevitably led to us reviewing practices and procedures ...also services we had to identify those we absolutely needed, which ones could be reduced or even cut...We've also had to draw on other areas within the system to devise strategies to make the money go further'. (CD2).

Thus the picture that emerges so far is one in which the clinicians were initially reluctant to take on board the managerial and financial responsibility that they perceived as being an impingement into their clinical duties. The administrative burden, and the lack of associated training to manage effectively, were highlighted as another objection to this structural change.

Budget Changes

An interesting finding from the discussion with pharmacists[60] indicated that on the initial transference of budgetary control to the Clinical Directorate, there was a perception that the cost of medicines had actually increased. This may be attributed to the fact that previously the drugs budget was allocated on a historic basis rather than the estimated needs of the particular ward or unit. Thus, although past inefficiencies were rewarded and the budget formula provided an incentive to 'artificially' increase costs before devolved financial responsibility took place, the historic budget provided a frame of reference for control restraining the new budget within its parameters.

The introduction of devolved financial responsibility was also accompanied by a change in budgetary allocation with historic allocation being given less attention and more emphasis being turned to estimated ward/unit activity, inflation, research and development and so on. This allowed costs to expand outside the budgetary frame of reference. It has been argued that clinicians lack the management and financial skills required to achieve the necessary efficiencies and that indeed such efficiencies often conflict with clinical judgments and autonomy.

The temporary improvement in drug expenditure might suggest that introducing budgetary control could have the long-term desired effect. However, such conflict would also suggest that in order for such improvements to be sustained, the introduction of micro-budgets that hold individual clinicians responsible only for their own expenditures and not providing them with the ability to cost shift[61], as has been suggested by junior clinicians is happening, may be one way forward. The general lack

[60] See chapter 7.
[61] This is also suggested within the quality section within this chapter.

of the knowledge of drug costs also suggests that the provision of cost information needs to be both easy to access and accurate, to address the needs of the clinicians and support their clinical decisions.

The data so far suggests that for some clinicians the initial transference of budget control through the establishment of clinical directorates was accepted rather reluctantly, with such clinicians viewing the associated management responsibility as an added management burden that would reduce the amount of time available for their clinical duties. Such opinions illustrate that the clinicians regarded changes in financial responsibility as an encroachment into their clinical autonomy and a time consuming exercise which has a negative impact on the quality of service to the patients. The administrative burden connected with devolved financial responsibility and the lack of associated training to manage financial aspects effectively was highlighted as another objection to this structural change.

Management and Financial Training

Indeed the majority of the interviewees expressed concern over their lack of financial training to be able to deal with issues of budget management. Under the current education structure for students studying to become doctors, management of healthcare, from a financial aspect, is only superficially covered at both undergraduate and postgraduate level. The clinicians interviewed claimed that they had been given no training on financial or budgetary matters. In general, those in a position of financial responsibility indicated that they had learnt such skills through trial and error and advice from senior colleagues.

> 'We are increasingly coming under pressure from the board and the government to cut costs. This makes our job very difficult as every clinical decision has to be justified . . . it makes you wonder if you're a doctor or an accountant....I trained as doctor to help people...If I wanted to be an accountant I would have trained as one. Yes, with the changing environment we need to consider costs but that's what administrators are good at, not us ....As far as financial and budget training is concerned this is not something that we had much of because that's a management task. Even now management training in my view is insufficient...It's simply just another tier of control... lots of paper and documentation'. (CD1).

Those who had attended courses on financial management tended to be in more senior positions. However, this lack of training did not indicate a lack of interest. Most participants said they would welcome the opportunity of financial and budgetary training. Interestingly, however, none of the clinician respondents indicated that they had undertaken any management or financial training independently. In contrast, two of the pharmacist respondents[62] did indicate that they have invested in such training. Nevertheless, all of the clinicians interviewed felt strongly that financial considerations were getting in the way of service delivery and that patient care could ultimately suffer. To this end many clinicians reported that they were increasingly turning to other specialists such as the clinical pharmacists for support and advice on the most cost effective treatments that maintained efficacy.

The introduction of clinical leadership into the healthcare arena was an attempt to integrate clinicians into the NPM discourses. The intention was to influence clinician behaviour by constituting them as utilisation or clinical managers in reviewing and regulating their own clinical output through case-mix information within the new organisational forms that demands more defined accountability[63]. Within this regime they were to become redefined as managers, economic agents and providers of health services with budgets and delegated responsibilities. The role of the clinician manager

[62] One senior clinical pharmacist had undertaken an economics degree part time while another had taken a part time management degree.
[63] See Doolin, 2001 & 2002.

straddles two occupational functions, medical and managerial which involves mediation and challenges pre-existing professional cultures and valued practice.

Holding both a managerial and clinical role thus produces a hybrid manager that has to establish skills that enable him to inhibit two worlds, one clinical the other managerial, and ensure his authority and legitimacy. From the data, it would appear that holding a managerial and clinical role, and the reduction of time available for their clinical duties as a result of the managerial responsibilities, was a cause of anxiety with regards to professional identity. Indeed clinical affiliation was extremely important to the respondents as means of maintaining their clinical legitimacy and identity with professional colleagues.

> ''I don't want to viewed just as a manager...first and foremost I am a clinician and here to help patients... its very important to me to keep my clinical role and engage in clinical duties with my colleagues' (CD2)

The clinician managers also hold responsibility for other healthcare operatives such as nurses. A further concern for the clinician manager is to make sure that nursing staff under his authority also feel part of the team and to ensure that he does '*not come across as only looking out for the interest of the medical staff*'. (CD 2)

The data thus illuminates some professional tensions and role conflicts as a result of taking on a managerial role. The perceptions of the clinical directors and clinicians with regard to management and financial training also reveal a distinct lack of training which could impede cost efficiencies being made and more effective use of financial resources. Issues of safety, efficacy and cost will be discussed next.

Safety, Efficacy and Cost

What has been established so far is that prior to the NHS reforms safety and efficacy were generally held as being the most important factors to consider in prescribing matters for clinicians; the issue of price was not their concern. Analysis of the data reveals that despite the introduction of clinical directorates it is questionable whether there has been any real change in attitude towards the issue of cost, as many clinicians remain outside of the managerial process and are therefore relatively isolated from the cost containment pressures that are being exerted by the government and health boards.

While there is evidence to suggest that there have been efforts to make clinicians more aware of the financial implication of their medical decisions, not all clinicians agree that that costs should be taken into account in prescribing decisions. Such sentiments are fuelled by the belief that prescribing according to cost will have a negative impact on the quality of care. Discussions with the directorates revealed that efficacy and safety remain the main factors in prescribing decisions with cost often being ignored completely. This was especially the case in specialist treatment areas. This may perhaps, be due to the fact that such areas generally have patients with more serious and complex conditions. '*I'm willing to consider different treatments but at the end of the day I prescribe according to the patients need. We have to maintain quality of care*' (C5). All of the clinicians interviewed, did however, acknowledge that drug treatment costs were increasingly becoming an issue and that the changes embedded within the NHS reforms were an attempt to make them more aware of the cost of their clinical decisions which includes the cost of prescribing.

When questioned on the issue of costs using specific drug treatments as a test sample, clinicians' response and knowledge of drug treatment costs tended to be vague and inaccurate. In the past there were no incentives for clinicians to have an awareness of costs. However, with the advent of clinical directorates and the devolving of responsibility for the drugs budget to the clinical directorate, it is not unreasonable to expect a greater knowledge of such issues. Further investigation revealed that this lack of knowledge could be attributed in part to some costs not being readily available, either because a standard method of assigning costs is not used (for example diagnostic tests) or because costs are not widely publicised. The lack of cost awareness may also be attributed to the prevailing belief within the profession that considering cost, when it comes to patient care, is unethical. Another common attitude observed in older clinicians was an aversion to non-clinical matters, such as management and administration, with costs being perceived as a management function and not a clinical entity and therefore of little importance.

> 'The clinical pharmacist has more knowledge on the pharmacological aspects of the drugs, side effects, compatibility cost and all that. So their views are likely to be more objective. They know the cost drugs and can suggest which ones will maintain efficacy but will also be cost effective...What I want is to ensure that my patients get the best possible treatment'. (C2).

The hospital formulary, which is the recommended reference point for clinicians in making prescribing decisions, is a comprehensive list which recommends drug treatment regimes, information on the pharmacological aspect of the drugs - dosage side effects etc and cost. The objective of the formulary is to provide the clinician with up-to-date information and guidance on appropriate and cost effective prescribing. As discussed in chapter 2, the use of formularies has been promoted by government initiatives in an attempt to curtail the rapid acceleration of drug expenditure, without

affecting the quality of patient care. Responsibility for the development, maintenance and implementation of the formulary lies with the pharmacy who liaises with the Drug and Therapeutics Committee, the Drug Evaluation Panel, the Clinical Resource Audit Group and the clinicians on the content of the formulary. In the chapter 2, it was suggested that the usefulness of the formularies would be governed by the clinicians' ability and motivation to engage with them. However, in the hospitals under study, the formulary was years out of date thus offering limited information with regard to the cost and availability of certain drug regimes, which was the main reason given for its lack of use. Criticism, in this case, about the under-utilisation of the formulary would be unjust.

> 'The hospital formulary's useless. It doesn't have up to date information. How are we supposed to learn the cost of treatments when we're working from documents that are out of date?' (JC2).

The imposition of formularies and limited lists were intended to control and challenge the poor prescribing practices of clinicians. While the formulary was considered to be out of date in terms of its cost information, it was recognised as an important tool of reference for the more junior staff that supported their prescribing practice. '*The formulary provides a reference point for junior staff and enables them to make appropriate prescribing decisions*' (SC1). However, it also suggests that one important source of information which could affect the prescribing activities of clinicians is insufficiently managed and therefore inappropriate as a control device.

The perceptions of junior clinicians with regard to cost issues however, revealed some frustration and tensions that appear to arise from their lower professional status.

> 'A primary objective is to cut spending without affecting patient care so we're interested in anything that keeps costs down...Adherence to the formulary, protocols, standards and

> so on are designed towards uniformity to bring problem areas into line but we have a few who are not interested in cost they do their own thing and get away with it because of their position'. (JC5)
>
> Some of the senior clinicians don't appear that concerned with cost when it comes to their activities but they really get on our case when it comes to money'. (JC1)

More recently, quality outcome frameworks directed at specific clinical targets and therapeutic outcomes have been introduced which are based on a points scoring system that is designed to direct the clinicians prescribing decisions. Such frameworks have the potential to challenge the clinician's medical autonomy further. NPM initiatives aimed at improving the quality of healthcare delivery will be discussed next.

Evidence Based Practice and Regulation

As discussed in chapter 2, the regulation of the medical profession has largely been contained within the medical profession itself. While the political objective of NHS reform is to control expenditure, it is also to minimise inequalities and variations in quality of care and clinical practice by ensuring compliance with national standards, treatment protocols, and establishing evidenced based practice (EBP). Having considered the impact of changes to financial responsibility, attention is therefore now turned to assessing another set of healthcare initiatives which respondents have highlighted as being potential factors in the changing relationship between pharmacists and clinician's; evidence based practice and quality standards. While the majority of standards are concerned with organisational issues, quality of patient care features as a central theme.

In order for pharmacists to direct and challenge clinicians prescribing behaviour they need to perform as corporate rationalisers who are interested in developing and

extending their control function within the healthcare team. It is therefore important to consider the clinician perspective of the clinical guidelines, protocols and standards as the pharmacists attempt to apply these as a means to direct and influence clinician behaviour. This section will focus on the data from the clinician perspective.

All of the interviewees on the study acknowledged that delivery of a high quality of service was important but that this was difficult, multifaceted and not easily defined. On discussing whether they could provide concrete examples of effective quality somewhat vague answers were given, but all of the respondents recognised that assessing performance in relation to quality standards and clinical protocols was a sensitive issue.

> 'Measuring quality opens up another can of worms how you determine quality? You might provide treatment which was effective and cheap but how did the patient react to this treatment? Did they have any adverse effects? If they did can you still claim that it was good quality'? You could say good quality is when the patient's ailment is treated successfully and the patient is satisfied' (C3).

The above quote highlights the clinician concerns over how quality is defined and resonates well with arguments for the preservation of clinical autonomy. However, it also suggests that the expertise of clinical pharmacists are potentially good proxies in the determination of effective medical treatments.

A general perception that clinical guidelines and initiatives would become more widespread was indicated by the clinician interviewees. However, there were rumblings that such initiatives were too bureaucratic and restrictive. Quality standards were regarded as a management task that was burdensome, time consuming and unreasonable. Clinicians in general were not interested in standards and, in particular,

resent the lack of flexibility that the standards impose. Indeed they were keen to emphasise the importance of clinical experience in treatment decisions and the need to maintain a high level of clinical autonomy.

> 'Quality standards and clinical guidelines are continually being pushed forward but these are sometimes hindered by the policy of the board... cutting down on availability of beds for example obviously has an impact on how many patients you can see and treat so you could say quality is compromised in these situations...keeping on top of these things takes up too much of our valuable [clinical] time' (C2).
>
> 'Sticking rigidly to treatment protocols and such like also restricts how we treat the patients... Sometimes experience tells you that following treatment A rather than B is not the best option so we have to be able to make these decisions' (C5).

One clinician informant held the view that the monitoring of standards did not address the areas that were important and that it was a rather crude counting exercise that failed to look at the real issues such as clinical outcomes.

> 'Monitoring compliance with the guidelines is often overlooked because we spend so much time monitoring the finances... Realistically we can't meet all of the standards imposed the moneys just not there so why waste time and resources trying to monitor them it's better to spend that time with patients and reducing the waiting lists...I think quite a few of these documents don't reflect the reality...We have lots of quality standards, protocols and so on for the most part they are very effective but sometimes they can leave our hands tied when it comes to treating some patients...We do have situations where our clinical judgement conflicts with these because what we consider to be the best treatment might not fit into the standards...There's lots of documents outline procedures and stuff for us to refer to but when you are on the ward and under pressure to get the rounds done you have to be free to make your own decisions'. (C4).

This sentiment was echoed by another clinician who admitted that *'We don't always meet the guidelines and achieve the quality standards'* and went on to explain that in order for the standards to be met there were resource issues that were not recognised by the Board. This was attributed to a general lack of money within the Board. The general view from the clinician interviewees indicated that the issue of quality had been thrust up the political agenda. Such developments were also recognised as a means to regulate their activities. Initiatives aimed at improving quality and patient

care were regarded as positive developments provided the final arbiter of such initiatives was a clinician.

> 'The emphasis now is on quality, evidence based medicine, clinical effectiveness we have regular clinical meetings to discuss clinical cases what's important is getting good results fast....The guiding force should be professionalism we're here to help patients that's what should count we constantly self audit if you feel the patient wasn't satisfied you starting thinking what was wrong with that how could I have treated her better we have a lot of good guidelines but if we didn't audit our performance and try to improve then we would continue to have dissatisfied patients'. (C1).

The above quote illustrates the importance of self regulation. However, further evidence suggests that much of the monitoring and regulation that is taking place is as a result of increased scrutiny imposed on the medical profession which may lead to a process of restratification within the medical profession and thus lead to further heterogeneity with allied health professionals such as pharmacists.

A significant sense of professional identity was attached to the professional role that their clinical activities served. Although such clinicians acknowledge the level of the financial crisis they were at the same time quite critical of the imposition of the rigid application of the reforms.

> 'There has to be sound clinical reasons for working outside of the protocols so control is much tighter ....Clinical guidelines and protocols are fine but at the end of the day each patients is different they have individual needs and therefore need individual treatment experience guides you on this so there's issues with clinical independence and autonomy'. (C5).

Another clinician informant felt that the continuous reforms were restricting his professional ability, autonomy and level of independence compared to that enjoyed prior to the emphasis being placed on clinical effectiveness. The expectation of patients

was also regarded as another driver of quality improvements as patients become more informed and involved in their treatment.

> 'Performance is much more regulated now clinical governance plays a big role its not like the old days when we were freer to self govern and held in high regard by our patients its dictated from policy we're more answerable... in many ways patients are more informed and demanding so we've had to change ... Unfortunately some of the performance targets are only concerned with how fast the patient was seen not the result of the consultation.. I'm really interested in outcomes but unfortunately a lot of what we do now is tied up in counting the pennies and budget balancing'. (C5).

Many of the clinician interviewees, including a few of the senior clinicians, indicated that while they still held a significant level of power and status that the position of the all powerful hospital clinician had waned: '*We hold a significant influence and negotiate in the most important decisions but we don't call all the shots anymore*'. (C3).

Overall the introduction of such policies were viewed as important developments as they are aimed at improving the quality of the healthcare delivery. They were also recognised as a mechanism to regulate and control their activities. However, this last statement illustrates the potential for regulatory requirements to be over-demanding and thus negatively affecting patient care. While regulation and controls to ensure compliance and good quality were viewed as important, the level and rigidity of the regulation was perceived negatively by many of the interviewees.

This section thus illustrates than clinicians consider quality to be an important aspect of their duty and that it has become embedded within healthcare delivery. Indeed the evidence demonstrates that the issue of quality and healthcare protocols etc have achieved greater importance and structure within the healthcare system as a whole; for

example clinicians expressed the view that such initiatives have had an effect on their day-to-day activities with them feeling more controlled and regulated. This suggests that the healthcare system was becoming more bureaucratic in nature and framed in corporate rationalists terms. The discussion from here focuses on clinician's response to the control aspect of NPM initiatives.

Control Reactions and Professional Identity

Managerial control is often portrayed as an intrusion that is defensively resisted within the literature.[64] However, such positions assume that systems of professional values are static and adversative towards managerial value systems. While this thesis does not dispute the findings of such studies, indeed it provides a considerable amount of data that supports such a view, it is also evident within this data that clinicians are to an extent, responsive to NPM discourses aimed at achieving a tighter financial regime and balanced accounts particularly where managerial responsibilities are viewed as non-challenging. In taking on the role of clinical managers the discourses of NPM became part of the clinician's repertoire and subjectivity which in turn influenced other clinicians in their acceptance of the clinical manager role and legitimacy. '*We have a close team spirit here professionalism dominates so for the most part we take their advice and directions*' (C3).

Thus in accepting the legitimacy of the clinical manager clinicians subjectivity could be acted upon and discourses reproduced to accommodate decision making within the new framework. However, the imposition of managerial discourses did not go

[64] see for example Kitchener, 2000; Doolin, 2002; Mueller et al, 2004

uncontested or without impact on the professional status or roles of the clinicians. Indeed to suggest such a thing would be to deny the agency of individuals composed through NPM discourses as subjects.

> 'Management and medicine don't necessarily go hand in hand. I am and always will be a doctor first my clinical judgement is what counts...But management and controls are biting into our clinical activity'. (C2).

People's behaviour, however, does not change simple due the fact that they are exposed to new rules or abstractly articulated managerial goals. This is particularly the case in an organisation such as the NHS which has a complex inherited ideological power relations and appeal situated around the various expert knowledges.

> 'The problem with managers [referring to non medical] is that they are only concerned with the finances not the overall quality of patient care so this causes conflicts....the financial systems don't reflect what is most important – how the patient was treated, how successful their treatment was which is upper most in our minds so it's not unusual for clinicians to make decisions that are not concurrent with the recommendations set out'. (C1).

Indeed for some it appeared that the acceptance of imposition of managerial discourses and financial accountability represented a betrayal of their professional identity. Thus the application of economic rationality for these clinicians reinforced their connection to their identification with medicine and associated professional culture.

> 'I went into medicine because I wanted to help people I get a buzz out of curing their ailments or just easing their pain and discomfort for me it's very important to retain this I'm not really interested in the managerial side of things... The only managerial thing I'm interested in is making sure we get enough money '(C3).

Reaction to the intensification of managerial discourses into the day-to-day management of the organisation depended to a large extent on whether such discourses were perceived as instruments which could be used by them to improve their own

position or clinical service or as devices intended to control their activities. Where perceptions of NPM were a controlling device that challenged clinical activity and autonomy and in effect threatened their professional identity, resistance occurred.

> 'Financing and control over resources are important but it shouldn't just be about control we're professionals and have to be able to get on with what we're here for ...We shouldn't be dictated to when it comes to patient care it's our reputation that's on the line if the patient isn't treated right'.(C4).

It would appear that although the principles contained within NPM discourses encouraged new attitudes towards efficiency, productivity and value for money, there remains a strong perception of professional care and duty and that health is not a business but a social duty and therefore adherence to strict management and financial regimes is not appropriate. Thus the application economic rationalism for some respondents served to revitalise the concept of social care and professionalism contained with their professions culture.

Social Care and Professionalism

The principles of medicine are clear. It aims to care for the sick, alleviate pain and suffering, treat disease, cure patients, and to create healing environments. Social care and professionalism are reputed to lie at the heart of being a good doctor. Indeed this is clear from the data presented so far that. While clinicians share some of the same desires as government officials, such as the creation of a superlative healthcare system, it is also clear that such altruistic values clash with the perspectives contained with NPM and financial accountability initiatives.

Indeed it is clear from the data that operating within tight clinical guidelines, treatment protocols and so are considered to negatively affect the clinician's ability to treat patients more creatively. Resource constraints were identified as '*obstacles which affect our ability to discharge our proper duty to the patients*' (SC3).

Debates over resource utilisation, particularly where it is very visible to patients, become major points of debate from both a social care and professionalism perspectives. Examples given of such debates included access to cancer testing and treatment and the restricted use of Herceptin in some health boards. The treatment of cancer was also described as being '*very much rule based and guideline governed*' (C5). This was considered to be particularly problematic '*when you have a patient demanding the newest and best treatment that the Board cannot sustain... its very distressing for both the patient and us*' (C5).

Further examples included the treatment of some psychiatric illnesses where older medicines were routinely used over newer drugs on a cost basis. The treatment of musculo-skeletal conditions was also identified as being guideline directed but to a lesser extent that chronic illnesses such as cancer.

> 'Sometimes the quality of treatment is compromised because of cost issues... sometimes this is where the guidelines come in useful we can demonstrated to the patients we are providing good treatments' (JC7).

> 'EBP, guidelines and so on are good as it speeds up the consultation and treatment decision process but at times social care and professionalism are compromised as a result' (JC4).

The creation of such bureaucratised systems of medical care thus have the potential to push clinicians to court gaming strategies, such as the cost shifting mentioned earlier,

that enable them to maximise apparent performance and satisfy their sense of identity and professionalism.

While the spheres of clinical practice and management are, to an extent, territories for conflict and debate it is also clear that the clinicians recognise the need for prudent management of limited resources within the healthcare system and that they have an important role to play in debates and decisions on resource utilisation.

> 'Financial resources are limited; we don't have bottomless pot of money so we need to prudent with how it's used many hours are put into making such decisions we work with the finance guys as well as some of the support staff within the healthcare [collaborative] teams to plan resource issues' (CD1).

Resource management therefore is a complex issue, involving multiple actors, which has to be managed with great skill to ensure that the finite resources are utilised in the most cost effective way. However, it is clear from earlier discussions that training in such matters is rather ad hoc and lacking. Likewise, training and education for team working is also lacking within both the doctors undergraduate training and professional development[65]. Collaborative teams and inter-professional relationships will be discussed next.

Collaboration

Another initiative that was highlighted by the respondents as having an effect on the clinician-pharmacist relationship was the drive towards collaborative teams. Collaborative Care Teams (CCT's) were designed around both health and social care principles with the main emphasis being on preventative medicine to promote and

[65] For examples see Owen & Wall, (2002).

maintain health and equality. CCT's provide a specialist multi agency and multi disciplinary services which span across primary care, acute care and secondary care. This service aims to support safe early discharge, prevent unnecessary admission and provides specialist input into other primary care services. The CCT's are thus a collection of health and social care professionals included in which are the clinicians and clinical pharmacists.

> 'These teams were developed to help us cope with the increasing financial pressure and demand on service but mostly because we believe that what's important is delivering the right service and support for the patient whether this is at home, in a day clinic or hospital. Drawing all relevant healthcare professionals into the team provides more opportunity to do this'. (CD1).

Increased collaboration within the NHS in general was one of the professed aims the health policies of the New Labour government. Clinical management innovation in the form of the collaborative team in effect became the focus of simultaneous managerial and professional objectives to '*cope with the increasing financial demands'* (CD1), and '*pressure to deliver the right service*' (CD1). Thus it can be argued that the introduction of NPM principles and the way in which they can be construed differ according to the role held and that some professionals integrate rather than reject such principles into their agendas. However, the finance director indicated that this was not always the case and argued that many senior clinicians were '*too focused on their own agendas*' to the extent that he felt that '*some decisions are made under pressure from certain senior clinicians when we, as finance advisors, feel they are the wrong ones...* (CD1).

Within the hospital setting the clinical pharmacists play a central role within the healthcare team. The professed aim of collaborative teams is to provide an integrated

and effective service that is responsive to patient's needs. The dynamics of such teams, however, are very complex. A good understanding of each member's role and the attitude of clinicians towards non-medical team members was considered to be important factor in the effectiveness of the team.

> 'I think most clinicians recognise that clinical pharmacist are increasingly important in being able to deliver good quality of care and do have to include and work more closely with them....and so have had to change their attitude to work with them' (C3).

A widespread view among the both groups of interviewees was that a greater appreciation of the each other's difficulties and stresses had been gained. This was cited as being achieved through increased communication as a result of the healthcare initiatives and expansion of the pharmacy service.

> 'We're working for the same organisation and to the same goals we want the same thing good results and quality of care for the patients so it makes sense for us to collaborate... We both know the financial constraints the figures are on the table so we have to work together and collaborate to make the funds go as far as possible and get the best possible care for our patients'. (C3).

This comment indicates that common interests exist between pharmacists and clinicians that serve to bind the two groups together. The clinicians interviewed did not regard pharmacists as marginalised healthcare professionals but rather viewed them as specialists in their own right.

> 'We've gotten to know the pharmacist much better there's definitely much more trust and respect than before we can see their value what they can contribute to clinical discussions. The level of their involvement is significant that's a big shift from 20 years ago...I suppose in terms of status quite clearly there's been a significant shift for them...Oh I think they are enjoying their new found status and quite rightly they are very much an integral part the healthcare team.... I have a great relationship with our clinical pharmacist'. (C3).

A clear message that comes across in the data is that clinicians have increased the level of communication and collaboration with pharmacists as a result of financial and clinical pressure. Indeed it was reported that clinicians and pharmacy managers regularly enter discussions about the development of services and how these services are organised and delivered across the hospital. The development of such services also includes clinical pharmacists taking on prescribing roles within predefined areas. Thus pharmacists are becoming increasingly involved in areas which were once very firmly held within the domain of the medical profession. In other words, pharmacy managers have successfully expanded their role within the healthcare team and have established a system through which they have the ability to influence and control the prescribing practice of the clinicians which can be identified as a corporate rationalisation process.

> 'Medical developments and education should be fed into service development you need to build up training and keep abreast of things or the trust in the service delivery will go. Professionals [within the service] need to develop their specialism's to keep on top of the game if that means a change in status for some then I have no problem with that if it means the patients get a better deal'. (C2).

Although communications between pharmacists and clinicians took place before changes to financial responsibility were imposed, these exchanges tended to relate to clinical issues specifically and not to the development of pharmacy services to support and improve clinical activity.

> 'Increasing the level of financial accountability and having to look after the budget does focus the mind...We had a lot of problems at first... to be honest we didn't really know what we were doing they realised our problem and helped us out....In some areas they were already getting involved but I think resource constraints and increases in financial accountability was the really driver of change here....Our relationship has matured a lot. At first we were the purchaser they the providers boundaries were quite explicit over time they have come to understand our needs and are quite sensitive to the needs of the patients this didn't just happen it was a managed process that involved a lot of communication and collaboration. Many hours were spent over the table discussing where our priorities lay what we need what they could do for us how they could facilitate our needs'. (CD2).

Clinicians in general also acknowledged that input from clinical pharmacists had highlighted that there were changes to clinical practice that could be made which would improve quality, efficacy and cost efficiency. This marks an important change as it demonstrates that pharmacists became involved in discussions over hospital services that were previously the domain of the clinicians and also indicates increased involvement on the part of pharmacists in issues relating to quality of care and efficiency.

The clinicians in general acknowledged that the pharmacists had a '*wide range of experience*' (C1) in their speciality area and a '*wealth of pharmacological knowledge*' (SC2) that was an important resource within the team. Indeed several respondents suggested that their input had resulted in safer prescribing decisions being made particularly on the part of the more junior clinicians. Incorporation of clinical pharmacists into the team was reputed to have encouraged a more critical view of various therapeutic interventions that resulted in team members being more educated about medicines in general. Thus the incorporation of clinical pharmacists into the teams '*provided an educational resource that enhanced the quality of care while achieve cost efficiencies*' (SC2). However, concern was also expressed that a conflict of interest may emerge with the new arrangements '*I don't think they should be regulating out clinical decisions*'. (C5).

The evidence from this clinician informant indicates that although changes in financial responsibility and the function of hospital pharmacy has allowed clinical pharmacists to enter into clinical meetings with clinicians the balance of power has perhaps not shifted as far as some of the other interviewees, particularly the pharmacists

interviewees, perceive. The same clinician informant went on to explain why the ability of pharmacists to challenge the clinicians power base is limited: *'I think it's still difficult for them though to say no to a specialist you should be prescribing this...How far can they demand that we follow the standards and protocols when we are the ones ultimately responsible for the treatment outcome? We still control such decisions but at the same time we rely heavily on their expertise'* (C5), thus illustrating the prevailing deep rooted conception of medical dominance within the healthcare system.

However, despite this view the continuing financial constraints were recognised as being a driving factor in the increasing the level of engagement between the two groups. Indeed, several clinical managers indicated that their mode of engagement with the pharmacy department in general had had to change but that this was a two way process.

The evidence thus far suggests that although the hospital clinician remains an important figure within the healthcare arena, expansion of clinical pharmacy services has enabled a more equitable relationship between these two groups to develop. In part, this has resulted from the increased communication and collaboration that the healthcare reforms have initiated. Such initiatives provide the potential for pharmacy to extend its influence and prescribing control function more into the clinician's activities thus changing the inter-professional relationship. This will be considered in the next section.

Inter Professional Relations and Negotiated Order

Within the NHS reform debates it has suggested that in order to achieve cost efficiencies, pharmacists should be involved more in clinical activities. This section considers the empirical evidence concerning the relationship between clinical pharmacists and clinicians and examines more directly how changes in financial responsibility and control structures over the last 25 years or so have affected this relationship.

With regards to the level of interaction between clinicians and pharmacists several clinician interviewees indicated that while communication and interaction took place between the two professions prior to the establishment of clinical directorates, the nature and level of such communication and interaction had changed significantly with pharmacists being much more involved in the clinical discussions that had previously been the sole domain of the clinicians. A clinician informant indicated that:

> 'On reflection we didn't really interact that much professionally before....Increasing the focus on financial accountability and tightening budgets I would say has had an impact on our relationship with the pharmacists, we do consult them more on prescribing issues than we did in the past...Before we made all the decisions when it came to patient treatments ...occasionally the pharmacy would call us up and tell us just how expensive a particular treatment was and recommend something else but in general we were pretty much left alone ...the senior pharmacist (the pharmacy manager) used to come along to some of our clinical meetings and give us some input but this was an informal arrangement... sometimes we took her advice sometimes we didn't and sometimes this caused a big fight [slight laugh] ...She could be a bit of a tyrant but came to our aid when we first took over the directorate role.' (C6).

He went on to state that both pharmacists and clinicians had to change their work practices as a result of NHS reforms and the pressure to increase throughput and efficiency.

> 'the changes that were taking place at that time made us all sit up and think about our role...we came (and still are) under pressure to get patients in and out quickly. Waiting lists and throughput became performance measures so the focus was on efficiency...so we [health professionals] had to rethink how we did things' (C6).

The expansion of clinical pharmacy services and extension of pharmacy into a prescribing function[66] within predefined areas is a development that could have a profound impact on the status of pharmacy as a profession and the future delivery of medicines within the hospital setting, and is something that the current government is actively encouraging. Although many interviewees regarded changes in financial control as another layer of bureaucracy, it was also recognised as a mechanism by which pharmacists could ultimately influence prescribing practice as they have greater awareness of the direct costs of medicines.

> 'Getting the pharmacist more involved was really important they know the price of treatments because they are the ones that do all the procurement so they can pass this information on to us... they know all the various alternatives and can guide us on the most cost effective ones...This is particularly useful for our junior clinicians who aren't quite up to speed yet'. (CD2).

Clinical pharmacy in particular was thus identified as being a valuable service that had enabled greater cost efficiencies and quality improvements in prescribing to be made: *'Involving the clinical pharmacist more in our clinical rounds has had an impact on quality of care and has saved us a lot of money and freed up some of our time'*. (C6).

The expansion of clinical pharmacy was generally viewed as a positive contribution rather than an encroachment on the clinician's clinical autonomy. Several clinician interviewees indicated that the involvement of pharmacists into clinical rounds and prescribing roles had been particularly beneficial as it freed up some time which could

[66] Pharmacist prescribing will be discussed shortly.

then be diverted to more serious cases. The value of such activity is reflected in the following quote:

> 'They do some of the work that used to tie us up this really helps it frees us up so we can spend more time with patients that really need our attention...Healthcare delivery is a collective thing so collaboration and communication within the team is key in getting the right treatment regime for the patient' (CD1).

The clinician interviewees generally agreed that as a result of the ongoing healthcare reforms and increased financial constraints and accountability this had enabled pharmacy as a healthcare profession to develop and increase its profile particularly in relation to the medical profession.

> 'I would say that clinical pharmacists have significantly increased their role within clinical meetings. They [clinical pharmacists] have a more direct role and clinical link to us than 15-20 years ago...20 years ago there was a big difference [professionally] between pharmacists and clinicians they weren't exactly looked down on but there was a big difference in status there's still a difference but not as much before...when you look at pharmacy services now and how much involvement they have in clinical decisions you can see how far they have come on as a profession'. (C4).

However, the ability of pharmacists to direct and control the prescribing behaviour was not regarded as a significant threat by one informant: *'I don't think this will result in clinicians losing their empires'.* (C7). Although this informant was less convinced of the actual impact of pharmacists on clinical activity the majority conceded that pharmacists had more opportunity to become involved and as a result had achieved greater recognition and input into clinical decisions:

> 'Because of all the standards and protocols and the expansion of clinical pharmacy there's more opportunity now for them to say you could do this or use this combination of drugs and get the same effect'. (C4).

The above quote illustrates the subtle shift where clinical pharmacists have a greater voice and control over clinical decisions and adherence to clinical guidelines and treatment protocols. This is further exemplified in the following quote: '*If they [the clinical pharmacists] recommend something different from what I prescribed provided it is reasonable I will approve it'.* (C8). However, caution must be exercised in order not to overstate the extent of such pressures on the pharmacist influence.

It was also recognised that the increase in accountability and control structures were likely to have a negative effect on the medical profession, which, as will be seen in chapter 7, echo some of the sentiments expressed by the pharmacists.

> 'We're definitely more interfered with...20 years or so ago we had a lot more autonomy then we called the shots it was an enormous responsibility and yeah some took advantage of it but now we've got all these guidelines, protocols and so on and patients are so much more informed and less inclined to take your word for it'. (C1).

Further discussion revealed the perception that devolved financial responsibility had provided the impetus for pharmacy as a profession to re-examine its role and function within the healthcare team. The development and expansion of pharmacy services which connect them more closely to the clinicians were attributed to the success of pharmacists in achieving a higher status within the healthcare team. Many clinician interviewees also indicated a change in attitude with regard to the professional worth of pharmacists regarding them as specialist in their own right and thus less as a marginalised profession.

> 'our clinical pharmacist is an important player in our clinical discussions quite often she comes up with suggestions that we hadn't really considered and points out both the cost and effect on the patient....this is where their pharmacological expertise really comes into play...this is their professional specialism'. (CD6).

This evidence suggests that pharmacists have the ability to direct and control the clinical practices of the clinicians, again demonstrating characteristics of corporate rationalisation. Indeed the above quote indicates that the medical profession is starting to feel a tightening of control from various angles which is leading them to rely on other healthcare professionals such as pharmacists in order to meet and comply with the changes imposed. The evidence also suggests that although clinical autonomy has largely been preserved that individual freedoms are perhaps more constrained within the new structures. Several clinician interviewees also indicated that the new arrangements had given pharmacists greater influence and status within the NHS.

Pharmacist Prescribing

Pharmacist prescribing was one area in which clinicians perceived that the status of pharmacists had improved, however, the majority of the clinician respondents did have some reservations and concerns over pharmacists taking on prescribing activities. Indeed several clinician respondents did not feel that such a role was suitable for pharmacists as '*they do not have the relevant diagnostic and patient factor*[67] *skills that are needed to make safe prescribing decisions*' (SC3). However, further discussions revealed that half of the respondents were not entirely clear of the role of supplementary prescribers. Several respondents also mentioned that the BMA did not approve of this extended role for pharmacists and had portrayed it as '*an irresponsible government initiative that's dangerous for the patients*' (C6).

Concerns were also raised over the type and level of prescribing training that was given to pharmacist prescribers as compared to the five or six years of training that the

[67] Patient factors skills were explained as doctor patient interactions in to getting to know the patient.

medical profession undertake. '*A major concern with pharmacists prescribing is their limited prescribing training. Patient safety has to be ensured. It's fair enough to get them to prescribe within limited areas but the more chronic illnesses should be kept to the clinician...They just don't have the diagnostic skills or experience to open this up further*' (JC7).

Another clinician went on to say '*I would not be happy to have a pharmacist making the prescribing decisions for anyone of my family... It's just not safe... Diagnosis can be very difficult and complex so you need a lot of skills in this area which are developed from years of experience... Pharmacists don't have this experience*' (SC4). Diagnosis and prescribing would thus appear to be inextricably linked in the mind of some respondents.

This view however, was not held by all of the clinicians. A feature that regularly appeared within the clinician respondents discussions was the issue of time. All respondents made reference to the amount of time (or lack of) spent with patients. A few respondents seemed genuinely open to the pharmacist prescribing and viewed it as a positive development provided they still retained a level of control.

> 'It frees up some of our time so we can focus on the more critical patients so in that respect it's good... But we need to be really careful how this is set up and make sure that they have the right training and support...and also keep it within the less critical areas' (JC2).

A senior clinician went on to state that the continuous reforms to the service would likely enhance this influence further in the future. He felt that as pharmacists became more involved the kind of prescribing activities undertaken by them would expand and thus might impact on the work of clinicians and their role as specialists. The data thus

illustrates the importance of the clinician-pharmacist relationship within the hospital setting and indicates as clinical guidelines, protocols and quality standards increase, the power balance between the two groups has the potential to shift in a favourable way for pharmacy as a healthcare profession. Indeed, it is clear from the data that there is a perception among some clinicians that the esteem and status of the hospital clinician within the last 25 years or so has not only changed vis-à-vis pharmacists but also with the populace. Indeed patients perception and trust in the medical profession were recognised as not being as deferential to the notion of the clinician as being the expert as much as it had been in the past.

> 'Patients expect much more they hear about new treatments and demand them...some even come to us and tell us what they want and resist no for an answer in such cases we have to work really hard to convince them that what we are giving them is appropriate and good enough'. (C8).

It was however, suggested that this is one area in which the pharmacists could help. Longer consultations with patients, particularly those with chronic conditions, were considered to be very important, but the time constraints of the clinicians made this difficult to sustain. '*Pharmacists have more time to spend with the patients so they can discuss all of the ins and outs of their treatment and reassure the patients that the treatment regime is the right and appropriate one for them*' (C4). This would suggest that the clinicians regard the pharmacist as being competent with regard to counselling patients and providing a concordat service. However, this contradicts their previous assertion that pharmacist do not possess the necessary patient factor skills.

Despite such mixed views over the role of pharmacists in prescribing, a common view that featured among most hospital clinicians was that due to the increasing bureaucratic demand and controls being imposed within the healthcare service that the power of the

medical profession in general was decreasing and that the time of the all powerful hospital clinician may be coming to an end.

> 'We're no longer making all the decisions regulation is building, more formal practices are in place so there's a greater need to conform...Ultimately what is happening is everything is becoming more transparent through more controls being imposed...We have to work with and take on board the advice of the pharmacists' (C8).

The last comment is particularly illuminating as indicates that the medical profession in general recognises a loss of prominence and influence which has enabled a certain amount of re-stratification to occur within the healthcare system to the benefit of the pharmacy profession. The perceptions of pharmacist with regard to this potential re-stratification will be discussed in the next chapter.

Chapter Summary

The objective of this chapter was to assess the reactions of hospital clinicians to the increasing usage of NPM discourses in their day-to-day activities and to obtain their perceptions of the impact of NPM impositions and increased financial accountability on their relationship with pharmacists. It is clear from the data that it is not just one element that is affecting their position but rather a culmination of NHS reform initiatives.

The information provided by the some of the clinicians suggest that, as they adapted to the changed organisational and environmental structures produced through NPM and financial accountability discourses, new meaning and sense of identity was derived thus producing a hybrid professional in the form of clinician manager. Despite this reported conformity, the data also suggests a significant level of resistance to this new

identity, with a group of clinicians maintaining their identity with the traditional values and culture espoused through their training and strong allegiance to the medical profession.

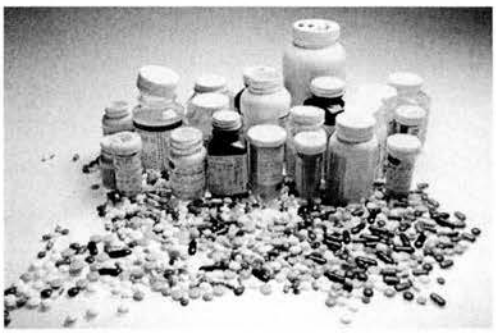
Indeed, the data also provides evidence that individuals respond agentially, sometimes in conflict, collaboration or compromise, to the associated NPM and financial accountability discourses in their attempt to negotiate dominant discourses and construction of self. Resulting outcomes from such actions and negotiation are thus complex and varied. While clinician managers conformed to NPM impositions, their primary socialisation remains entrenched in their clinical role thus while the attributes of NPM and financial accountability are taken on board their traditional professional values and need to retain professional credibility still hold true.

The data thus far demonstrates how the structural changes to financial responsibility has forced clinicians to listen to and work more closely with pharmacy than they had in the past thus giving pharmacists an opportunity to increase their role and influence which is ultimately contributing to the changing relationship between these two groups. The clinician interviewees did not speak of confrontation with clinical pharmacists but were more concerned with the impact of healthcare initiatives in general on their professional autonomy.

A positive outcome of the deliberations mentioned above was the perception of a better level of understanding of the problems that both sets of professionals face. While the data illustrates that the initial perceptions of the transference of financial responsibility was viewed negatively the relationship between pharmacists and clinicians has

matured into one based on mutual trust and understanding which suggests that time has enabled both parties to come to better appreciate and understand each other's problems. The perceptions of pharmacists with regard to this changing relationship will be discussed in the following chapter.

Chapter Seven: An Exploration of Attitudes to Extended Roles: The Pharmacists Perspective



This chapter discusses the impact that changes in financial accountability and NPM initiatives have had on pharmacy and its position as a healthcare profession. It will be shown that, over the last 25 years or so, there have been significant developments in hospital pharmaceutical services which have served to erode the boundaries of the professional interface through the emergence of specialist pharmacy services and clinical pharmacists operating in the clinical setting. The findings demonstrate that, clinical pharmacists, whose specialism is to assist the clinicians in the safe, economic and effective use of medicines by optimising pharmaceutical factors, are increasingly being utilised and regarded as an essential function within the hospital setting. The importance of the pharmacist – hospital clinician relationship will also be discussed. The chapter will focus on the data collected from a sample of pharmacists across NHS Health Boards in Scotland. Interview data will be used to further highlight the impact that changes in financial accountability and NPM initiatives have had on concerns over quality of care and the pharmacist – hospital clinician relationship.

Changes in Financial Responsibility

As discussed in chapter 5, pharmacy managers have in the past had considerable autonomy over which services to provide and how and to whom such services should be provided. Within the healthcare reforms that have been initiated one major change has been the control over financial resources for the provision of drug therapeutic treatments and in particular the holding of the drugs budget being transferred from pharmacy to the clinician dircetorate. The rationale behind transferring control of the drugs budget from pharmacy to the clinical directorates was to put the responsibility of costs onto the shoulders of the people actually spending the money – the clinicians.

> 'One of the biggest changes that have come out of the NHS reforms has been clinicians being forced to recognise the costs of their decisions. Everyone now has to stand up and be counted.' (UM)

However, the transference of control over the drugs budget to that of the clinical directorate was perceived by a few pharmacists as having a negative effect on the level of autonomy that they hold. Indeed a few interviewees viewed the reality of this change as being a somewhat downgraded role for pharmacy departments. It was stated that:

> 'Holding the budget gives you control of the money and therefore control over purchases and supply ...basically holding the purse strings means you've got power...'The removal of control over the drugs budget has essentially reduced the pharmacy's overall role to that of procurement and distribution... we're now reduced to being over qualified store-keepers' (PMS)

While it can be argued that this simply puts the funding into the hands of those best placed to manage it, pharmacists argue that it also removes one important check on overspending; the pharmacy. Previously pharmacy controlled expenditure by offering therapeutic advice and directing the clinicians prescribing towards cost efficient drugs

of high efficacy. The supply of more expensive or new drugs of questionable improved benefit was also blocked until sufficient justification was presented[68]. The devolving of control over the drugs budget essentially had the effect of removing this control mechanism. From the pharmacist perspective, control of the budget, was thus seen by a few respondents as a means that enabled pharmacists to influence and exert some control over clinician prescribing and hence treatment cost.

In contrast to this perception, the majority of pharmacists regarded the transference of control of the drugs budget as an opportunity that had been long awaited. Such interviewees believed that the lifting of the administrative burden of the budget would enable their profession to develop and improve hospital services. Such interviewees reported that they had already established good working relationships with the senior clinicians within their hospital and had initiated clinical pharmacist services within defined areas of their hospital some time before such initiatives were being discussed in the reform process. While some disadvantages were recognised for some small units, such as the downgraded role previously mentioned, it was generally felt that this change provided the impetus and leverage required to develop the hospital pharmacy and clinical pharmacy services.

Interestingly, the pharmacists interviewed reported that after the clinical directorates took control of the budget, drug expenditure actually increased with the majority of the directorates having spent their allocation some three or four months before the end of the financial year. Discussions with the pharmacy managers revealed that this was an outcome that they had anticipated.

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[68] The function and role of hospital pharmacy is outlined in chapter 5.

'For some clinicians the overspend was unintentional they just had no idea about the cost of some drug therapies its not part of their education process....on the other hand we had a few who overspent in the hope that their budget would be judged on a historical basis in the hope that the more they spent would mean a bigger budget the next year... We had no illusions about clinician's lack of interest in the budget. There was a lot of concern over the transference of the budget mainly that it wouldn't be managed properly....Cost had never been an issue for clinicians they ordered what they like and expected the cost to be covered ....After they took control and overspent they expected us to sort it out but it was no longer our problem...'. (PM)

The Issue of Cost

As outlined in chapter 1, the cost of drug treatments within the UK has been escalating for some time. It has been suggested that many factors are contributing to this increase. In particular, inappropriate prescribing and drug wastage have been cited as major causes. This applies to both primary and secondary care. Such issues contributed to some extent to the catalyst of healthcare reforms. It is reported that as a result of NPM initiatives, within the hospitals under study, greater involvement of pharmacists in medical audits and prescribing decisions within the hospital setting and the use of joint formularies are already in place with the objective of addressing such issues. While there appears to be mixed views as to the effectiveness of such involvement from some pharmacy and clinical staff members, discussion with the Regional Principal Pharmacist was more positive.

The RPP was in fact quite evangelical about the role of pharmacy in prescribing practice; drugs budget management and medication review process and clearly felt that their input was not only important, but also very effective. While he agrees that the pharmacy continues to play an important role in the procurement and distribution of medicines he believes that the role of the clinical and directorate pharmacists, the drug information service and their input into pharmaceutical care is becoming increasingly

important. He also believes that the clinical pharmacists have a significant influence on the prescribing patterns of the clinicians through their involvement with medical audits, joint prescribing committees, drug evaluation panels etc.

The RPP also explained that regional pharmacy managers and some senior clinical pharmacists participate in various interest groups and committees (as discussed in chapter 5) and are involved in the budget setting process and medicine resource management schemes. He went on to say: '*Although pharmacy does not have a direct influence on these issues they have an indirect influence through their recommendations and use of their expertise.*' (RPP1). A desire to develop services which enabled hospital pharmacy to support the clinicians and the value that such systems could contribute to overall patient care was echoed by several pharmacist interviewees. This view is support by the RPS and Minister of Health.

> "Your expertise in the area of drugs is far greater than any of the existing prescribers. If anybody is to be allowed to extend into the prescribing arena, then it should be highly trained clinical pharmacists"

When questioned on the issue of inappropriate prescribing it became apparent that the regional pharmacist's also believes that the greater involvement and utilisation of their skills has contributed immensely to the successful management of the clinical directorates and has reduced the level of inappropriate prescribing and drug wastage.

> 'Without our input clinicians would have continued to prescribe inappropriately and overspend their budget'. (RP1)

The regional pharmacist also commented that the level of drug wastage had not only been reduced due to the greater involvement of the clinical pharmacists but also

because of the state of the art computerised stock control system that was in use within the hospital under study.

> 'We also have in place an ace stock control system which can track ward and directorate expenditure....we can use this to feed them all the drug and financial information that they need.....this system also enables us to recycle stock whether it is open or not and to credit it to the directorate'. (RP2)

In general, the regional pharmacist believed that the changes that have taken place within the NHS, while not without implementation and political problems are, in fact, a positive step towards rationalising the use of drug treatments and the utilisation of pharmacy as a support function and that such advancements will facilitate good medicines management in the future: '*Provided we have cooperation a greater role for pharmacists should facilitate good medicine management'.* (RP1). Such issues will be discussed in more detail throughout the chapter.

Quality and Equity Issues

At a broader level the removal of power from pharmacy to provide a service to the whole hospital on an equal basis and placing it the hands of a few directorates, who are only concerned with their own unit, was reported to have raised concern over the quality and equity of service provision. Such concern was expressed from both pharmacist and nursing staff. Before the introduction of the clinical directorate and the transference of control of the drugs budget, each ward/unit received the same basic level of service, with the exception of the high cost units[69]. This was viewed by nursing staff as a fair system that ensured good levels of services for all. However, with the

[69] Clinical pharmacy at this time was still relatively under developed as a service.

introduction of clinical directorates and the expansion of pharmacy into directorate areas some ward staff feel that they are suffering as a consequence.

> 'Now we have a system where wards have to buy services... if you've no money then there's no service... The end result is a poorer quality of service ... the patient suffers'. (SN)

These concerns were also expressed as an issue by pharmacy staff. However, they also recognise that they could not continue to provide an un-funded service without adverse long-term consequences for the department and that rationalisation of the service had to be implemented. There is a clear acknowledgement that the decision to utilise pharmacy services is now the responsibility of the clinical directorate and that expansion of the service into these directorates poses a risk of creating an inequitable service, but as most of the participants noted, '*there have always been inequities in the healthcare system they are now just more explicit'*. (P & SN).

It is unclear how such inequities can be avoided given the constraint on resources however, pharmacy managers have tried to rationalise the service and lessen such inequalities by conducting a needs assessment based on the type of ward and relative drug expenditure in the area. As part of the rationalising process, the non-directorate wards are still provided with the basic level of service that ensures patient safety, but some of the specialist functions which were subsequently developed (these are discussed later in the chapter) have been removed to achieve cost efficiencies.

The evidence presented so far illustrates that a segment of the hospital pharmacy profession were initially reluctant of the budgetary responsibility change as they perceived such a change as threatening to their already marginalised position. While

the new arrangements were seen as an additional layer of bureaucracy, they was also viewed as an opportunity by which pharmacy could develop and influence hospital services and potentially gain more financial resources and thus mould the new structure to their own advantage. This will be discussed next.

Decision-making Regarding Pharmacy Services

One of Pharmacy's main concerns over the devolved financial responsibility was that constraints on the availability of resources would result in the directorate reappraising all areas of service provision including the pharmacy service. They were especially concerned about services such as the Drug Utilisation Review (DUR) and Drug Information (DI) service that span across the whole hospital, and where the benefits, although real, are not readily identifiable at individual directorate level. A senior pharmacist noted that:

> 'There had been a lot of questioning over the benefits of some of our support systems...our main concern was that services would be cut to provide money elsewhere'.(SPDUR)

This provided the impetus to re-evaluate and improve these particular services in order to meet clinical demands. Interestingly, however, this informant also felt that such scrutiny also provided pharmacy with benefits. If a particular pharmaceutical function was valued by the clinical directorate, this could be use as leverage to qualify for more financial resources allocated by the Health Board management. Pharmacists identified this as an opportunity to exert change in terms of the hospital pharmacy service:

> 'Before there was no real established system for getting our services out there...We've seen loads of reforms some them good some bad in general we have really benefited just look at the service we have now compare that to 20 -25 years ago...The difference is

> enormous 25 years ago there was very little communication between pharmacy and clinicians now we have regular discussions that include clinical dimensions as well as service developments' (DIP)

Another pharmacist informant who was also involved in specialist pharmacy services such as the DEP felt that clinicians were slow to realise the value of input from pharmacists with regard to prescribing decisions in achieving high quality treatments at lower cost.

> 'Many of them viewed us just as pill counters...What they fail to appreciate is that we not only have knowledge about which drugs are best but also about the drug interactions, side effects etc as well as the cost....I think many clinicians were and some still are unaware of just how useful we could be to them....' (DEPP)

Given the wide range of services that pharmacy can provide, directorates have to decide which functions they wish to utilise. Such decisions are heavily influenced by factors such as the ability of the service to achieve cost efficiencies while maintaining a good standard of care: '*I am looking for input into ways to improve the quality of patient care while at the same time achieving cost efficiencies. If the clinical pharmacist can't provide this then the service will be discontinued'*. (CD1). Thus it can be seen that the devolving of control over the drugs budget has had considerable impact on the pharmacy department not only in decisions about the provision of pharmacy service but also with regard to what is provided. Such changes are a major concern for pharmacy managers and added to their reservations over the decentralisation of decision-making.

Some pharmacists perceive that such changes have resulted in the pharmacy service being pushed into a position whereby they now have to justify their services and actively promote and develop their role as healthcare professionals. Some also perceive

a loss of power and status for the pharmacy profession. In response to these changes, the pharmaceutical profession has called for the pharmacists to continue their education and specialise in specific areas such as general medicine, geriatric care, paediatrics etc, thus enhancing and securing the professions status.

> 'The buzz words are clinical effectiveness, evidence based medicine, clinical governance and so on....What we need to know and prove is whether what we are doing is valuable or not....We are constantly reflecting, monitoring, auditing whatever you care to call it, on what we do....Service provision now is all about balancing the numbers...We [healthcare providers] in general are held more to account'. (SP3)

The development of more specialised support functions which should enhance the status of the pharmacists and give them a greater role in drug management is now in operation in most hospitals. These include a Drug Evaluation Panel (DEP), Joint Prescribing Committee (JPC), and a Drug and Therapeutics Committee (DTC)[70]. Interviews with pharmacists who were also representatives on one or more of these committees revealed mixed views as to the amount of influence and input that pharmacy has into these areas. A DEP pharmacist held the opinion that pharmacy's input into medicine resource and budget management was relatively limited with the clinical pharmacists only having a cursory role in the use of new medicines.

> 'The clinical pharmacist serves as an advisor to the clinician, but at the end of the day, the clinician prescribes the treatment that he wants to use'. (DEPP)

This view was supported by an interview with a JPC member. The interview established the view that the clinical pharmacists perceive that they have an indirect influence in the clinical decisions of clinicians and medicine resource management through their expertise in the field of medicine. However, they feel that their influence

[70] The functions of these committees are outlined in chapter 4.

in such matters is limited and believe that, while involved in medical audits and joint prescribing matters, their input to patient drug regimes serves as an advisory role only and stated that: *'The clinician prescribes the medication that he deems to be appropriate and cost doesn't matter'.* (CP4). What emerges is a picture in which some pharmacy personnel feel that the introduction of clinical pharmacy has at least to some degree increased the status and influence of pharmacy, although ultimately their influence would appear to last only as long as the clinicians are prepared to listen.

The result of this structural change within the hospital setting thus allowed the hospital pharmacy sector to develop specific support functions through which they could exert their specialism and input into clinical decision making and challenge the clinical decisions of hospital clinicians. The government, through the process of healthcare reform at the macro level created, conditions of corporate rationalisation through changes in budgetary and financial control and promotion for the development of specialist pharmacy functions which feed into clinical decision making. Such macro level changes and increased involvement of clinical pharmacists in clinical decisions, although slow to develop, thus challenge hospital clinicians at the micro level over the utilisation of prescription medicines. One of the consequences of this new arrangement has been that pharmacists have had to adapt to take on board a corporate rationalisation role which is quite different from their traditional marginalised position. The professional development of pharmacist and their extended roles will be discussed in the following sections.

Professional Development

Within chapter 2 it was established that pharmacy, as a healthcare profession has been subjected to some major changes as a result of the healthcare reforms implemented, with the most profound effect being the transference of monetary power to the clinical directorates to select and purchase pharmacy services independently. As the findings demonstrate, the removal of monetary control has, in the view of some, reduced the autonomy and status of pharmacists as healthcare professionals. However, it would appear from further discussions that the people who hold this view have also been relatively inactive in developing their career with the result that they still remain in basic function positions.

> 'Resistance to change generally came from a few older pharmacists who would have like things to remain the same...they'd no ambition it was up to us the younger generation to develop the profession further'. (CP2)

It is evident that while the initial transference of responsibility for the drugs budget from the pharmacy to the clinical directorates gave the pharmacy little motivation to intervene in prescribing decisions it soon became apparent that in order for pharmacy to maintain its authority with regards medicine management, changes in attitude and the functions performed by pharmacy would have to be implemented. Such changes were viewed as a positive step towards greater professional recognition by some pharmacists.

> 'The removal of the burden of the drugs budget has enabled us as professionals to develop and promote our expertise'. (SCP1)

One pharmacist informant expressed a more ambivalent view with regard to the effectiveness of the new structural regime. On the one hand they recognised that

pharmacists less focussed on professional development ran the risk of remaining as a marginalised healthcare professional, while on the other it gave those more professionally orientated the opportunity to develop and expand their professional services and thus the potential to become more integrated within the professional healthcare team.

Within the healthcare reforms there have been several initiatives put forward by successive governments and the pharmaceutical society for an enhanced role for pharmacy in the management of medicines, some of which have been implemented in the hospitals under study. The most significant change has been the drive towards integrating more clinical pharmacists into areas such as medical audit and medication review teams. What is clear from the documentary evidence and from the interviews conducted for this study is the fact that it is in these areas that there is potential for pharmacists to take an enhanced role in the dissemination of information to clinicians. Some studies[71] show that where clinical pharmacists have an active involvement, drug costs have been contained or reduced. While development in these areas have been slow, progress is now being made with the growing recognition of the clinical pharmacists expertise in the area matching compatible drugs thus reducing potentially harmful side effects which would otherwise have to be treated with more drugs resulting in the overall drug treatment cost increasing. Directorates are also making more use of the clinical pharmacists' knowledge of costs and are more inclined to seek and listen to their advice with regard to alternative treatments.

> 'As the clinical directors feel the pressure to contain or even reduce costs they increasing turn to us for advice..... The days of this is how I've always done it is gone for the

[71] For example Hudson, (1990)

clinicians.... They're held more accountable now they have to look harder at what they are doing and what the outcomes are'. (CP1).

'The requirements of the clinical directorates are becoming more clearly defined. Pharmacy has been involved in detailed discussions covering a wide range of issues and service requirements. Many of these were already in place such as a basic formulary, shared care protocols, quantities on discharge but others such as the Drug Evaluation Panel required developing' . (PM2).

The tightening financial pressure thus provided leverage for service expansion and development. The development of such services however, is not straightforward. Pharmacy has to ensure that each directorate does not define its own preferred service profile at the expense of another. Efficiency of scale savings have to be maintained. Pharmacy also has to justify the implementation of any new service and apply for funding just like any other department: '*Now we have to negotiate with finance to expand our service to meet the needs of the directorate, if you can fight your corner well it's possible to achieve resources to improve services*'.(PM1). However, it was also felt that if a particular service was valued by clinicians that this could be used as leverage to apply for more financial resources from the Trust management.

It was also recognised that changes at the macro level could be a vehicle for effecting change in terms of the professional involvement and status of the pharmacy profession within the hospital setting.

'There's a strong emphasis now on the delivery of a good quality of service this is hard to achieve when there is limited resources...A constant problem is a lack of money so you could say a good quality service is when you get a good clinical result that is also relatively cost effective that's where our expertise comes into play'. (RRP1)

It would appear that the overall level of clinical service delivery has increased significantly in the last decade. What is not clear is which initiatives have contributed to this enhanced service.

'It's difficult to identify which initiatives were prompted by the NHS reforms from those that we might have deemed fit to make for professional reasons. Issues of optimising the use of resources has always been important and setting standards for the quality of our performance is a professional necessity....The changes being introduced by the White Paper were being brought in long before 91'. (CP2)

Transforming Relations

This section considers the empirical evidence from the pharmacist's perspective on their professional relationship with the clinicians and examines how the changes in financial accountability and NPM initiatives have affected this relationship. The quality of drug therapeutic treatments are situated at the professional interface between pharmacists and clinicians and for this reason are used a way to investigate the importance of the pharmacist- clinician relationship and the attempts of pharmacists to influence the prescribing behaviour of clinicians.

The importance of the relationship in achieving change in prescribing behaviour was neatly summed up by a senior clinical pharmacist who stated that: '*Progress is made if the clinician wants it; if he doesn't then we have a lot of difficulty trying to change his mind.... Their cooperation is a key factor'* (SCP2). The same clinical pharmacists also made the point that discussion and negotiation is important because they are both part of the healthcare team with the same goal: '*Ultimately we both want the same thing, the best possible treatment for the patients so we need to listen to each other'* (SCP1).

It is important to consider the perceptions of the participants as to the impact of quality protocols into the clinical arena on the relationship between pharmacist and clinicians. The setting of quality protocols was considered to be a sensitive issue that: '*Hits on*

clinical responsibility and independence.... and could compromise clinical autonomy' (SCP4).

The above quotes indicate both the limitations and the possibilities of such healthcare initiatives. Although greater communication and collaboration between healthcare professionals feature highly within the NHS reforms and NPM discourses, the evidence presented here suggests that within the hospital setting the clinician-pharmacist relationship requires further development. Clinical pharmacists in general however, recognised that clinical and quality protocols were becoming more widespread and were keen to put forward their role in aiding clinician compliance. In particular, pharmacists' interviewees felt that the expansion of their pharmacological expertise made clinicians listen more to their advice.

> 'We provide them with specialist information and opinions as to the most effective drug treatments that are also cost effective.' (SCP5).

The involvement of pharmacists in establishment and control of prescribing practices and clinical protocols also enable them to challenge clinical decisions that do not comply with the guidelines. However, it was also indicated that influencing prescribing practice was a sensitive issue that required careful handling in some cases.

> 'If you disagree with the drug treatment regime being suggested you have to be tactful in your approach with some clinicians particularly if they have not directly asked for your opinion. To say you disagree can potentially be considered confrontational...We can influence to an extent but this can be uncomfortable'. (SCP2).

Such quotes indicate a sense of professional tension between pharmacists and clinicians which is rooted in the perceived dominance of the medical profession. However, this same informant stressed that the relationship between pharmacists and

clinicians were generally good. Despite such concerns, perceptions of a more equitable relationship were reported to be developing as a result of increasing communication and collaboration between pharmacists and clinicians.

> 'As the money tightens they, [the clinicians] are becoming more reliant on our expertise and knowledge.... We are increasingly invited to give our opinions' (SCP1).

This increased communication, and collaboration was also reported to have led to better understanding of each others situation, and indeed some pharmacists perceive that there had been a shift in the balance between the two professions with the gap between the professions becoming narrower that that of the past.

> 'Participation in the drug rounds and clinical meetings means we get to know each other and each others roles much better....There's more trust and respect, less of a them and us feeling.... We operate more as professional allies now'. (SCP3).

This marks an important change in the professional relationship as it indicates that pharmacists are becoming more involved in clinical discussions which were previously the sole domain of the clinicians. Another pharmacist informant expressed the hope that clinicians would want to increase the level of collaboration between the two groups; however, it was recognised that this will require time cooperation and commitment from both parties: '*Hopefully this trend will continue*' (SCP3).

There was also a feeling that pharmacy and clinical pharmacy in particular as a healthcare function had achieved greater prominence. Although most felt that pharmacy as a profession had gained recognition the general view was that the relationship between the professions should be viewed as one of partnership rather that a fight for power and dominance. There were relatively few pharmacy personnel who

felt in a position to challenge the clinicians, with the exception of the Chief Regional Pharmacists and Senior Pharmacists, with only a few indicating that they had done so on relatively few occasions.

> 'If they are straying off from the clinical guidelines and quality standards set for no good reason then they have to be brought back into line.... Sometimes they just want to flex their muscles and remind everyone of their clinical dominance but at the end of the day they are accountable just like the rest of us'. (CRP1).

This vividly illustrates how the expansion of clinical pharmacy services and increased financial accountability are effectively feeding into and challenging clinician's clinical decisions.

On discussing how pharmacists perceived their relationship with clinicians mixed views were identified. It was generally reported that a good rapport between pharmacists and junior clinicians existed: '*The junior clinicians are much easier to get on with, probably because of their inexperience they are more willing to listen or ask for our opinions of specific drug treatments...In general we have a good level of collaboration with the junior clinicians'*. (SP1) It was, however, also reported that this rapport was prone to change as the clinicians gained in experience and grade: '*For the most part the rapport with the clinicians that came in at the junior level and stayed on in the hospital remains the same but some, as they progress up that career ladder, they sometimes like to show their authority by ignoring our recommendations even when those recommendations make perfect sense'*. (SP1)

The data so far suggests that a greater degree of communication and collaboration between pharmacists and clinicians is occurring and indicates that this is a continuing trend that is being promoted by both government and the RPS. However, the data also

indicates that this process requires sustained commitment and investment by both parties. The data also suggest that despite advancement in the level of collaboration between these two groups that more needs to be done in order to establish a greater level of trust that would allow pharmacists more involvement in clinical activities.

Recognition and respect was reported to be harder to achieve from the older clinicians. The dominant role and importance of the clinician within the hospital setting are neatly illustrated in the following quote from clinical pharmacist informant who explained that: '*In the early days of clinical pharmacy and participation in clinical meetings it was extremely difficult for us to be taken seriously. We really had to stand our ground and fight hard to prove our worth. There were constant battles particularly with the senior clinicians who were used to getting their own way all of the time*'. (SCP3).

Such sentiments suggest that collaboration is not an impartial activity but rather is tied to issues of power and authority. It is not just a question of whether or not collaboration takes place; it is the nature of the collaborations that are important. The data indicates that although there is a lot of oratory concerning collaboration between pharmacists and clinicians, there is a feeling among the former that the willingness of clinicians to collaborate had definite limits:

> 'Sometimes when you are taking part in clinical discussions you feel that your opinions are just being humoured or with certain older clinicians just blatantly disregarded – they make it clear they are the ones in authority and will make their own decision regardless of our input'. (JP2).

It is notable form such a comment that the clinician-pharmacist relationship is not something that all clinicians have regarded as being that important. While the development of collaborative working and increased communication between the two

professional groups may bring new ways of working that could lead to a greater utilisation of key skills and competencies, work satisfaction and a new era of patient safety, if not handled sensitively, could be considered as an affront to traditional professional roles. Thus poor clinician-pharmacist communication and collaboration has the potential to have a negative impact on the level of healthcare provided and overall patient care, for example the failure to detect and communicate a prescribing concern.

Interactions between pharmacists and clinicians can be difficult and may even be conflictual (as is evident from the quote below) which may affect subsequent exchanges and result in a disharmonious working relationship. In such circumstances the relationship that develops may lead to resistance to collaborative working. A phased introduction under the wing of a more experienced mentor and greater involvement and interaction between pharmacist and junior clinicians, including during their final year of study, would seem an ideal forum to encourage a positive attitude towards collaboration between these two healthcare groups. Developing high level communication skills can also ensure that even the most resistant actors succumb to collaborative efforts.

> 'I remember my first few clinician meetings. I was quite new to clinical pharmacy and although I knew I had lots of knowledge and a lot to contribute the senior clinician was completely intimidating and constantly looked for flaws in my recommendations, he blew me off at every opportunity... It took me quite some time to recover from that luckily I was also involved in clinical meetings with less senior clinicians who were more supportive which got me through'.(SCP4).

As already discussed, the medical profession have a deep seated perception of hierarchy. A key component in achieving successful collaboration is an understanding this hierarchy. Essential components for establishing practitioner collaboration include

proximity, clinical knowledge, professional practice interests, equality and time. The development and expansion of a ward-based clinical pharmacy service provides a platform for bringing these attributes together and may assist the development of a stronger collaborative working relationship.

Prior research[72] suggests that the development of collaborative relationships is dependent on personal variables, the nature of exchanges between the practitioners and the context (practice) environment. Although personal variables differ, these can be improved at the professional level through appropriate training. While communication skills feature highly within the medical professions training, such training within pharmacy education programmes is limited which could be a contributing factor in the level of poor communication and collaboration reported here.

> 'If we have a difficult clinician to deal with we always send our most senior clinical pharmacist they are less likely to fold under the pressure so the power games still go on'. (JP2).

In terms of the exchange characteristics, these broadly relate to whether or not people can get on, and as such it is not unsurprising that they are included in this discussion of collaborative process between clinicians and pharmacists. Keystones that are considered to enable high quality social exchanges and facilitate rapport between practitioners are trust and accountability. Such attributes, however, take time and effort by all individuals involved to be developed. The traditional ward rotations applied within the NHS, where medical and pharmacy staff covering particular wards change regularly, makes the development of such attributes difficult. However, if at an organisational cultural level, trust exists between professional groups, then this

[72] See Gorman, (2010) on managing multi-disciplinary teams in the NHS.

difficulty can be overcome. The ability of individuals to be persuasive can affect how the exchange proceeds. An important factor however, is that the interaction must be considered as fair and non-threatening without one party being forced into a position or action that they had not desired for the exchange to be true collaboration.

> 'It is absolutely imperative that you walk into these meetings with a positive air if you show any sign of weakness or insecurity they pounce on it, trust me its not an experience that you want to have... its all about power and authority they [clinicians] don't like being questioned or challenged so you have to couch your recommendations carefully and with confidence'. (SCP4).

The practice or 'context' environment is another important element in establishing good collaborative practice. Involving pharmacist more in the clinicians ward rounds is representative of a context change. The traditional rotation and shift patterns of medical staff can make the continuity of patient care difficult. Such difficulties can be alleviated with the interactions of the ward pharmacist. However, this relies on the confidence of pharmacists to believe that their input will be valuable and beneficial.

It is clear from the data presented here and in chapter 6 that clinicians and pharmacist in general seek to work collaboratively with one another and desire respect for their specific skills and competencies. A clearer understanding and appreciation of individual professional roles, effective communication, accessibility, trust and mutual respect are essential attributes in achieving successful collaboration. Healthcare delivery is a highly complex and multi step process that lends itself to human error which can potentially have catastrophic consequences. Effective collaboration within the healthcare team should at least decrease the risk of error and provide an optimal and safe patient management system. This will be discussed next.

Communication Barriers

Within the hospital environment there are many barriers to communication between healthcare professionals which affect the level of collaboration that takes place. Such barriers include, time constraints, a lack of access to required information, and misconceptions of the roles and responsibilities of individuals within the healthcare team. Clinicians record their findings, diagnosis and actions in a standardised format using patient's charts and notes. These are used to communicate with other clinicians within the medical team. Pharmacists however, do not routinely record their thoughts or actions in the patient's notes. Rather, comments on the patient's drug treatment are generally made verbally to the clinician, or if the clinician is not present added in colour pen on the patients drug chart in the hope that it is spotted during the clinician's next ward round. In terms of quality control this is a rather loose arrangement as it offers no guarantee that the clinician will spot the comment or indeed act on it and can lead to delay's in patient management and the resolution of errors. A further problem in using this system is the current shift patterns and rotations of clinicians who may be responsible for managing the patient today but may not be tomorrow. This situation indicates that communication between pharmacists and clinicians regarding patient care is an area that needs considerable attention.

> 'If we see a mistake on the patients drug chart and the clinician is not around then we highlight it and amend it accordingly but the clinician has to sign it off on his next round its not an ideal situation but we have no other formal control mechanism' (CP3).

Enabling pharmacist to formally record their input into the patients notes would increases the probability of the clinicians reading and acting on this input and provides a clear chain of thought and decision making in a more legally legitimate form. Most other healthcare professionals record patient interactions and their clinical comments.

For example, physiotherapists record the patient's treatment therapy and nurses keep nursing record notes. Indeed within secondary care there appears to be a growing trend towards creating proformas or patient pathways as means of enhancing the communications[73] between different healthcare teams to ensure that treatment protocols are followed. A further and more complex barrier relates to the professional groups themselves, in particular their own perceived professional isolation, status and power – a 'them and us' scenario that stems from the hierarchical structure within the professions.

So far the data has illustrated the importance of the pharmacist – clinician relationship. It was also felt that the imposition of clinical guidelines and protocols would continue, indeed the development of the National Service Frameworks is a good indicator of this trend. The changing relationship between pharmacists and clinicians has resulted in part from the transference of the drugs budget from pharmacy into the hands of the clinicians and the increasing financial constraints within which the clinicians have to operate. In the next section the extent to which clinical guidelines and quality protocols can be used by pharmacists to affect the behaviour of clinicians prescribing practice and thus put them in a position of corporate rationalisers will be presented.

Guidelines and Protocols

Within the hospitals under consideration, the senior pharmacy managers felt that the clinical guidelines and protocols implemented were consistently worked to as these feed into and became part of the clinician's professionalism. However, it was also clear from discussions held that when it came to patient care and professionalism on the part

[73] See Astrom, Duggan and Bates, 2007.

of the clinicians that this, as far as the pharmacists were concerned, was never in any doubt. Rather they expressed the view that before such guidelines and protocols became official documents that quality of care and standards were implicit and based on high levels of trust and morality.

> 'Like ourselves they [the clinicians] have a high ethical code which is instilled in them throughout their training they have their own professional moral base I don't think anyone really doubted that'. (CP1).

The above quote provides a nice illustration of alliance with the clinicians, who are considered as the professional monopolists, in an attempt to increase their own professional legitimacy. A significant change in the delivery and management of healthcare services has been the introduction of explicit and codified documentation of clinical guidelines, quality standards, clinical protocols etc and a move towards ever increasing accountability[74]. The following quote provides a good illustration of the significance of such changes in terms of the pharmacist's ability to direct and control the prescribing practices of the clinicians.

> 'The problem before was that the clinicians were pretty much free to do their own thing... they had very little financial accountability... of course that's all changed now.....Now we have a situation where everything has to be done according to the guidelines everything is written down, documented and justified.... Its been good for us we have more points of reference so when we are taking part in the clinical rounds we have something concrete to base our recommendations on so its harder for them [the clinicians] to argue against'. (RP2).

The above quote recognises the key position that the medical profession holds within the healthcare system however, it also indicates that regulation is considered a valuable target and a possible way of directing and controlling the activities of the clinicians. One of the main driving forces behind many of the healthcare reforms identified within

[74] See Power (1997)

chapter 2 was the lack of financial resources and financial accountability on the part of the clinicians. The imposition of clinical guidelines, quality protocols and so on were intended to improve service provision, patient care, use of limited financial resources and accountability. All participants in this study acknowledged that: '*rightly or wrongly the purse strings have tightened which is having an impact on clinical activity*'. (RP2).

It was also acknowledged that while the clinical guidelines etc had improved service provision and had some impact in terms of control over the use of resources that it was in reality extremely difficult to adhere to the guidelines and standards due to the lack of money.

> 'At the end of the day we have patients to treat, standards to meet and very little money... we want to give the best possible treatments but the money's just not there so sometimes lots of the time really we have to compromise and give the next best treatment so the money can stretch further this doesn't always tie in with the guidelines'. (RRP1).

The above quote suggests that the clinical guidelines, protocols etc imposed within the hospital setting are limited in their effectiveness to improve service provision and control as a result of the financial constraints. However, it is also clear that the financial constraints are being used as a tactic on the part of the pharmacy to increase their involvement within the clinical setting.

> 'Really the best thing that happened for us as a profession was making them responsible for their spending. They had no idea really of the costs of their treatments. They just expected it to happen... magically it would be paid for...After the change we had some fun. They completely blew up the budget we took full advantage of this we had to... we used it as a means of developing our role and contribution in the clinical meetings... It took a long time years really but gradually we have become an integral part of the process... now we increasingly have a voice and recognition professionally'. (RRP2).

Financial constraints and the imposition of clinical standards etc and the pharmacological expertise of pharmacists in particular were identified in chapter 6 as factors that made clinicians more responsive to pharmacy's input. Reflection on the data presented so far indicates that pharmacist hold a paradoxical view of the quality standards, clinical guidelines, protocols and so on. On the one hand they regarded them as important regulatory and control devices, while on the other they were regarded as management functions that impeded clinical freedom. This was particularly evident in the data collected from the more junior clinical pharmacists who were happy to leave this aspect to the senior clinical pharmacists to deal with. In other words their lack of experience constrained them from applying bureaucratic tools implicated in the corporate rationalisation process. Clinical pharmacists however, also face new challenges as they take on new roles such as prescribing within defined treatment areas and take on more responsibility for patient care. This will be discussed in the next section.

Pharmacist Prescribing

An enduring symbol of professional expertise within the medical profession is the ability to prescribe. Indeed, within the wider structures of society, the monopoly over prescribing has been an indicator of the medical profession's clinical autonomy and power with full jurisdiction for prescribing being the sole domain of this profession. Recent governmental activities that have extended this jurisdiction within a framework of supplementary prescribing to other health care professionals such as clinical pharmacists, thus affect the professional control of this aspect of the medical professions work.

The increasing involvement of pharmacist in clinical activities in all its guises can be seen as a professionalising strategy and a means to enhance the professional standing of pharmacy and sense of professional self-worth: *'Our involvement in clinical activities and prescribing has been good for us, most of the clinicians treat us with more respect now'.* (SCP1). In contrast, a few prescribing pharmacists held reservations with regard to their authority of autonomously prescribing.

> 'It makes you think more seriously about the accountability and consequences of what you are prescribing, its not like telling the clinician what to prescribe and him holding the responsibility, it comes back on me that's a bit scary'. (CPP1)

Another went on to state that:

> 'I tend to casually check with the clinician first for example I'll say Mrs Smith needs medication for eczema I'm going to give her E45 and Betnovate 1 in 4 cream...It gives him a chance to recommend something else but if he says ok then I just order it'. (CPP2).

It is interesting that even where pharmacists hold the authority to prescribe that they still seek the clinician's approval which is not required within the supplementary prescribing framework and thus emanate a subordinate position. Such views support the theoretical perspective of Friedman's argument that the success of the medical profession to control the healing process was the result of their ability to control other healthcare groups.

There was also a deal of confusion over what constituted prescribing. The Oxford Dictionary definition of prescribe is '*to advise or order the use of a medicine with directions for the manner of using it*'. A series of events precede any prescribing decisions. These involve, taking note of the patients clinical history, making a clinical diagnosis through the application of a clinical examination which then leads to a decision on which therapeutic treatment is most appropriate. Thus the prescription is

determined by the drawing on and application of detailed scientific knowledge and experience as appropriate to the individual patient circumstances. The preceding decision making process rather than the act of writing the prescription were identified as important factors in pharmacists developing a sense of professional self-worth and enhanced professional status.

> 'We [clinical pharmacist] through our input into clinical rounds and clinics were in effect making prescribing decisions its just that they [the clinicians] were putting pen to paper and not us'. (SCP3).

Additionally, it was debated whether or not an omission in the patient's drug chart on admission which was identified and corrected by the pharmacist constituted a prescribing decision.

> 'I had a patient with a heart condition who was on statins and aspirin 75mg come onto the ward but the aspirin was left off his chart so I added it on so would that count as prescribing?' (SCP3).

The quote above highlights a problem with clinician prescribing in terms of safety and efficacy which could further justify the extended role of pharmacists into clinical areas and prescribing activities. Key features identified in prescribers are the demonstration and application of professional judgement. Reflecting on the historical[75] role of pharmacists it can be argued that pharmacists have held such attributes all along. Indeed pharmacists today still hold the legal right to refuse the supply of a substance if their professional judgement determines that it is inappropriate or in conflict with the patient's other medication regime: '*We can refuse to supply a medicine if we believe it inappropriate*'. (SCP4).

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[75] See chapter 4

The act of prescribing is a complex process that involves specific tasks and decision points; however this complexity opens up the possibility for other health professionals to become involved in the process. The fact that pharmacists within secondary care were already involved in clinical activities before legislative changes occurred, combined with the confusion over what constitutes as prescribing within the hospital setting such as dose adjustments and the ability of pharmacists to refuse the supply of an inappropriate medicine, have all contributed to pharmacist prescribing becoming more acceptable.

While a few pharmacist interviewees were reluctant to prescribe autonomously, the expanded role of clinical pharmacists into prescribing activities was perceived by many of the interviewees as an improvement in their professional status. Interestingly a few interviewees did not recognise that this was not a major change to their activity compared to previous practice.

> 'We've always made prescribing recommendations and added things to patient charts if needed it's just that now it's more formal'. (SCP2).

Quality, safety and efficacy have featured highly throughout the NHS reforms, and have also pervaded debates on prescribing practice particularly in terms of competency and the activities of new prescribers and as a means of containing and constraining prescribing practice. Indeed a key concern for pharmacists was the amount of errors that appeared in the patient drug history charts on admission, nurses adding medications on to the patient chart, and the faxed and verbal instructions to the pharmacy all of which are not signed off by a clinician and are clearly in breach of 'Safe Prescribing Practice' as set down by the profession.

> 'We deal with prescribing issues on a regular basis, sometimes a patients drug history is wrong so we have to change it or the nursing staff will change it but it can be a few days before the clinician is back on the ward which is a problem as the change is not signed off'. (SCP2).

A further complication that was identified was that formal prescriptions (as used in primary care) are not utilised within the hospital setting: '*We don't use prescriptions like the ones issued by the GPs we have patient record cards'.* (CP1). Rather, the prescribing process within secondary care is in the form of patient medication charts. These charts are an authorisation to supply and to administer medication which was argued is not necessarily a prescription, particularly if the medication on the chart is medication that was prescribed by a GP, but is rather a transcription.

Indeed several interviewees held the view that given the need for safe prescribing practice, they are ideally placed to ensure that quality, safety and efficacy is achieved. Previous research[76], where those who refrain from risky behaviour perceive themselves to be more rational and responsible than those who do engage in risky activities supports such opinions. Indeed within the wider political context of the need to ensure quality, safety and efficacy, the discourses of risk provide the rationale for self examination and audit[77] as a professional requirement:

> ....It makes sense that the person with the most pharmacological knowledge should be allowed to prescribe it not only improves quality and safety but can save money...and frees up some of the clinicians time...' (CP1).

The emphasis on developing a culture of safety and efficacy not only provides a rationale for extending prescribing authority to pharmacists but also opens up explicit

[76] For example see Leicht & Fennell (1997) on the changing organisational context of professional work and Bradley & Nolan, 2008 prescribing safety.
[77] As advocated by Foucault, 1977, in his writings Discipline and Punish: The Birth of the Clinic.

discussions of the competence of all prescribers, clinicians included. The focus of safety and the need to be competent promotes a new core professional ideal, particularly for new prescribers and provides a medium of constraint on the desire to prescribe and a level of self-limitation:

> 'You need be able to justify your prescribing decision so you need to be aware of the clinical guidelines, protocols and up on evidence based regimes otherwise we end up with variations in prescribing practice which is something we are trying to avoid'. (CP3)

The blurred perceptions of what constitutes as prescribing and the increasing focus on safety and competence underpins the notion that prescribing should be more of team activity that pulls on the knowledge and experience of key healthcare groups. Working within a team at one level suggests an inherently safer system by drawing on the competence and expertise of individuals more fully and which to some extent could also provide a check on each groups input. On the other hand, unless efficient communication systems are in place, such a system could increase the risk of inappropriate prescribing occurring.

An issue that was raised by pharmacist interviewees, with regard to them taking on a prescribing role, concerned the diagnosis of the patient's condition. This was an area where the pharmacists showed the most reluctance to engage with independent prescribing.

> 'I am not entirely comfortable with conducting clinical examinations. It's not part of our training so I'm not convinced we have the necessary skills to do this competently... It one thing the clinician doing the diagnosis and us doing the prescribing but even they [clinicians] get it wrong sometimes so we need to be very careful'. (CP1).

The majority of pharmacist interviewees indicated a preference for the clinicians to continue with the diagnostic role with the pharmacist doing the prescribing and any subsequent drug therapy adjustments. Such a collaborative effort thus draws on each individual's expertise and has the potential to improve the overall quality of patient care.

A common theme that appears within the NHS reforms and NPM discourses is the drive towards increased collaboration between healthcare professional groups and multi-professional working teams[78]. Within these reforms, the government has mandated a change in the authority to prescribe as exemplified by the introduction of pharmacist prescribing into the system. It can be argued that the function of pharmacy in terms the level of attention to prescribing detail and dispensing applied provides a valuable safety check on clinical decisions. Additionally, pharmacist's unique competence in terms of their pharmacological expertise and focus on safety can arguably provide a key force on any prescribing jurisdictional claim. Such attributes also exhort the emphasis on self-limitation on practice and the benefits of collaborative teams.

It can be further argued that fragmenting the process of prescribing into distinct tasks that pulls on each individuals area of competence such drug history taking, clinical examination and diagnosis, treatment decision and monitoring has the potential to provide improved patient safety and quality of care through a team approach. While the traditional dominate role of clinician prescribing has been taken for granted, the rhetoric of collaborative teams, safety and quality within the NPM discourses and NHS

[78] Collaborative teams was discussed in chapter six.

reforms has exhorted the idea of each professional group with their respective areas of competence working together to establish a culture of safety and self imposed limitations.

> 'Clinicians doing the diagnosis and pharmacist doing the prescribing seems the obvious way forward and makes prefect sense but clinicians are also reluctant to let go, they see it as us encroaching into their area too much...Some think it's too dangerous for the patients, they're worried that we get it wrong and kill them [patients]'. (CP1).

A point that was evident from discussions with the pharmacist interviewees concerned their legitimacy to prescribe which, from their point of view, was unquestionable. While not explicitly expressed, legislation providing delegation of prescribing areas to pharmacists has in the main been influenced by the medical profession[79]. It is evident from this section of data that pharmacists perceive that they have a singular expertise with regards to medicines that is superior to other healthcare professionals including the medical profession. It is also evident that they believe that this expertise is undervalued and utilised within the hospital setting. With regard to pharmacist prescribing, mixed views are held, with a few reluctantly engaging with it while others fully embraced the concept. However, despite such reservations, a report, provided by the RPP on the collaborative medicines management and pharmacists prescribing within Royal Infirmary of Edinburgh, established that pharmacists prescribing produced benefits in patient outcomes and reduced costs by use of their expertise.

[79] See Allsop, 2006 who argues that the medical profession has accommodated to change rather than being annihilated by the legislative process of change. The medical profession retains control over the knowledge base for prescribing and has developed an 'overseer' role in the prescribing process.

Control

As discussed in chapter 2 another important element of the healthcare reforms was the issue of financial accountability and control. Within this study participants aired the view that there was greater regulation within the healthcare system in general. Pharmacists also recognised that, as far as the drugs bill was concerned, this had been spiralling almost out of control for some time before the transference of the drugs budget into the hands of the clinicians took place. While several reasons for this were given; it was recognised that this was an issue that could not continue to go unaddressed and that some regulation was necessary. There was however, also recognition that, while regulation was necessary, it should not impede or negatively affect the level and quality of patient care.

During the interviews, interviewees were asked how they perceived the purpose of the quality standards, how important they regarded them and how effective their input into clinical meetings helped clinicians in meeting and complying with the standards. All of the pharmacists involved in the study reported that the standards were important issues. One informant stated '*improvement within the service is tied up with the standards'.* (RP1).

Another viewed the standards as a means to resolve or minimise inequities within the service: *'an expectation was that the good directorates might not necessarily improve because they are already pretty efficient but the bad ones might'.* (CP2). However, while quality standards were regarded as being important in the drive towards improvements in efficiency and equity a degree of caution was also expressed. It was felt that '*Clinical autonomy has to be preserved*' (CP1), which illustrates concern that

over demanding standards may negatively impact on clinician's professional autonomy.

> 'Regulation is obviously important because its public money and a public service... we have to avoid wastage and misuse of resources as much as possible but they [clinicians] and us also need to be able to make our own decisions so the level and type of the regulation has to be carefully thought out'. (RP1).

While such comments highlight the importance of regulation and control they also illustrate the importance placed on autonomy and professionalism. In contrast, the boundaries of responsibilities between pharmacists and clinicians still cause some pharmacists difficulties when it comes to following the set guidelines and protocols.

> 'It can be difficult at times with certain clinicians to get them to follow specific regimes... Sometimes I get nervous when insisting they follow the set regime but at the same time why have the guidelines and protocols if we're not going to use them...How much policing if that's what you can call it should we do?'. (JCP1).

Although this pharmacist's view is not an isolated one, his account illustrates the change of the role and influence of pharmacist in controlling and challenging the activity of the clinicians. This situation resonates with depiction of corporate rationalisers who attempt to control and restrict the activities of the medical profession[80].

Although the quality standards were considered to be important, reluctance on the part of a few pharmacist interviewees to monitoring adherence to the standards was evident as the practicality of effectively imposing the standards was regarded as a management task that they were unwilling to take on board. To undertake this task effectively a

[80] See Alford (1975).

change in clinician attitude was cited as being necessary along with additional resources.

It is interesting to note that some pharmacist interviewees indicated that the inability of clinicians to meet the quality standards was not necessarily the fault of the clinician but rather down to the lack of resources allocated by the Boards management. There was however, clear recognition that pharmacy have some influence and control over the clinicians in terms of their prescribing practice:

> 'There's definitely been a change of attitude when it comes to our input ... I think the added financial responsibility has made the difference. I think our relationship has developed really well over the years a lot of the distrust has gone and there is definitely more understanding of our position'. (CP1).

Although professional boundary issues still appear most of the pharmacist interviewees indicated that they felt a shift in status and power vis-à-vis the clinicians had been achieved in their favour. However, such opinions were also countered with the view that both parties should be working towards partnership rather than engaging in a fight for power and status. Such opinions illustrate the paradox in the clinician-pharmacist relationship where the pharmacy profession seeks alliance with the clinicians but at the same time recognises the need to challenge some of their clinical decisions.

The data presented here suggests that although some pharmacists were initially reluctant and sceptical with regard to changes in financial responsibility it was also envisaged that the freeing of managerial responsibility provided the hospital pharmacy profession with opportunities and leverage for professional development and expansion. This evidence can be viewed as an example of a healthcare professional group using and moulding the new structure to their own advantage. The

regional pharmacist interviewed suggests that as the purse string tightens, clinicians increasingly have to turn to them for advice. He also attributed the closer connection between pharmacists and clinicians to the successful development of specialist pharmacy functions.

There is evidence to suggest a more negotiated and co-operative relationship between clinicians and pharmacists, but the reluctance on the part of some clinical pharmacist to exercise their control function not only poses a management problem, but can also hinder improvements in patient care and slow further developments in the pharmacist-clinician relationship. The involvement of pharmacists in agencies for establishing clinical guidelines, protocols etc. and engaging in the control of prescribing practices also enable them to challenge clinical decisions that do not comply with the guidelines. Such a position resonates of Alford's depiction of corporate rationalisation in which healthcare monopolists such as pharmacy attempt to restrict and control the activity of another healthcare group – the clinicians. However, it was also indicated that influencing prescribing practice was a sensitive issue that required careful handling in some cases.

Chapter Summary

The thrust of this chapter was on an examination of the impact of NPM initiatives and financial accountability on pharmacy as a healthcare profession. In particular, it focuses upon the changing relationship between pharmacy and the medical profession. The information provided by pharmacists indicates that while some pharmacists believe devolved financial responsibility has downgraded their role as professionals, this view was not held by all. In fact, it appeared that such a view was mainly held by

the older pharmacists, which suggests that there may be some generational factors at play. Resistance to change was also evident in a few of the pharmacists who felt that imposing control on clinician prescribing was not their remit. Such views however, were in the minority. Indeed it would appear that changes with regard to financial responsibility and pharmacists being given the opportunity to develop their professional service was an opportunity that was fully embraced by the profession as a whole. It can be further argued that NPM initiatives also provided systems through which pharmacists gained the potential to become corporate rationalisers and indicates a challenge to the status quo of the professional monopolisers – the clinicians.

The findings also highlight concern over issues such as equity of service and the viability of some pharmacy functions. However, it was also evident that issues of equity existed before the reforms were implemented. It would also appear that the overall level of pharmacy service functions have increased over the last couple of decades. The development of functions such as the Medical Audit Groups, Drug Evaluation Panels etc. were intended to assist clinicians in the prescribing decisions with the aim of achieving cost effective prescribing.

Inclusion of clinical pharmacist into clinical management teams are argued to provide benefits in the improved use of evidence-based prescribing, detection of errors in patients drug histories and drug safety through rigorous drug level monitoring. It is further argued that such collaboration has improved the level of cost-effective prescribing and control of the drugs budget. It has also been argued that closer inter-professional collaboration have led to greater utilisation of skills and knowledge resulting in increased work satisfaction for pharmacists and improved quality of care

for patients. However, as was illustrated, the level of trust and communication in the clinician-pharmacists relationship was still absent on the part of some clinicians.

The result of such developments also means that clinical pharmacists have to deal with the paradox of their enhanced influence with regard to the establishment of and adherence to treatment protocols. Continued collaboration between these two groups may in the future lead to a greater degree of trust between pharmacists and clinicians and further serve to narrow the professional gap between these two healthcare groups. This is something that is needed if pharmacists are to take a more central role within the healthcare team and patient care. It also entails a releasing of control on the part of clinicians.

The data presented in this chapter also illustrates the importance of the pharmacist-clinician relationship within secondary care. As a result of the succession of NHS reforms, a greater level of communication and collaboration has been achieved. It was also reported that such relationships are now more equitable in nature. The data suggests that such a situation may not necessarily be a redistribution of power but rather a levelling down of influence within an already weakened medical profession. The following chapter will provide a summary discussion of the key findings of the study.

Chapter Eight: Summary Discussion of Key Findings

This thesis so far has investigated the emergent effects of NPM initiatives and financial accountability changes on pharmacy as a healthcare profession and has elicited the views of some of the key actors in medicine resource management within the hospitals under study. These were contrasted with information gained from documentary sources and available literature. It was envisaged that there would be differences and convergence of opinions over the devolved financial responsibility of the drugs budget and its impact on the status and inter-professional relationship of clinicians and pharmacists. This was in fact the case.

The reforming of the NHS has been undertaken in concert with the reshaping of professionals in healthcare in response to the severe decline in financial resources. Within NHS hospitals, clinicians have traditionally held a dominant position in terms of decision making with regard to the use of resources and clinical autonomy. As outlined in chapter 2, the medical profession have been granted considerable autonomy within the NHS in return for their cooperation in providing healthcare to the populace. The results demonstrate that reforms intended to curtail or control the level of professional autonomy have in general been resisted. Even where clinicians have adopted and adapted to the role of clinician manager or clinical director there is clear evidence of frustration and resistance to managerial impositions that threaten or weaken their autonomy and sense of professionalism.

Within the thesis financial control and accountability was viewed through the prism of NPM and modernisation. It is here that issues of accountability and the underlying

tensions of NPM were most apparent with traditional arguments by the medical profession for self regulation and accountability being countered with arguments that such regulation and accountability is limited and subject to an inevitable tendency to oligarchy[81]. The thrust of the thesis argues that imposing managerial and accountable controls are less likely to be effective than informing the process by which healthcare professionals construct and enact a sense of being accountable. It considers and mandates illumination of political incentives and incorporates the assumption that NPM and accountability can be constitutive as well as reflective. It further highlights that faced with exogenous constraints beyond their control, both professions, but pharmacy in particular, has become more self-critical. In doing so, pharmacists appear to have challenged the notion of pharmacy as a marginalized or quasi-profession through the development and expansion of specialist pharmacy functions such as clinical pharmacy in which pharmacists are actively involved in prescribing decisions which were once firmly held within the clinicians' domain thus, narrowing the boundaries between the two professions.

It was shown that within NHS hospitals, clinicians traditionally have held a dominant position in terms of decision making with regard to the use of resources and clinical autonomy. However, the reforming of the NHS, in response to declining financial resources, has led to the reshaping of healthcare professionals' roles. Indeed it is argued that the changing environment now faced by hospital clinicians, in the form of increasing financial, legal and regulatory complexities, is having an impact on their power base, as managerial and accounting control becomes a key element in the changes advocated by healthcare reformers. Increasingly, clinicians are faced with a

[81] This was also contended by Walsh, (1995).

shift of emphasis from process accountability to output accountability; with traditional costing and budgeting systems that focused on the control of total expenditure and provision of information for government purposes being replaced by new systems that delegate financial responsibility and accountability for medical decisions. Under this new system clinical autonomy is preserved but made more visible through financial calculation and accountability.

The result of this structural change within the hospital setting thus allowed the hospital pharmacy sector to develop specific support functions through which they could exert their specialism and input into clinical decision making and challenge the clinical decisions of hospital clinicians. The government, through the process of healthcare reform at the macro level created conditions of corporate rationalisation through changes in budgetary and financial control and promotion for the development of specialist pharmacy functions which feed into clinical decision making. Such macro level changes and increased involvement of clinical pharmacists in clinical decisions, although slow to develop, thus challenge hospital clinicians at the micro level over the utilisation of prescription medicines. The evidence thus suggests that pharmacy as a profession was using and moulding the new financial arrangements set out in the Hospital Trust to their own advantage and thus exhibiting some form of professional monopolist's characteristics in order to secure more resources and legitimacy[82].

The separation of purchasers and providers through the Clinical Directorate structures have been identified as contributing significantly to the renegotiated order of professional relationships and autonomy. The potential effect of such structural

[82] See Alford (1975) on corporate rationalisation within healthcare.

changes and the engagement of clinicians in the financial management of resource utilisation shaped clinician subjectivity in a more rational and efficient manner thus aligning their clinical activity more towards the overall goals and objectives of the healthcare reform agenda.

Differences of viewpoints as to the effects of devolved financial responsibility on pharmacy as a healthcare profession, not only from a pharmacist point of view, but also from the clinicians, were established. While some pharmacists believe this devolved financial responsibility has downgraded their role as professionals, this view was not held by all. In fact, it appeared that this view was mainly held by the older pharmacists, which suggests that there may be some generational factors at play. Resistance to change was also evident in some of the older clinicians who felt that financial accountability was not their remit.

The evidence presented illustrates that a segment of the hospital pharmacy profession were initially reluctant of the budgetary responsibility change as they perceived such a change as threatening to their already marginalised position. In contrast, the majority of pharmacy respondents saw the new budgetary arrangements as a means of improving and expanding pharmacy services. While the new arrangements were also seen as an additional layer of bureaucracy, it was also viewed as an opportunity by which pharmacy could develop and influence hospital services and potentially gain more financial resources and thus mould the new structure to their own advantage.

The discourses of NPM and financial accountability and how these were reproduced, assimilated and their capacity to influence clinical subjectivity are also shown to be

instrumental in the renegotiated order of clinician and pharmacist status. The power effects of NPM and financial accountability are not, however, deterministic or inevitable but are contingent on the reactions, whether in support or resistance, of the actors. Indeed the findings support to the conclusions of Reed and Anthony (1992, p194) that hospitals have '*a unique culture and an extremely complex set of organisational relationships which makes the transition from ideological doctrine and political programmes to operational reality extremely difficult to deliver*'.

Reflection on the data presented indicates that pharmacist hold a paradoxical view of the quality standards, clinical guidelines, protocols and their influence on clinical activity. Pharmacists regarded the standards as a means of ensuring equity, quality and financial control and regarded them as important regulatory and control devices on the one hand, while on the other they were regarded as management functions that they did either not feel comfortable with or wish to employ thus demonstrating a reluctance to engage in a corporate rationalisation role.

Overall, however, the data suggests that pharmacists were exhibiting corporate rationalising attributes but their ability to influence the prescribing behaviour of clinicians is limited by the inbuilt professional boundaries which are in common with traditional corporate rationalisers (health service managers) and medical professionals. Indeed it was suggested that limits to the extent of collaborations and cooperation between these two groups tended to be related to issues of autonomy and power and are therefore not a neutral activity. Thus although changes within the healthcare system have altered the level of power between these two professions, the power of the hospital clinician still remains albeit a bit bruised.

It is argued that these changes challenge the power and autonomy of clinicians and their relationships with other healthcare professionals and society; perhaps best exemplified by the increasing role of clinical pharmacists in prescribing decisions and prescribing activities. In the past, pharmacy as a health care function has been termed a marginal or quasi-profession due to its apparent inability to promote and control its own existence. Traditional professional and jurisdictional boundaries militated against a closer working relationship between pharmacists and clinicians, contributing to this marginalisation. Faced with exogenous constraints beyond their control, both professions, but pharmacy in particular, has become more self-critical. In doing so, pharmacists appear to have challenged the notion of pharmacy as a marginalized or quasi-profession through the development and expansion of specialist pharmacy functions such as clinical pharmacy in which pharmacists are actively involved in prescribing decisions which were once firmly held within the clinicians' domain. Indeed it has been suggested by both clinicians and pharmacists that as clinicians increasingly feel the pressure of financial constraints that pharmacy's involvement in clinical decisions and prescribing practice should continue to increase.

Within the next chapter the findings of the study and the underlying assumptions of NPM and financial accountability initiatives are connected with sociological debates on professional status and the management of professional experts.

Chapter Nine: Connecting Theories, Values and Practice

This thesis began by introducing the notion that discourses in NPM within the context of NHS reforms and their intended increase in financial accountability and control of the activities of clinicians in secondary care would result in hegemonic struggles that would have an impact on the professional boundaries between two healthcare professionals, clinicians and pharmacists. Within this thesis NPM is investigated not just as a discourse, but as a set of real practices with real effects. In order to do this, the theoretical framework for the research is based on the sociology of the professions. The rationale for this choice hinges on its applicability to the argument of changing professional boundaries as a result of NPM initiatives and increased financial accountability being placed on the medical profession. This chapter contextualizes the present situation using healthcare reform from the Conservatives government era under the leadership of Margaret Thatcher through to the end of Gordon Brown's reign as Prime Minister as the historical baseline. It then reflects on the data produced alongside sociological perspectives of the professions. The chapter is theoretical, analytical and interpretative. It scrutinises the assumptions underlying NPM and financial accountability initiatives and connects these developments with sociological debates on professional status and the management of professional experts.

Medical Dominance and a Changing NHS

This thesis began with a discussion of the distinctive feature of the UK - the extent to which its health service is state owned and run and the extent to which government pays the costs. It also highlighted that doctors within the NHS have played a major role

in its development to the extent that a central and prevailing characteristic of the NHS has been the dominance of the medical profession (Webster, 2002). Indeed during the development of the NHS there was a general acceptance of the arguments of the medical profession that they held unique knowledge and expertise for the delivery of healthcare that warranted a high degree of autonomy and trust with regard to decision making and limited external regulation (Elston, 2009). It is evident within chapter 6, that many medical professionals perceive that, as a result of their medical expertise, they still hold (and deserve to hold) a dominant position within the health care arena. Indeed it is clear from the data that medical professionals' resent, and are resistant to, managerial intrusions into their clinical practice.

Critical sociologists[83] argued that the medical profession had attained its position as a dominant occupation primarily through their own strategic manoeuvres rather than, as earlier researchers had assumed, having it bestowed on it because of its social and altruistic virtues (Freidson, 1970; Johnson, 1972). The altruistic nature of their service combined with their medical expertise was however, considered by the clinician respondents to provide justification for the maintenance of self regulation and autonomy. McKinlay (1977) argues that the incorporation of physicians into healthcare institutions such as the NHS means that physicians no longer operate altruistically but rather, like any other worker, are employees of the institution and have thus been proletarianised. While such an argument seems logical, it is, however, clear from the data that the medical profession, while being affected by NPM initiatives and increased accountability structures are still predominantly shaping and determining the nature and scope of their clinical activities and have not therefore been truly proletarianised.

[83] Such as Navarro, 1976, Johnson, 1977, & Haug, 1973.

As discussed in chapter 4, the professions medical contract which is characterized by the government's acceptance of self regulation and clinical freedom had reinforced the medical professions dominant position. However, as discussed in chapter 2, by the start of the 1980's the historical management arrangement set out above had started to change. The focus of the 1979 Conservative government's ideological commitment to patient and consumer power, introducing internal market forces, reducing the extent of the medical professions control over policy decisions and the introduction of internal competition to offset producer dominance, highlights the growing scepticism over the professions claim to occupational autonomy, self regulation and professionally controlled licensing. It is clear within this study that the medical profession still profess an avowal to extraordinary trustworthiness[84] and strive for the maintenance of self regulation of the medical profession but are succumbing to increased regulatory control.

Griffiths Report Onwards

Until 1974 the management structures of the NHS contained a large proportion of doctors each of whom carried a power of veto (Harrison, 1982) which left health care managers and planners in a weak position. The recommendations of the Griffiths report in 1984 went some way to address this situation. During the 1980's NHS reform agenda was dominated with the drive towards general management principles and a move away from consensus management. This however, did not go uncontested by the medical profession who were vehemently opposed to such a change. A particular concern for the profession was that they would become increasingly dominated by officials and have their professional interests marginalized (Baggot, 1994). The

[84] As discussed in chapter 4.

introduction of general management systems thus led to conflict within various occupational cultures with the medical professional in particular continuing to regard themselves as accountable to their own professional bodies rather than general managers within an increasingly bureaucratic organization (Small, 1989). It is clear from the data presented in this study that such conflict, particularly when clinicians perceive their professionalism and clinical autonomy is being compromised, remains today.

While such conflicts occurred, the success of the government to introduce general management into the NHS thus represents a major defeat for the medical profession (Harrison, 2001). Indeed this report and the implementation of its recommendations signify a radical change in the management of NHS services and its actors and is an example of an efficiency form of NPM being introduced into the NHS (Dopson, 2009). The recommendations of the Griffiths report[85], combined with a severe lack of financial resources and continuing spiralling costs, contributed to the imposition of further NPM initiatives and financial control systems in the NHS. Such changes further signify a shift in the relationship between the government and the medical profession.

Another significant blow to the medical profession was the success of the government to introduce a 'limited list'[86] for prescribing. Up until the mid 1980's the medical profession were relatively free to prescribe whatever medicines they liked regardless of the cost. The introduction of the limited list was of health policy and sociological significance as it established the principle that under the advice of medical scientists the government could dictate and control the prescribing activities of the medical

[85] See DHSS, 1983, *The Griffiths Report.*
[86] See chapter 2 page 36

profession (Abraham, 2009). Within the data, it is clear that working within the confines of the 'limited list' and other initiatives aimed at standardising patient care, has affected the ability of clinicians to be more innovative in their treatment regimes. While this cannot be claimed as definitive proletarianisation of the medical profession, it does provide a good demonstration of the government acting in its own interests.

NPM is characterised with the introduction of private sector management discourses and practices with the intention to increase efficiency, effectiveness, value for money and make public agents more accountable for their use of resources (Ham, 1999). Within health policy such characteristics are based on the assumption that healthcare providers when integrated into systems of organisation control will become more rational in their decision making and responsible for the resources they consume. The rationale to tighten and strengthen managerial systems and increase financial accountability within the system challenged the dominant paradigm of medicine and attacked the old-style administration inefficiencies and constraining practices of the medical profession (Cox, 1992). Indeed it is evident within the data that there are cross boundaries between management and medical tasks that result in conflicts with professional values and their ability to make autonomous decisions outwith the managerial control systems.

The Conservative government at this time put forward the argument that in order to make public services, including the NHS, more efficient they required more discretion over resource utilisation. The creation of self governing trusts and subsequent clinical directorates were designed to provide this freedom (Dobson, 2009). The introduction of clinical directorates which were headed by senior clinicians, the devolution of power

and decision making to unit level and making clinicians into budget holders was a strategy aimed at making the clinicians more aware of wider budgetary considerations and more responsible for how the budget was used. It is clear from the data that for some clinicians the initial transference of budget control through the establishment of clinical directorates was accepted rather reluctantly with such clinicians viewing the associated management responsibility as an added burden that would reduce the amount of time available for their clinical duties. A further concern of such clinicians was that managerial responsibilities would affect their professional identity with them being viewed as managers rather than clinicians.

Such changes were in essence, an attempt to use clinicians as managers who also had a responsibility to control the activities of other clinicians (Harrison, 2002). It was further envisaged that placing budgetary constraints on the clinician manager would encourage them to think and act in more efficient and managerial terms which would then be disseminated to non managerial clinicians. While the evidence suggests that this has been the case, it is also evident from the junior clinicians that took part in the study, that they perceive the clinician managers use their position to cost shift in order to prioritise their own clinical activities to the detriment of the junior staff.

Devolved financial accountability however, did not negate the need or desire for greater political control over NHS resources and its actors. Although clinical managers were to be given discretion over resource utilisation and allocation, they were expected to be held to account which encouraged the development of tighter audit and control frameworks (Power, 1997). This is exemplified by Strong and Robinson (1990) who suggest, that the increased focus on managerialism, bureaucracy and proliferation of

policy objectives have all served to restrain the activities of doctors as medical audits, performance measurement and control systems became embedded within the system. Coupled with managerial access to medical audit data, this strategy made it easier for healthcare officials to challenge clinicians over resource utilisation and allocation decisions (Packwood *et al*, 1991, 1992). Indeed it can be seen from the data that clinicians are feeling the pressure of such initiatives with respondents reporting that their clinical decisions are becoming increasing controlled through bureaucratic regulations and thus reducing their clinical freedom.

Debate however, continues as to the true extent of managerialism on the activities of the medical profession.[87] The successive reforming of the NHS and organisational change makes it difficult to determine the current balance of power within the healthcare system. From a neo- Weberian perspective, professional standing is determined by the occupations ability to attain and maintain its own authority and regulation by controlling the boundaries between them and other occupational groups and minimising intrusions from the government into their activities while also benefiting from its protection. The data suggests that there has been loses and gains in terms of power and status between clinicians and managers and clinicians and pharmacists and thus presents a complex picture in which, through a process of professional adaptation, some gain ground while others lose it.

It is also clear from the data that the management of professional activity is regarded as the domain of the medical profession with external scrutiny and control being strongly resisted. Systems that increase the level of transparency and control over professional

[87] See Osbourne & Gaebler, 1992; Fairlie *et al.* 1996; & Hoggett, 1996a & 1996b).

activity have fundamental implications for professional status. For example, the changing nature of organisational roles has implications for role boundaries which will require attention to be paid to understanding organisational priorities (Cassel, 1997). The role boundaries between clinicians and pharmacists will be discussed shortly.

Within the management of health care, NPM initiatives also generate questions with regard to accountability for individual decisions, individual patients, systems for improvement and control. Such initiatives also represent a change in the acceptance of traditional assumptions of professional competence and trust to one in which there is increased expectation of what professionals should deliver (Levenson *et al.* 2008). While it would appear from the data that although the principles contained within NPM discourses encouraged new attitudes towards, efficiency, productivity and value for money there remains a strong perception of professional care and duty: that health is not a business but a social duty and therefore adherence to strict management and financial regimes is not appropriate. Thus the application of economic rationalism for some respondents served to revitalise the concept of social care contained within their professional culture.

Control

The common theme of the NHS reforms centers around the concept of NPM and accounting control with regard to the efficient and cost effective use of resources. Framing clinical issues and redefining performance in the language of business however, problematizes healthcare delivery as exemplified with the espoused views of the senior clinicians presented in chapter 6. Despite an element of resistance on the part of clinicians, the healthcare arena is continually faced with increasing financial, legal

and regulatory complexities which are arguably having an impact on the power base of clinicians as managerial and accounting control becomes a key element in the changes advocated by the reformers. The success of the government to impose a 'limited list' that constrains the prescribing activities of clinicians provides a good example of such control in action.

Kurunmaki (2004), posits that control systems traditionally serve two purposes: to aid decision making and to control behaviour. Control systems are thus implemented by senior management to encourage goal congruent behaviour. Within the NHS greater accountability, management efficiency and value for money are increasingly being demanded. Managerial control is often portrayed as an intrusion that is defensively resisted within the literature.[88] However, such positions assume that systems of professional values are static and adversative towards managerial value systems. While this thesis does not dispute the findings of such studies it is evident within this data that clinicians are to an extent, responsive to NPM discourse aimed at achieving a tighter financial regime and balanced accounts particularly where managerial responsibilities are viewed as non-challenging.

As discussed earlier a key change to the management structure of healthcare was the establishment of clinical directorates and the subsequent devolving of financial responsibility into the hands of the clinical director. Within this structure clinicians are faced with a shift of emphasis from process accountability to output accountability with traditional costing and budgeting systems that focused on the control of total expenditure and provision of information for government purposes being replaced with

[88] see for example Kitchener, 2000; Doolin, 2002; Mueller et al, 2004

new systems that delegate financial responsibility and accountability for medical decisions (Kurunmaki, 2004). Under this new system clinical autonomy is preserved but made more visible through financial calculation and accountability.

It is clear that many of the NPM initiatives were a governmental attempt to increase the regulation and management of medical practice and thus reflects a shift from earlier values of self regulation and autonomy to increased transparency and accountability (Levenson *et al.* 2008). All of the study respondents acknowledged that such initiatives were attempts to direct and control professional activity through increased regulation, peer and inter professional pressure. Indeed several clinician respondents indicated that they felt their professional identity and status had been negatively affected by such initiatives.

Differences of viewpoints over the effects of devolved financial responsibility on pharmacy as a healthcare profession, not only from a pharmacist point of view, but also from the clinicians, were established. While some pharmacists believe this devolved financial responsibility has downgraded their role as professionals, this view was not held by all. In fact, it appeared that this view was mainly held by the older pharmacists, which suggests that there may be some generational factors at play. Resistance to change was also evident in some of the older clinicians who felt that financial accountability was not their remit.

Due to the shift in the responsibility for drug budgets, from pharmacy managers to clinical directorates, pharmacy managers no longer have a strong motivation to intervene in prescribing decisions, in order to offer more cost effective alternatives.

They do, however, have a motivation to develop their expertise and establish themselves as health care professionals in their own right thus bridging the gap between pharmacists and clinicians. The placement of responsibility for drugs budgets on the shoulders of clinicians, presumably to make them more aware of the cost of clinical decisions, largely seems to have failed as a mechanism of cost control. This, it has been suggested, might be because clinicians prioritize the efficacy and safety of drugs over their economy, or, because they simply do not have the required knowledge about the cost of drugs to make sensible economic decisions.

Collectively, such initiatives demonstrate a loss of confidence, in former modes of recourse and accountability. While the evidence suggests a perceived gain in influence on the part of pharmacists it would appear that this gain cannot be attributed solely to the control function of clinical pharmacists to ensure compliance. Indeed the loose control could perhaps account for the ambivalent attitude of clinician's towards the treatment protocols and standards which, will be discussed shortly.

Application of a Marxist analysis (Braverman, 1974 for example) to the effects of NPM initiatives and financial accountability on the medical profession and the ways in which the labour process has become tightly specified and controlled through such initiatives presents a rather bleak (at least from the medical professions point of view) picture of the position of the profession. Analysis, using this tradition, regards the decrease of medical autonomy and increased control of medical activities as an example of proletarianisation in which the medical profession is '*divested of control over certain prerogatives relating to the location, content and essentiality of its task*

activities, thereby subordinating it to the broader requirements of production under advanced capitalism' (McKinlay & Stoeckle, 1988, p200).[89]

Johnson (1995, p16) on the other hand, regards the relationship of the government and the medical profession as symbiotic: '*the independence of the professions depends on the interventions of the state, but...the state is dependent on the independence of the professions in securing the capacity to govern as well as legitimating its governance...We must develop ways of talking about the state and the profession that conceive of the relationship not as a struggle for autonomy and control but as the interplay of integrally related structures..*'. Taking this view, the professions regulatory activities shape its members conduct so that it does not challenge the state (Hindess, 2001, p44).

It is evident, however, that the application of devolved financial responsibility and management principles represents a fundamental challenge to the notion of a selfless public service and healthcare delivery (Strong and Robinson, 1990). Regardless of which political party is in power, the concept of managerialism and control, even if its form and focus changes over time, appears to be here to stay in the organization and delivery of health care. Starkey & Mckinlay (1998) argues that this will only lead to the eventual subordination of clinicians to managerialism, and thus, threaten their autonomy further.

[89] See also McKinlay and Arches, 1985).

Regulation

From the outset of the NHS, regulation of medical education, training, resource consumption, clinical practice and standards was predominantly controlled by the medical profession through the General Medical Council and the Royal College of Physicians (Harrison, 1988; Flynn, 1992). As has been demonstrated the explicit focus of NPM initiatives on cost-efficiency, effectiveness and quality transformed the traditional regulatory arrangements. The New Labour Government elected in 1997, required all healthcare professionals to take more responsibility for quality improvements and responsive to patient needs (DoH, 1997). This was followed quickly with a statutory requirement to demonstrate quality assurance in clinical practice being placed on NHS Trusts. Quality featured highly in discussions with clinicians regarding patient care and was tied to arguments for the preservation of clinical autonomy. However, there was also a general perception that quality control initiatives would become more widespread as a result of the regulatory agencies established by New Labour.

Such agencies[90] were established with the explicit remit of setting national clinical standards and performance monitoring which were to be linked through a new concept 'clinical governance'(NHS, 1999a & 1999b)). Indeed the establishment of regulatory bodies such as NICE, CHI[91] etc were a hallmark of New Labour and provided a form of neo-bureaucracy which placed rules above hierarchy (Harrison & Smith, 2003). Indeed the preferred managerial logic of New Labour was management metrics coupled with networks. Whilst these new agencies were presented as independent bodies with a broad focus and clinical orientation, and had clinicians as part of their

[90] See chapter 2.
[91] See chapter 2 for an outline of the function of such agencies.

composition, they were (and still are) significantly under government control (Walshe, 2003a, p127).

Within the discourses of political science, governance is frequently used to indicate a means of co-ordination based on networks rather than hierarchy (Rhodes, 1997). The professions, including the medical profession, are a component in the apparatus that controls society. As such it is rather ironic that the term governance has been applied to hierarchical arrangements that monitor and control the activities of the medical profession. Harrison & McDonald, (2008), argue that the medical profession is increasingly becoming regulated through government agencies and control structures. The data presented here supports this view. Flynn (2002) argues that the contemporary regulation of the medical profession is a form of '*soft bureaucracy where processes of flexibility and decentralization co-exist with more rigid constraints and structures of domination*' (Courpasson, 2000, p157). Taking this view, it can be seen that there are links between how clinicians view medical production and the biomedical models of evidence based practice (EBP), clinical guidelines and protocols: patients can be counted, costed and treated as production outputs.

NPM Initiatives and Professional Autonomy

Abbott, (1988), suggests that in order to examine change within professions, the most appropriate approach is to investigate the factors that affect the content and control of its work rather than its organisation. In the study of the concept of 'profession', many analysts have identified autonomy as being an important component[92]. The principle of clinical autonomy has permeated the management and organisation of the NHS since

[92] See Harrison & McDonald (2008) for a review

its inception. From this standpoint, it makes sense to examine the effects of NPM initiatives such as EBP, clinical guidelines, protocols and control systems and their potential impact on professional autonomy. In particular, if EBP, clinical guidelines, treatment protocols and control systems are viewed as a form of bureaucratic rule, this then raises questions with regard to their potential to undermine of the status of the medical profession (Harrison & Checkland, 2009).

It is clear from the data that status is an important consideration for clinicians. However, differences of opinion with regard to the effects of increased managerial and financial accountability on the status of the medical profession were also evident from both clinicians and pharmacists. A few clinician respondents believed that that their status relative to pharmacist had not changed to any great extent while pharmacists, in general, perceived an increase in their status. In contrast to such opinions, the majority of respondents, clinicians and pharmacists, acknowledged that the power of the medical profession in general was decreasing and that the time of the all powerful hospital clinician may be coming to an end.

After two decades of reform within the NHS, by 2002, it was clear that the 'politics of the double bed'[93] (Klein, 2001) arrangement that had been established at the outset of the NHS is no longer accepted by the government. After two significant defeats, it was also clear that the medical profession were increasingly mistrustful of the government. Indeed as NPM initiatives and control systems took hold, tensions between the medical profession and the government have increasingly been reported (Harrison, 1999).

[93] This term was coined by Klein, (2001) see chapter 2

Clinical guidelines, protocols, quality standards and other systematizations of medical practice can ostensibly be regarded as a government attempt to 'blackbox'[94] aspects of clinical practice into a set of scientific or technical rules which through their political legitimacy suppress contestation (Gray & Harrison, 2004). Such initiatives, when taken together, represent a new form of bureaucracy that is characterised by policies and formal rules that increase the level of surveillance and decrease professional autonomy (Harrison, 2003). While it can be argued that such changes represent a change from substantive to formal rationality it cannot however, be fully interpreted as a form of Weberian bureaucracy (Ritzer & Walcak, 1982; Harrison & McDonald, 2003).

It is clear from the data that, clinicians are resistant to excessive managerial control of their medical practice. Indeed the clinician respondents were keen to emphasise the importance of clinical experience in treatment decisions and the need to maintain a high level of autonomy. Initiatives aimed at improving quality and patient care were regarded as positive developments provided the final arbiter of such initiatives were the medical profession. However, it is also evident in the data that clinical autonomy, while closely guarded by the profession, is being affected by such initiatives.

Abernethy and Vagnoni, (2004) argue that NPM initiatives and increased financial accountability challenge the power and autonomy of the clinicians and their relationship with other healthcare professionals and society. Doolin, (2002, p385), however, suggests that '*the subjectification of individuals is a complex phenomenon reflecting the ambiguity of human agency*'. From the evidence presented within this research it is clear that clinicians within the Trusts studied, derive substantial meaning

[94] Blackboxing is the condensation of a set of political criteria into a mode of scientific and technical rules. For more information see Latour, (1986).

and identity from the traditional values and public service ethos espoused from the public and the medical profession. The evidence further indicates that professional identity and autonomy are closely guarded through their membership of the medical fraternity. However, it also demonstrates that the imposition of NPM and increased financial accountability has eroded the level of autonomy and professional boundaries held by clinicians as exemplified from the respondent views that suggest clinicians are no longer making all of the decisions within clinical practice and thus indicates a level of subjectification of the profession in general.

Pharmacy Re-Professionalisation

In the past, pharmacy as a health care function has been termed a marginal or quasi-profession due to its apparent inability to promote and control its existence. Traditional professional boundaries and territoriality militated against a closer working relationship between pharmacists and clinicians, contributing to this marginalisation (Blenkinsopp, 1992). Jamous & Peloille (1970) with their technicality/indetermination ratio[95], indicate that a problem for pharmacy lies with its precise and systematic knowledge base, which is founded on exact science that does not allow for a wide range of interpretation and thus leaves little scope for hermeneutics. Additionally, pharmacy as a profession has not developed a patient counselling role in its own right. Rather this has been mediated through the medical profession. The paradox of this situation is a profession with an over developed science in the form of pharmacological knowledge and under developed interpretative skills in relation to patient welfare.

[95] The I/T ratio was coined by Jamous & Peloille (1970). It refers to an increase in the proportion of elements within medical work that can be clearly specified, with a corresponding reduction in the proportion that must be left to the judgement of the clinician.

It is apparent from the data that the change in responsibility for the drugs budget as a result of NHS reforms has had major implications for pharmacy as a healthcare profession and its relationship with the medical profession. It is interesting to note that, while coming under scrutiny and stringent external pressure over the last couple of decades or so, this is the profession which has been most dynamic in terms of development; identifying weak areas and coming up with suggestions for improvement. Over the last 25 years or so there have been significant developments in hospital pharmaceutical services which have served to bridge the gap at the interface between the two professions through the emergence of specialist pharmacy services and clinical pharmacists working in the clinical setting. It should be noted however, that the development and expansion of clinical pharmacy within secondary care has, to some extent, been made possible by gaps left by the medical profession in the area drug information and inadequate drug counselling.

The development and expansion of hospital pharmacy services thus suggests an important transformation in the technicality/indetermination ratio (Jamous & Peloille (1970). Pharmacists are no longer constrained to supply, distribution and procurement, but are providing professional services that include drug therapeutics, prescribing advice, drug monitoring and control and prescribing within defined areas. As can be seen from the findings, clinical pharmacists whose specialism is to assist the clinicians in safe, economic and effective use of medicines by optimizing pharmaceutical factors are increasingly being utilized and regarded as an essential function within the hospital setting. Indeed it has been suggested from both parties that as clinicians increasingly feel the pressure of financial constraints that pharmacy's involvement in clinical decisions and prescribing practice should increase.

Faced with exogenous constraints beyond their control, both professions, but pharmacy in particular, have become more self critical. In doing so, pharmacists would appear to have challenged to notion of pharmacy as a marginalized or quasi-profession through the development and expansion of specialist pharmacy functions. The data suggests also that as NPM initiatives and increased financial accountability took hold that this marginalisation has diminished. Yet although pharmacy looks to the efficiency and economy of drugs, no significant improvements have been identified in the area of drug cost containment. Rather the irreconcilable chasm between the concepts of safety, efficacy and value for money appears to persist.

The development of functions such as the Medical Audit Groups, Drug Evaluation Panels, etc. were intended to assist and direct clinicians in the prescribing decisions with the aim of achieving cost effective prescribing. As demonstrated from the discussions held the effectiveness of such functions remain unclear. Interestingly the data indicates that pharmacists perceived that there were, and should be limits to the amount of influence they hold over clinician's behaviour. Also, despite the advancements made within hospital pharmacy as a profession a few respondents still sensed a lack of professional acknowledgement and understanding of their value by clinicians which is perhaps a good reflection of the dominance of the medical profession per se. For further improvements to the level of equity between the two groups to occur further reforms that challenge medical education so that it reflects modern values rather than entrenched hierarchical practice, as is currently the case, will be required.

Pharmacist Prescribing

Within the study of the professions and the wider structure of society, the ability to prescribe has traditionally been used as an indicator of the professional power and autonomy of the medical profession (Mesler, 1991). The proximity between clinicians and the substance prescribed (and arguably pharmacists and the substance prescribed) is illustrated by the use of the word medicine which describes both the substance and the profession (Britten, 2001). Extending the authority to prescribe to pharmacists was a government driven initiative, with the support of the RPSGB. Pressures exerted by the state through the NHS reforms and NPM discourses have resulted in prescribing authority becoming a battleground in which clinical autonomy is vigorously defended (Britten, 2001).

Freidson and Lorber (1972), in particular noted that the services of pharmacy were essential to the practice of medicine and contended that developments in pharmaceutical services and pharmacist prescribing could potentially threaten the medical professions position and lead to conflict between the two professions. Freidson further contended that the medical profession would be driven to circumscribe the activities of pharmacists in order to ensure the medical professions dominant position. If such a theory is correct, then it is unsurprising that segments of the medical profession, including some of this study's respondents, view the expansion of prescribing authority to non medical healthcare groups such as pharmacists with distrust.

During the 1970s, Eaton and Webb (1979) argued that the expansion of clinical pharmacy activity into prescribing practice did not necessarily offer much threat in

terms of boundary encroachment as clinicians delegated some of the tasks involved in prescribing such as drug therapy monitoring and counselling to clinical pharmacists previously. They further argued that the expansion of prescribing into clinical pharmacy did not suggest that the dominance of medicine has been threatened but rather indicated a renegotiation of order within a limited predefined area in which clinicians retain control over the patient management programme. This is further noted by Allsop (2006) who argues that the medical profession, rather than being annihilated have accommodated such legislative changes and thus succeeded in retaining its high status relative to other healthcare groups.

However, it is evident that the medical profession held (and as the data suggests still holds) concern over the extension of prescribing authority to non-medical groups including pharmacists. Indeed, there was (and still is) much concern that such initiatives are intended to undermine clinical autonomy and increase the level of bureaucratic control. Perhaps this concern stems from the medical professions realisation that the act of prescribing is one area in which medical practice can be broken down into distinct technical tasks which can then be delegated to other healthcare professionals such as pharmacists. This is of sociological importance as it indicates that medical practice can be subjected to rationalisation in the same way as other occupations (McKinlay, 1977).

The expansion of prescribing activity into the clinical pharmacy function involved a slow process of encroachment and delegation. Indeed, although heavily contested, pharmacist prescribing within the hospital setting, including the sites under study, started to appear within constrained areas during the 1970s (Abraham, 2009). The

legislative changes which extended prescribing authority to pharmacists in 2003 in particular, have affected the professional control of this aspect of the clinicians work. Pharmacists increased involvement in clinical activities such as drug history taking, patient counselling and prescribing can be regarded as a professionalising strategy and a means to enhance their professional status. Within this system, clinicians retain the authority but, as the data suggests, due to increasing financial pressure, quality standards and treatment protocols, frequently succumb to the, sometimes unsolicited, advice of the clinical pharmacists particularly where it was envisaged as non-threatening and tactful. It is therefore clear that by applying the activity of prescribing as an indicator of medical autonomy, control and professional status held by the medical profession, that this has changed.

Weiss and Fitzpatrick's (1997) explored proletarianisation and deprofessionalisation in relation to prescribing and concluded that deprofessionalisation was a key influence in the prescribing behaviour of doctors. Within the deprofessionalisation thesis, it is argued that the medical profession is losing its cultural authority in terms of prestige and trust as a result of both political changes and increased awareness and knowledge of the patients which it serves (Harding & Taylor, 2002). The evidence presented in this study supports this view.

Deprofessionalisation theory, however, has limitations similar to that of proletarianisation in as much as the evidence proffered is limited and hard to test due to its lack of specificity thus the significance of changes reported tend to be inferred rather than demonstrated (Elston, 1993). Attempts to challenge the authority and power of the medical profession are often promoted in terms of consumerism. In relation to

the UK experience, patients have little opportunity to exercise choice with regard to health care access therefore when considering the deprofessionalisation thesis circumspection needs to be applied.

However, the function of prescribing at the micro level of patient consultations can also be viewed as a sign of professional status. Some pharmacists indicated that they felt that such activity had enabled them to gain professional status not only within their own professional group but with clinicians as well. This was particularly illuminating as it indicates that the medical profession in general, recognises a loss of prominence and influence which has enabled a certain amount of re-stratification to occur within the healthcare system. Following Haug's (1973) deprofessionalisation argument, pharmacist prescribing represents a loss of a unique quality to the medical profession and thus could be considered as deprofessionalising for the medical profession and a professionalisation of pharmacy. The pharmaceuticalisation of prescribing which, has been encouraged by the government and the RPSGB, thus may be potentially of more importance to medical sociology than its traditional preoccupation that focuses on curbing clinical autonomy and alleged proletarianisation (Abraham, 2009).

Chapter Summary

The application of the sociology of the professions with NPM initiatives is important as it sheds light on the nature of the professions and paved the way for a more specific discussion of the real effects of NPM and financial accountability on the inter relationship of clinicians and pharmacists. In particular, it enabled the exploration of how the concept of jurisdictional boundaries of prescribing has been negotiated and affected by NHS reforms and NPM discourses.

Investigation into the sociology of the professions demonstrated that social theories of the professions place a high degree of importance on the amount of autonomy, either individual or collective, that medical professionals hold compared to other occupational groups. Indeed while theoretical interpretations vary, medicine has consistently been regarded as the archetypal profession that exhibits substantial autonomy over its activities and dominance over other occupational groups. It is also clear from more recent works, including this study, however, that the medical profession has been experiencing challenges to its status and autonomy for the last few decades. Indeed some of the distinctive features of the medical profession identified by early health care sociologists would appear to have diminished as a result of the successive round of NHS reforms, NPM initiatives and financial accountability being imposed on the profession.

A critical issue in debates of inter professional relationships and power within health care relates to who should make resource utilisation decisions regardless of their size. Adoption of new clinical innovations for example, no matter how scientifically based, have cost and social care implications. Such decisions are linked to clinical practice, and once were the sole responsibility of the medical profession; however, as this study demonstrates such decisions are increasingly being made through managed networks and are no longer entirely the decisions of the medical profession.

The establishment of regulatory agencies and growing governmental and professional understanding of the importance and need for good medicine management programmes and the potential of pharmacy has also opened the way to a sea of change within the

pharmacy profession. The most influential relationship that pharmacy has is with the medical profession. What has been shown here is that the boundary between medical practice and pharmacy still exists, but as a result of the many changes to the core activities of hospital pharmacy, such boundaries have arguably become less significant and easier to cross. Indeed the development of this traditionally marginalised occupation provides direct evidence of Abbots conception of professional jurisdictions as always being in flux.

It is clear from the evidence presented that there are complex interactions across the boundaries of medical practice and pharmacy. These boundaries affect the motivations of both parties for seeking professional improvement and upgrading. Such relationships cannot be regarded as a set of static and independent variables but rather should be viewed as a condition of forces which interact in complex ways.

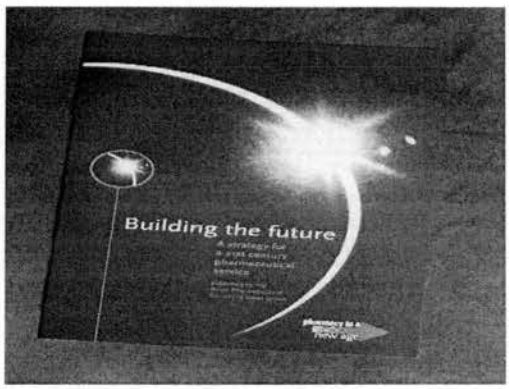
Indeed, pharmacists appear to be emerging as alternative bureaucrats, who intercede between managerial initiatives in the form of EBP, clinical guidelines and protocols and the professional practice of clinicians. Such a position, from the data presented, illustrates a profession driven primarily out of self interest in response to NPM initiatives and financial accountability changes but also a profession that needed to establish status and power while also serving the needs of the patients.

While it cannot be argued within this study categorically, that the medical profession has been truly proletarianised or deprofessionalised, the impact of NPM initiatives and financial accountability on medical autonomy and dominance is clear. Indeed such challenges also appear to have impacted on the professional status and identity of the

profession, not just in terms of its inter professional relationship with pharmacy but also from public perceptions as well. However, the impact of such initiatives on the status of the medical profession should not be overstated.

Within the literature on the sociology of the professions interpretations of governmental and managerial challenges to the professions autonomy and dominance are based on different sets of assumptions about how the medical profession and the government interact. As such, straightforward comparisons between them cannot be made. However, the increasingly complex division of labour with clinicians delegating some routine tasks to clinical pharmacists, the increased involvement of pharmacists in clinical decisions, pharmacist prescribing, and pharmacist involvement in regulatory agencies and prescribing control functions suggest that a restratification is taking place. The future will show whether we are observing the beginning of corporatization of the medical profession or merely a more pluralized health care system in which traditional medical dominance prevails. The overall conclusions of the study will be presented in the following chapter.

Chapter Ten: Study Conclusions



The main purpose of the research was to understand and explain the views and practices of the key actors in medicine resource management within the NHS, how they have responded to policy changes and government pressure and the resultant impact on their professional status. In doing this the study focuses on how the discursive nature of NPM techniques and language are implicated in controlling the activities and partisanship of pharmacists and clinicians within secondary care. It further considers the power effects of management discourses associated with healthcare reforms and discusses how the control of clinical activity through the discursive shaping of clinical subjectivity can occur. Additionally it explored the impact of managerial discourses on the negotiated order within the context of the hospital and how such individuals manoeuvre in relation to such discourses.

The empirical findings, the research method and design employed within the study generated valuable information that helped to explain and understand the perceptions of the clinical pharmacists and clinicians in the drive towards rationalising prescribing and costs containment procedures. The data also illuminates some professional and

political tensions that may be hindering progress. This study produces an overview of the changes that have taken place within medicine resource management and provides coverage of a number of related issues. The study also highlights a gap in public sector research in the area of the professional relationships between the clinicians and clinical pharmacists in the management of medicines.

The study is informed by a body of research contained within the sociology of the professions concerned with power, control and issues of discourse. This literature has played an important role in developing an understanding of the changing institutional context of the NHS and the penetration of NPM discourses into medical practice and discursive approaches to organisational analysis. The study thus can be usefully located within a body of research that considers the changing nature of professional roles and identities under the influence of NPM.

What is clear from the investigation is that research in this area has mainly been concerned with the technical aspects of pharmacy as a profession and little attention appears to be given to the relationships between the clinical pharmacists and the clinicians and their effect on medicine resource management. Little attention has also been paid to the effect of NPM initiatives and increased financial accountability on these relationships. Indeed despite changes in political and professional thinking it is notable that the clinician-pharmacist relationship and their complementary roles to each other have not been brought to the fore of NHS reforms and NPM discourses more. While the discussions held demonstrate that advancements have been achieved in medicine resource management within the hospitals under study they also indicate that there is scope for further improvement.

It is in this last area that perhaps the greatest gap in existing research is revealed. Little work has been done that examines the relationships between the parties involved in clinical prescribing decisions. The micro-level relationships between pharmacists and doctors, doctors and administrators and administrators and pharmacists have not been studied in depth and are poorly understood. Equally, the attitude of clinicians and clinical directors to the budgets under their control and the cost of drugs that they prescribe are under researched. Much of the work that does exist in this area is to be found in professional journals and often appears to be based on conjecture and anecdote.

The study thus contributes to closing this gap in healthcare research by providing an examination of professional relationships between the clinicians and pharmacists involved the management of medicines. Indeed this study is the first attempt to consider and understand the effects of NPM initiatives and financial accountability on the inter-professional relationship of clinicians and pharmacists and opens up opportunities for further studies in this area.

The introduction of NPM discourses into the NHS with their intention to increase both financial accountability and the control of the activities of clinicians in secondary care would indeed appear to have resulted in hegemonic struggles that have had an impact on the professional boundaries between two healthcare professions: clinicians and pharmacists. The process of prescribing within secondary care through drug history charts, the emphasis on competency and the collaborative approach to patient management would appear to have aided the legitimacy of pharmacist prescribers and

enhanced their professional status. Furthermore the structural changes to financial responsibility has forced clinicians to listen to and work more closely with pharmacy personnel than they had in the past thus opening up opportunities for pharmacists to increase their role and their influence. Despite the reported general acceptance of a greater role for pharmacists and conformity to increased management of health care delivery, it is also clear that NPM and increased control of health care is viewed as a constraint by the clinicians in terms of their autonomy and ability to perform their duties innovatively. Thus the evidence presented demonstrates that conformance to the principles of NPM and financial accountability, while not without hegemonic struggles, has resulted in a renegotiated order between management, clinicians and other healthcare professionals.

The study highlights the views of actors from all parts of the political spectrum involved in the attempt to shift public perceptions and political priorities of healthcare provision. Current UK health policy has a top down, formalised and prescriptive focus that reflects NPM style of control and performance that is highly embedded within the NHS. This has policy implications at both the macro and micro level. Current emphasis with health care policy is focused on national frameworks, guidelines, protocols and evidenced based practice. Drawing on the classical literature on health organisation, it was demonstrated that the medical profession is portrayed as the dominant profession which potentially limits the top down approach.

The micro level is strongly linked to action. The study recognises that changes to the activities of one professional group, can have profound implications for other professional groups. Political bodies, however, when making such changes, appear to

underestimate the tensions and conflicts that can arise when policies that affect role boundaries are introduced. The study therefore suggests that despite only partially being translated into policy, the individualist ideology has resulted in significant shifts in the social relations of healthcare provision. It further notes that such issues are embedded in deeper and still unresolved conflicts regarding collective and individual responsibility. It is clear that role restratification can potentially disrupt multi disciplinary working, thus policy makers need to consider how to stimulate inter professional dialogue and learning that encourages knowledge flow and cooperation across the professional boundary of the medical and pharmacy profession.

It must also be acknowledged, however, that from the data produced in this study, it is not possible to interpret the full extent of the impact of NPM and financial accountability initiatives on the relationship of the medical profession and pharmacists. Nevertheless, important issues regarding this inter relationship and its potential for improved medicines management within secondary care has been raised.

Additionally it demonstrates that NPM initiatives and changes in financial accountability have served as a catalyst in the erosion of professional boundaries between the two professions. In terms of the impact of healthcare reforms and changes to financial accountability on the role of 21st century hospital pharmacists it would appear that they have gone full circle with the expansion of their clinical role and duties not being dissimilar to that of the earliest apothecaries. The pivotal role that pharmacy can play within medicines management ensures that it will be in the spotlight for some considerable time to come thus making it both interesting and exciting to study.

Appendix: Study Research Instrument

The study:

- Focuses on how the discursive nature of NPM techniques and language are implicated in controlling the activities and partisanship of pharmacists and clinicians within secondary care; and
- Considers the power effects of management discourses associated with healthcare reforms and discusses how the control of clinical activity through the discursive shaping of clinical subjectivity can occur.
- It further explores the impact of managerial discourses on the negotiated order within the context of the hospital and how such individuals manoeuvre in relation to such discourses.

In order to achieve these aims the following research questions were utilised to define the scope and focus of the investigation:

- Which health care reform initiatives do you think has had the most impact on your professional role/status?
- To what extent are NPM initiatives controlling your professional activity?
- How is the professional role of pharmacists being coordinated and integrated with that of other healthcare professionals?
- Are there boundary disputes between pharmacy and other medical professionals?
- To what extent do boundary disputes with other medical professionals impinge on pharmacy's ability to take on new roles and responsibilities?
- What is your perception/opinion of pharmacists taking on a greater prescribing role?
- Do occupational boundary disputes limit the pharmacists' scope to recommend alternative treatments?
- To what extent do risks and anxieties about safety and efficacy of medicines undermine clinician's power?
- How, and in what ways, has health care reform and NPM initiatives affected the occupational status of clinicians/pharmacists?
- Are current perceived changes in the status of the medical profession affecting the pharmacy profession?
- How, and in what ways, will present trends in healthcare policy impact the occupational status of clinicians/pharmacists?

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