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Pastoral power in the community pharmacy: a Foucauldian analysis of services to promote patient adherence to new medicine use

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Abstract

Community pharmacists play a growing role in the delivery of primary healthcare. This has led many to consider the changing power of the pharmacy profession in relation to other professions and patient groups. This paper contributes to these debates through developing a Foucauldian analysis of the changing dynamics of power brought about by extended roles in medicines management and patient education. Examining the New Medicine Service, the study considers how both patient and pharmacist subjectivities are transformed as pharmacists seek to survey patient's medicine use, diagnose non-adherence to prescribed medicines, and provide education to promote behaviour change. These extended roles in medicines management and patient education expand the 'pharmacy gaze' to further aspects of patient health and lifestyle, and more significantly, established a form of 'pastoral power' as pharmacists become responsible for shaping patients' self-regulating subjectivities. In concert, pharmacists are themselves enrolled within a new governing regime where their identities are conditioned by corporate and policy rationalities for the modernisation of primary care.

Keywords: community pharmacy; medicines management; extended services; power; Foucault; England

Introduction

Community pharmacy increasingly features in global strategies to modernise primary healthcare (Hassell et al.2000; Williams, 2007; Smith et al., 2013). Policy-makers in countries such as Canada, the Netherlands, and the United States have turned to community pharmacists as an under-utilised resource that can manage the demands on family doctors, improve patient access, and make cost-savings (Mossialos et al., 2015). In the UK, the Nuffield Committee (1996), the Royal Pharmaceutical Society (Smith et al 2013), and successive government policies (Department of Health, 2003; 2008) have called for the extension of pharmacists' roles from dispensing and information-giving, to prescribing, patient education, health promotion and supporting medicine-use. Within the English National Health Service (NHS), the revised 2005 pharmacy contract reflected these ambitions, offering enhanced remuneration for meeting service quality standards and taking on extended roles in the delivery of primary healthcare, including four new 'advanced services': Medicines Use Reviews (MURs), Appliance Use Reviews, Stoma Appliance Customisation Services, and the New Medicine Service (NMS) (PSNC, 2014).

The extension of pharmacist roles has led to sustained social science debate about the changing status of the profession, especially in relation to family doctors and patients (Britten, 2001; Dingwall and Wilson, 1995; Harding and Taylor, 1997; Hibbert et al 2002; McDonald et al. 2010; Petrakaki et al 2012). Change is interpreted as extending pharmacy's jurisdiction in the social organisation of healthcare, e.g. prescribing, at the expense of other professions, e.g. family doctors (Britten, 2001; Harding and Taylor, 1997). Conversely, research suggests the expansion of pharmacy's jurisdiction is often framed by wider political, economic or professional interests, e.g. where new roles are in some sense 'delegated' by other more powerful professions (Hibbert et al 2002; McDonald et al 2010).

We contribute to these debates by developing a Foucauldian analysis of the changing forms of power brought about by extended roles. A growing number of scholars draw upon Foucault's ideas to examine how pharmacists' practices are transformed by new services (Barber, 2005; Hibbert et al

2002; Jamie 2014; Ryan et al 2004). A Foucauldian perspective offers a view of professional power that goes beyond the analysis of jurisdictional change or autonomy, considering instead how social practices and subjectivities are reconstituted in relation to changing discursive expectations (Foucault, 1994). Policies aimed at modernising primary care in the form of more patient-centred and cost-effective services might be seen as expanding pharmacy's professional jurisdiction, but from a Foucauldian perspective policy discourses reconstitute the relations of power through transforming professional and patient subjectivities. This includes transforming pharmacy's disciplinary gaze (Jamie, 2014) and new forms of subjectification for both patients and pharmacists (Ryan et al 2004).

This paper develops a Foucauldian perspective with reference to the introduction of the New Medicine Service (NMS) in the English NHS. The NMS aims to promote patient adherence to newly prescribed medicines by affording patients the opportunity to discuss their experiences of medicine use with their pharmacist, who can offer advice to support patient learning and encourage adherent behaviour (Elliott et al. 2014). Like Medicines Use Reviews (McDonald, et al 2010), the NMS might expand pharmacy's jurisdiction in medicines management, but it also transforms the relations of power within the primary care sector as pharmacists play a greater role in classifying, surveying and disciplining patient subjectivities. Our paper examines this possibility and further demonstrates the relevance of Foucauldian theory to the analysis of contemporary reform in primary care.

Transforming the professional roles of community pharmacy: a Foucauldian perspective

Transitions in the social organisation of community pharmacy have led to significant debate about the changing status and power of the pharmacy profession. Drawing on the sociology of the professions (e.g. Abbott, 1988; Freidson, 1970) analysis often centres on the connections between pharmacy's expert knowledge, autonomous practice, and jurisdiction with the division of labour (e.g. Britten, 2001; Harding and Taylor, 1997; McDonald et al 2010). Dingwall and Wilson's (1995)

influential paper challenged the idea of pharmacy being an 'incomplete' profession by showing its distinct ability in the system of modern healthcare to symbolically transform inert chemicals into medicinal drugs. This is found in their expertise in medicinal properties and their unique understanding of and ability to counsel patients. Although the profession has lost much of its role in medicines procurement and compounding with the industrialisation of production, it has expanded its jurisdiction in primary healthcare tasks (e.g. Britten, 2001; Harding and Taylor 1997; McDonald et al, 2010; Motulsky et al 2010; Petrakaki et al 2011).

However, Harding and Taylor (1997) interpret extended roles in advice-giving as reducing professional status because it moves practice away from its specialist pharmaceutical knowledge. Similarly, McDonald et al (2010) question whether advanced services, such as Medicines Use Reviews (MUR), necessarily expand professional jurisdiction, especially if there is limited demand from patients, and where services are driven to meet financial incentives. As such, expanded roles might appear to enhance pharmacist status (Britten, 2001), but can be delegated by other (more dominant) professions, and place power in the hands of consumers, commissioners and corporate bodies (Hibbert et al 2002; McDonald, et al. 2010).

This line of analysis locates the source of professional power *within* the profession, being premised on its expert knowledge, e.g. to transform drugs into medicines (Dingwall and Wilson, 1995).

Another way of understanding the connections between pharmacy's knowledge and power is through the work of Foucault. In the closing paragraphs of their influential paper, Dingwall and Wilson (1995: 125) allude to Foucault in describing the profession's "contribution to the maintenance of order or discipline in the social world". For Foucault, knowledge represents a form of power through its capacity to define the subjects of which it speaks and, in turn, to influence how these subjects are disciplined by others or how they discipline themselves (Foucault, 1980, 2008). In his earlier studies, *disciplinary power* is manifest through the 'gaze' of experts who define, survey and discipline their subjects (Foucault, 2012). These disciplinary discourses constitute subjects in two interlinked ways. First, they constitute the subject of the 'gaze', e.g. the ill, rendering them

amenable to surveillance by the expert. Second, they constitute the 'medium' of the gaze, e.g. the doctor, whose practices are constituted as surveying the patient. In other words, the practices of both are the product of, and disciplined by, particular forms of knowledge.

Foucault's later works considers how power in contemporary society operates less through discipline and more through subjectification and self-discipline (Dean, 2010; Foucault, 2008; Lempke, 2011). His concept of governmentality describes how people internalise societal discourses through their embodied practices and identities (subjectivities) so they discipline their own behaviours through their own freedom (Foucault, 2008). This results in a situation where individuals routinely regulate their own thoughts, behaviours and identities through a variety of strategies, calculation and assemblage - 'technologies of the self' - which align individual subjectivities with prevailing discursive rationalities. Although experts play a less direct role in the 'conduct of conduct', they continue to promote desirable subjectivities and coordinate the technologies of calculation through expert guidance (Rose 2007). This can be seen, for example, in public health promotion where health expectations are reframed as the individual's responsibility to adhere to expert guidance through their consumer choices (Petersen, 1997). The enhanced agency offered to patients in the delivery of healthcare, highlights the emergence of new technologies of control that rely upon self-care (Armstrong, 2014).

Ryan et al (2004) suggest a number of areas where Foucault's theories can enrich the analysis of how pharmacy practices are re-constructed through new policy discourses; how pharmacists interact with other health professions as a de-centred form of power; and how pharmacists discipline patient subjectivities. Barber (2005) describes pharmacy's professional distinctiveness as its 'pharmaceutical gaze' or unique ability to observe and predict the properties of medicines. More recently, Jamie (2014) extends Barber's account by showing how pharmacists can have role in the surveillance of patient bodies. She shows, for example, how pharmacist survey patient bodies in different practice

settings, including forms of bodily surveillance in primary care that are manifest through standardised testing and the production of 'algorithmic' bodies. Other studies draw on Foucault's ideas to interpret the changing role of pharmacy in patient education, health promotion and self-care (Hibbert et al 2002; Ryan et al 2004). These reveal how underlying neo-liberal rationalities inform the reconstruction of professional subjectivities with pharmacists increasingly responsible for helping patients become responsible for their own health. In this paper, we apply Foucault's ideas as a means of re-considering the changing dynamics of power within the social organisational of primary care. These ideas are particularly relevant to the analysis of advanced services, such as the New Medicine Service (NMS), that are interpreted as transforming professional boundaries and power.

The New Medicine Service

The NMS was developed in response to evidence that patients do not always take medicines as prescribed by healthcare professionals (Haynes et al 2008; Pound et al 2005). This 'non-adherence' is significant for chronic conditions, such as asthma and diabetes, and associated with poor health outcomes, unnecessary hospital admission, and additional treatment costs (Ho et al., 2006). Research suggests non-adherence is more common when patients are unfamiliar with their health condition and prescribed a new medicine (Barber et al., 2004). Pound et al (2005) suggest reluctance to take medicines as instructed often stems from patients' concerns about stigma and side-effects. Drawing on Leventhal and Cameron's (2003) self-regulatory model, the NMS aims to promote behavioural change through the pharmacist better understanding the patient's beliefs and experiences of their illness and new medicines, from which tailored guidance can be given to improve patient learning, support behaviour change, and encourage self-directed and adherent medicine use (Barry et al .2001; Barber et al., 2004; Elliott et al. 2008).

The implementation of the NMS in England involves a range of contractual incentives, organisational and workflow changes, and educational interventions for community pharmacy; made possible by the 2005 community pharmacy contract (Barnett 2014; PSNC, 2014a,2014b). The service is configured around three points of pharmacist-patient interaction. Consistent with current practice, the pharmacist continues to offer advice to patients when dispensing new medicines. At this time, the pharmacist can invite eligible patients to participate in the NMS, i.e. those receiving new (for that patient) medicines for asthma or Chronic Obstructive Pulmonary Disease (COPD), type 2 diabetes, hypertension and illnesses requiring antiplatelet/anticoagulant medicines. The main feature of the intervention is a one-to-one consultation between pharmacist and patient scheduled 7-14 days after a new medicine is dispensed, giving the patient sufficient experience of the new medicines. In the consultation, the pharmacist follows an interview schedule (table 1) to elicit the patient's experiences of the new medicine, which affords both the pharmacist and patient an opportunity for mutual learning, and from which the pharmacist can offer individualised guidance to improve patient adherence. The patient is offered a follow-up appointment two-three weeks later, where the pharmacist will again ask about their experiences and assesses the continued relevance of their advice. In cases where the patient is suffering severe side effects the patient will be referred back to their prescribing GP.

<Table 1: Interview Schedule Summary>

Through these extended roles in patient education and medicines management, the NMS might be interpreted as expanding the pharmacy's professional jurisdiction within the primary care setting. Taking a Foucauldian perspective, however, the NMS might be seen as having more dynamic implications for social power. Professional roles are not merely expanded, but rather professional subjectivities are reconstituted in line with prevailing discursive rationalities. In particular, the

pharmacist is increasingly responsible for not only surveying patient medicine use, but also encouraging patients to become self-surveying. The NMS is explicitly based upon a theory of 'self-regulation' (Leventhal and Cameron, 2003), and the expectation that patients will discipline their behaviours if appropriately guided by the pharmacist. As such, the expert role of the pharmacist centres on the reconstitution of patient subjectivities and fostering 'technologies of the self' so patients remain adherent without the need for on-going surveillance. Our paper develops this line of analysis.

Methods

The paper draws upon the findings of a qualitative study within a larger appraisal of the New Medicine Service in the English National Health Service, carried out between August 2012 and November 2013 (Elliott et al 2014). This appraisal was undertaken in community pharmacies located in London, the Midlands and South Yorkshire, within which the qualitative study aimed to develop an in-depth ethnographic understanding of the situated practices, cultural context and organisational field within which the NMS was implemented, including observations of pharmacist-patient interactions. Field researchers invited 26 patients to take part in the study with sampling taking into consideration differences in age, gender, ethnicity and health condition (table 2). Researchers were careful to explain that the study was concerned with the implementation of the new services and their interaction with pharmacists, not their medicine use. Twenty patients agreed to the observations, which developed a detailed descriptive understanding how of pharmacists' and patients' subjectivities were reconstituted through the NMS. These observations were recorded in hand-written field journals and, where consent was given, audio- or video-recorded. In addition, short 'before-and-after' ethnographic interviews were carried out with patients and pharmacists to understand their expectations and experiences of the interaction.

< Table 2: Patient participants >

Nineteen of these patients also participated in semi-structured interview to explore their experiences of the NMS and how this related to their medicines-related behaviours. Interviews were conducted within the patient's home, at the pharmacy, or by telephone, according to preference. In addition, 27 community pharmacists participated in semi-structured interviews, which explored their experiences of the NMS and the changes in the pharmacy practice. The study received favourable ethical opinion through NHS Research Ethics procedures (12/WM/0096), and all participants gave written consent.

Following an interpretative grounded approach (Strauss and Corbin, 1990), observational and interview data were analysed using nVivo (v10). This initially involved open coding of data to describe the organisation of the NMS. Coded extracts of data were further analysed through constant comparison to clarify the internal consistency of codes and conceptual relationships. Informed by the principles of abduction (Reichertz, 2007), subsequent thematic coding related emergent codes to the theoretical concepts, with a particular emphasis on the social practices and (inter-) subjectivities realised through the NMS. The findings describe and analyse the delivery of the NMS as a series of interactions between pharmacists and patients to elaborate the specific practices and subjectivities constituted by this new service.

The NMS 'in practice'*Introducing the NMS*

We first examine how the service was introduced to patients, and how this framed subsequent practices and expectations. Patients were invited to participate in the NMS at the point of being dispensed a new medicine. This 'over the counter' interaction was relatively informal with the NMS

described as a “free service” to “check on how you are getting on with the new tablets”. An interesting feature of this encounter was the lack of talk about ‘adherence’. Although pharmacists usually alluded to some notion of ‘checking’ it was usually left vague as to whether the ‘check’ was on patient behaviour or the medicines. More significantly, pharmacists appeared to ‘sell’ the NMS to patients by making it attractive and acceptable, e.g. as a follow-up service. This reflected what many pharmacists saw as a corporate ‘push’ to enrol NMS patients to generate additional financial income, following a reduction in their dispensing fees to fund the service. As such, espoused discourses around patient adherence and medicine safety appeared to interact with wider commercial or business rationalities (McDonald, et al 2010).

“Categorically, yeah we’ve lost a lot of money, we have to recuperate it back through services. NMS does pay us to do it, that’s also an incentive.” [Pharmacist 103]

“The amount of money that we get for purely dispensing is reducing and the amount that we get for services is increasing. So you know to balance the books then it’s expected that you engage with new services and we do.” [Pharmacist 112]

Initiating the NMS consultation

The main NMS consultation was a more formal ‘clinical encounter’. Almost all consultations started with the pharmacist asking the patient to reflect upon their experiences of using the new medicine, e.g. ‘*how are you getting on with your medicines*’, which was usually followed by subsidiary questions about adherence, e.g. had the patient “*been taking it regularly*” or “*missed a dose*”:

Extract 1:

Pharmacist: OK, people often miss taking doses of their medicines for a wide range of reasons. Have you missed any of your doses or changed when you take it?

Patient: No. I think I have been taking my medication, quite well every day. I am having it after breakfast. I make sure I take it. I haven't missed any dose.

Pharmacist: Ok, you're a good patient. You know you take it every day. Is there anything else that you would like to know about your new medicine, or is there anything that you would like me to go over again.

Extract 2:

Pharmacist: And have you been taking it every day [clopidogrel]?

Patient: Pardon?

Pharmacist: Have you been taking it every single day or have you missed any doses or anything?

Patient: Oh no, every day. Actually [patient's wife] makes sure I get them all about 1 o'clock every day at the same time yeah.

This line of questioning established the NMS consultation as a 'pharmacist-led' interaction, with the expectation that the pharmacist is questioning the patient, and where the patient is expected to account for their behaviours. Moreover, it framed the interaction in such a way that the pharmacist was explicitly 'monitoring' patient behaviours in terms of their understanding and use of medicines. Integral to this was an expectation that the patient should admit to 'non-adherence'. As shown above, this was often framed with some sense of morality, where being adherent is 'good' and being non-adherent 'bad'. As these extracts show, patients often claimed to be following medical

instruction, indicating perhaps they were indeed adherent or alternatively mindful of giving a 'good' impression.

Looking further at these interactions, patient understanding of medicine use was usually located within the context of their wider lifeworld, such as eating times or familial support (Barry et al 2001; Whyte et al. 2003). This was important, because it opened up new possibilities for the pharmacist to see how medicines 'work', not only in terms of their pharmacological properties, but in their interaction with the patient's wider health and lifestyle circumstances; i.e. widening the pharmacist's gaze. It is also worth noting subtle differences in how pharmacists interacted with patients in their use of the NMS interview schedule. Our observations found some pharmacists modified or disregarded this schedule to develop their own lines of questioning. Compare, for example extract 1 and 2, where the former closely follows the provided NMS question. These modifications seemed to reflect pharmacists' desire for a more flexible and patient-friendly approach, but it might also suggest some pharmacists are eager to enact greater autonomy in their practice. Specifically, more experienced pharmacists seemed more willing to go 'off-script' to enhance their relationship with patients. Where the 'official' NMS schedule appeared to reinforce the underlying policy rationale, these 'off script' questions allowed other rationalities to flow through pharmacists' questioning, especially opportunities to probe wider aspects of patient wellbeing.

"I was trying really hard to ask the questions almost the way they were worded and it wasn't making for a natural flowing conversation. So I do use that format [schedule] but I've tweaked it a little bit to make it more me. So I'll ask about have you got any problems or concerns I will ask those sort of specific phrases but not necessarily in the order that, or in the way they've specified does that make sense?" [Pharmacist 01]

Managing the 'non-adherent patient'

Pharmacists reported that about a quarter of patients described some form of non-adherence, such as missing a dose, which was broadly confirmed through observations. When this occurred, pharmacists would ask the patient to talk about what might have influenced their behaviours. In some instances, their questions probed anticipated issues, such as common side-effects, based upon the pharmacist's prior understanding certain medicines. For example, pharmacists often asked whether the patient experienced 'indigestion' or 'felt sick' as a means of encouraging them to explain their non-adherent behaviour.

Extract 3:

Pharmacist: Right okay now do you think you've had some side effects with this then? Do you feel different with it then?

Patient: The only thing is, I wee a lot more. But apart from that no, no, no I haven't had any bad side effects at all.

Pharmacist: I mean this weeing effect, I don't think it's due to these tablets ... It's got to be due to something else ... Do you feel anxious and a bit worried?

[Consultation 103 (2) intervention Clopidogrel]

Extract 4:

Pharmacist: How are you getting on with the purple one? Are you still using that every day?

[Yes]. You've not missed a dose or anything?

Patient: I've missed one ... because you have to leave it like 12 hours in between ... yesterday, I took it like at 2 o'clock in the afternoon ... I forgot it in the morning ... has there got to be 12 hours in between?

Pharmacist: It's normally just twice a day, I mean you don't have to keep it to 12 hours exactly ... I wouldn't be that precise with it ... So I'd rather you take it twice a day than keep missing your dose. I know you've only missed it once so that's absolutely fine ... But just get into a routine which suits you best, just to try and fit your two doses in the day.

Through these interactions, pharmacists sought to investigate how patients understood and experienced their medicines in the context of their wider life and health circumstances. Through this insight, the pharmacist was expected to offer specific guidance to enhance patient understanding and promote behaviour change. This guidance seemed to work on three levels, each suggesting a different assumption about the source of non-adherence, and understanding of the NMS. First, pharmacists would often seek to address patient knowledge deficiencies through providing information about their medicines, e.g. how they worked, how they should be taken, and common side-effects. This often involved explaining the health benefits of taking medicines appropriately and detailing the risks of non-adherence.

"I think patients still need to be made aware, educated...you know they will get benefits from talking to pharmacists....I would say that they haven't got enough information you know"

[Pharmacist 104]

Second, patients were offered broader advice about how it might be best to take their medicines in the context of the personal circumstances, e.g. work patterns or eating arrangements. In this sense, pharmacists looked beyond the pharmacological properties of the medicines, to consider the patients' lifestyle. Third, pharmacists provided more practical 'hands-on' instruction, where relevant, about how to take certain medicines. These hands-on encounters were significant because they presented an opportunity for pharmacists to promote 'learning-through-doing', with opportunities for corrective instructions, rather than relying upon information-giving.

Extract 5:

Pharmacist: So now let's twist this to the Spiriva setting ... that needs the extra speed and a bit more resistance but I'm sure you'll be able to do it ... [patient inhales through device].

Terrific, oh look at that, you're nearly off the scale ... If we go too hard then that's when it's going to start hitting the throat again. But really all that energy that you're putting in is smashing that powder up. We'll just have one more go [patient inhales through device].

Brilliant spot on.

These three forms of guidance seemed to work on two levels, one being concerned with giving patients an enhanced technical understanding of their medicines' pharmaceutical properties; the other with changing patients' use of medicines, informed by pharmacists' extensive practical experience of working with similar patients and medicines. Patients talked positively about being provided with more information about their medicines and clearer instructions about use, which many described in terms of feeling empowered or having greater responsibility for promoting their own health.

"I thought they [pharmacist's questions] were great actually because they made me think about certain areas that would help along with the medication. The lifestyle choices that would support the medication in lowering the blood pressure ... so in that sense they were really good ... it was good to sort of bolster the kind of treatment and the service that I would get from the GP." [Male, 40 years]

"Actually yeah ... It's always daunting, you know when you take something for the first time ... like say such as with my toes hurting and my knees hurting it's like is it the medication or is it not. So it's nice to be able to talk to somebody so they can say no I don't think it's that."

[Female, 57 years]

In some cases, pharmacists' scope to question and guide patient behaviours appeared problematic. A number of patients, for example, were unsure about the purpose of the NMS, and appeared to disengage from the interaction offering only limited responses or accounts of their behaviour. Like other advanced services, the NMS interaction deviates from the usual pharmacist-patient interaction, and was not always welcomed by patients (McDonald et al. 2010). As shown in Extract 6, some patients appeared to challenge the expertise of the pharmacist by drawing upon their unique, and more detailed, understanding of their health condition to justify non-adherent behaviour. However, the scope for patients to challenge the pharmacist seemed to reflect underlying variations of both actors' experiences; i.e. patients with extensive disease-specific experience could question the knowledge of a more inexperienced pharmacist. That said, the NMS is targeted to patients with new medicines, usually for new conditions, who might not be expected to draw upon detailed experience to challenge the expertise of the pharmacist.

Extract 6:

Pharmacist: I just wanted to see how you're doing with that one [aspirin].

Patient: The problem is I'm not going to be able to continue taking them ... Because they're giving me a really bad stomach ... I've already on a past occasion had seven days in hospital with quite a large stomach bleed that needed five units of blood.

Pharmacist: And when was that?

Patient: That was in 1989 ... as soon as I started taking the aspirin I started to get sore quite quickly and then it lasted for about 16 hours before my stomach seemed to settle down and then I took the next one again with my tea and it got even worse ... So I don't know really what my options are.

Pharmacist: No that's fine. What we are going to do we are going to refer you back to the doctors...

[Consultation 169 (intervention) Aspirin]

Extract 6 also shows the limits of pharmacists' ability to guide patient behaviour, in part because of the lack of access to patient records, but also because of the lack of prescribing authority. In these cases, it was necessary to refer the patient back to the prescribing GP who retains overall responsibility for medicines-management. Seen in this light, the role of the pharmacists appeared to become concerned with identifying potential risk, and the GP resumed their role in prescribing and patient education. This indicates the over-arching continuity of the medical gaze, but how it is now manifest through the 'proxy' of the community pharmacist.

Responding to the 'adherent patient'

Many patients described themselves as taking their medicines as instructed. As discussed above, this might reflect some patients' desire to show adherence and be regarded as a 'good' even where they have not followed the provided instruction. Where patients did give this impression, pharmacists used the NMS consultation as an opportunity to explore wider aspects of the patient's health and lifestyle, from which to find other areas to offer advice, such as diet, exercise or smoking.

"I always like to throw in some lifestyle information at the end as well. It's generally ninety-nine per cent of the time people need to have a healthier diet and do more exercise. So those are the two that's the most common advice I'm giving." [Pharmacist 117]

Extract 7:

Pharmacist: Can we have a quick chat about your lifestyle? Okay so you have a healthy diet do you, with a lot of fruit and vegetables?

Patient: Yes, I do yeah.

Pharmacist: And you don't have too much salt as well?

Patient: No.

Pharmacist: Okay right, what about smoking, you don't smoke at all?

Patient: No, no.

[Consultation 102]

In these situations, pharmacists appeared to be searching for some way of maintaining the purpose of the NMS consultation. This might suggest pharmacists saw the NMS as more than checking or promoting patient adherence, but rather as an opportunity to develop more personal relationships with their patients and to play a fuller role in patient health promotion. This could be linked to pharmacists' underlying ambitions to expand their professional role and jurisdiction in primary care.

Discussion

The study shows subtle changes in the social organisation of community pharmacy, especially the relationship between pharmacist and patient. Drawing upon Foucault, we discuss the changing dynamics of power that might be emerging as a result of the NMS, and similar extended services.

We first consider the 'governing' rationalities that inform the NMS and contemporary reconfiguration of community pharmacy. For Foucault (1980), a 'rationality' describes the underlying assumptions, reasoning and ideologies that 'programme' behaviours and associated forms of social order (Lemke, 2011). Reflecting on national policies, training guides and corporate documentation (Barnett, 2014; Centre for Postgraduate Pharmacy Education, 2014; PSNC 2014b), and studying the

NMS in action, four discursive rationalities might be delineated, each associated with particular expectations about pharmacists' and patients' relational subjectivities.

On one level, the NMS might be interpreted articulating a 'surveillance' rationality, and concerned with 'monitoring and checking' patients' medicines use. This was not exclusively associated with checking patient 'adherence', but rather patients' general experiences of new medicines.

Significantly, this checking went beyond the effectiveness or safety of medicines, to include wider health and personal factors. In this sense, the pharmacist is constructed as a surveyor of patient behaviour whose pharmaceutical expertise helps categorise 'problem' behaviours. From a different perspective, the NMS illustrates a rationality of 'risk management' through which 'risky' behaviours can be identified and appropriately managed (Nettleton, 1997). This involves a more technical categorisation of non-adherence, often associated with side-effects and, importantly, assumes a more interventionist response. Within prevailing socio-legal parameters, however, there are limits to which pharmacists can change prescribed medicines; with patients being referred instead to their prescribing GP. As such, the NMS reconstructs the pharmacist as a risk assessor, but the GP remains the over-arching manager of risk. Where problems were identified that did not require a prescription change, the NMS articulated a further rationality of 'patient education', with the pharmacist identifying knowledge deficiencies and guiding behaviour change. In this sense, pharmacists assume a 'teacher' role, with patients a corresponding 'pupil' role. A final more implicit rationality sees the NMS as a politically-driven strategy for managing demand for GP services, and in concert, an opportunity for professional and business development for pharmacists, e.g. where NMS patients attract additional funding. This rationality addresses wider socio-economic priorities, and sees a convergence of policy-makers' and the corporate interests creating a coercive influence not only on patients', but also on pharmacists' practices.

Importantly, these discursive rationalities co-exist, converge and, at times, compete revealing a more complex reconfiguration of power. For example, the emphasis on monitoring patient

behaviour might stem from policy-makers' desire to reduce costs associated with inappropriate medicines use, e.g. hospital admission; but the study also found pharmacists' willingness to educate patients about their wider health and wellbeing. More significantly, the reconstruction of both pharmacists' and patients' (inter-) subjectivities speaks directly to Foucauldian interest with, on the one hand, surveillance and disciplining, and on the other, subjectification and governmentality.

Taking the first of these themes, we suggest the NMS transforms and extends the 'pharmaceutical gaze' (Barber, 2005). Foucault's analysis of disciplinary power describes how social discourses are realised through the 'gaze' of experts, who survey, categorise, and control 'problem' subjects (Rose, 2007). Barber (2005) described the 'pharmaceutical gaze' as stemming from pharmacist's ability to predict the pharmacological properties of medicines. Jamie (2014) suggests the 'pharmaceutical gaze' metaphor has had only limited relevance to pharmacy because of the lack of 'diagnosis' usually involved in pharmacy practice; but when the wider aspects of pharmacy practice are considered, such as their surveillance of body, the scope of the pharmacy 'gaze' becomes apparent. With the NMS, the pharmacy gaze is extended to include the diagnosis and categorisation of non-adherent behaviours, including behaviours and lifestyle factors beyond the traditional scope of the pharmacist's expertise. Although Harding and Taylor (1997) saw advise-giving as moving pharmacy practice away from its core knowledge domain, we suggest the NMS might show how pharmacy expertise can be extended to understand the interaction of medicines with the wider lifeworld of patients (Barry et al 2001; Whyte et al 2003). As such, the pharmacy gaze extends beyond the pharmacological properties of the drug and its clinical health benefits, to include surveillance of how medicines interact with more diverse patient behaviours, such as diet, smoking or exercise. The community pharmacy might therefore be interpreted as an extended panopticon that supplements, or perhaps substitutes the surveillance work undertaken by the GP surgery.

However, the study finds that pharmacists' extended ability to diagnose problems in medicines-use does not always translate into their ability to intervene, with some patients needing to be referred

back to their GP (Tinelli et al., 2009). Despite pharmacists' extended opportunities to survey patient behaviours, GPs retain socio-legal authority for prescribing. From this perspective, the NMS might be interpreted as helping to manage the demand on GPs by diverting patients that might be managed by a less costly and under-utilised professional resource, and not necessarily expanding their authority.

Turning to our second line of analysis, the study shows how the 'pharmacy gaze' is involved in the reconstitution of patient subjectivities. The NMS illustrates the 'conduct of conduct' (Foucault, 2008) through shaping the beliefs and behaviours of patients so they take greater responsibility for governing their own behaviours. As shown above, this involved exploring 'misguided' beliefs, diagnosing 'risky' behaviours, and offering guidance to promote a more virtuous (adherent) patient. The role of the pharmacist becomes one of changing how patients understand and relate to themselves as being 'good' or 'bad'. This is exemplified by the 'self-regulation' model on which the NMS is developed (Cameron and Leventhal, 2003) whereby patients are compelled to survey and manage their own behaviours through 'technologies of the self' (Rose, 2007). As suggested by Rose (2007) the contemporary arts of government not only involve experts governing others, but experts helping us to govern ourselves under the illusion of freedom.

Of particular note, the NMS illustrates how governmentality is achieved through 'pastoral power' (Foucault, 1982; 2008). Foucault developed this concept to account for how religious leaders 'shepherd' the moral behaviour of their 'flock' – through sermons, hearing confession, and offering salvation. Although Foucault talked of pastoral power as a regime of religious discipline, it is central to his analysis of contemporary subjectification and governmentality, especially how experts conduct the moral conduct of individuals (Golder, 2007; Foucault, 1982; Nettleton, 1997).

Developing this idea, the NMS re-constitutes the pharmacist as shepherding the medicines-related behaviours of their patients. This involves, for instance, hearing patient 'confession' about non-adherence; drawing on 'scripture' (pharmacological expertise) to justifying appropriate behaviours;

constructing these behaviours as moral imperatives; and retaining the possibility for monitoring patient behaviours. Following Rose (2007), community pharmacists are developing their position amongst the 'new pastorate', where they work to align patient subjectivities with the contemporary rationalities of medicines use, including those of surveillance and risk management, but also political and economic imperatives to reduce the burden on primary care. As with other forms of neoliberal health promotion, responsibility is transferred from the State to the individual, and the role of the expert moves from discipline to subjectification through this pastoral power (Nettleton, 1997). The study suggests extended services, like NMS, involve a dynamic reconfiguration of power within the primary care setting, as pharmacists not only develop enhanced disciplinary power, via the pharmacy gaze, but also enhance pastoral power as they become active in the reconstitution of patient subjectivities.

One consequence of following a Foucauldian approach is that analysis can over-emphasise the control of patients, and neglect how experts are equally disciplined through these governing rationalities (Miller and Rose, 2008). With the NMS, pharmacists might become the new pastors of medicines-use, but they are themselves disciplined by and accountable to healthcare funders and corporate bodies. Echoing McDonald et al's (2010) analysis of MURs, community pharmacists are guided by corporate and policy imperatives, where the enrolment of patients is associated with both financial income and reduced demands on primary care. As such, pharmacists are themselves subjects of a new regime of governance where their subjectivities are equally the focus of discipline and subjectification. Through these relational practices *both patient and pharmacist* identities are reconstituted at the 'boundary of coercion and consent' (Rose, 2007), or the 'nexus of disciplinary power and subjectification' (Waring and Martin, 2016) as both become enrolled within new discourses of medicines management. It is worth considering through further research how the boundary of coercion and consent between pharmacists and GPs might also be changing as pharmacists have enhanced indirect scope to survey GP prescribing practices.

Finally, the study highlights a number of contingencies that complicate the operation of the NMS, at least from a Foucauldian perspective. First, many patients described themselves as generally adherent and experiencing few problems, which might reflect patients' impression management in the face of pharmacist questioning, even when they might be non-adherent. This makes it difficult for the pharmacist to survey and categorise 'problem' behaviours. Second, the pastoral role necessitates a range of non-clinical skills for questioning and guiding patient behaviours, especially through forms of 'moral instruction'. However pharmacists might lack these skills and be constrained by their prevailing pharmacological expertise to address non-pharmacological issues. The study found, for example, not all pharmacists were equally skilled at communicating with their patients, with some more able to go 'off-script' to engage patients and ask about lifestyle factors. Significantly, these pharmacists tended to be more experienced and concerned with developing a relationship with patients, and possibly re-stating their professional autonomy.

Concluding remarks

Transitions in the organisation of community pharmacy often focus on the relative power of professional groups, especially pharmacists and family doctors. The recent introduction of four Advanced Services in the English NHS exemplifies this trend with pharmacists offered expanded roles in primary healthcare (Mossialos et al., 2015). Dingwall and Wilson (1995) suggest pharmacy's professional status rests on its expertise in transforming 'chemicals' into health improving 'drugs'. Through the NMS, pharmacy's professional status might be enhanced through its new roles in transforming 'drugs' into wider improvements in 'health'. This is significant because it suggests a transition in the dynamics of pharmacists power, based not only on pharmacological expertise, but on relational access to and understanding of patients' wider health and lifestyle circumstances, including aspects of health that stretch beyond the pharmacological effect of medicines. Advanced services like the NMS, might therefore be seen as expanding the jurisdiction of the profession as it

moves from dispensing and advice-giving to monitoring of medicine use, patient education and intervening to change behaviours.

Developing a Foucauldian perspective, the paper looks beyond more customary analysis of professional boundaries and jurisdictions, to consider instead how power operates through the inter-connected practices and subjectivities of pharmacists and patients as constituted by different governing rationalities (Ryan et al., 2004). From this perspective, power relationships are not seen in terms of dominance and subservience, but as operating through the reconstitution of subjectivities. In terms of the NMS, the changing configuration of power is manifest through the pharmacist's extended 'gaze' to survey non-adherent patients, and more significantly pharmacist's 'pastoral power' as they shepherd the moral behaviours of patients and foster adherent subjectivities. Importantly, this system of medicines management, like other extended services, reconstitutes the inter-connected practices and identities of *both* pharmacists and patients resulting in a more complex configuration of relational power.

References

- Abbott, A. (1988). *The system of professions: An essay on the division of labor*. Chicago: University of Chicago Press.
- Armstrong, D. (2014) 'Actors, patients and agency: a recent history', *Sociology of health & illness* 36(2),163-174.
- Barber, N., Parsons, J., Clifford, S., Darracott, R., & Horne, R. (2004). Patients' problems with new medication for chronic conditions. *Quality and Safety in health care*, 13(3), 172-175.

- Barber, N. (2005). The pharmaceutical gaze the defining feature of pharmacy?. *Pharmaceutical Journal*, 275(7358),78-78.
- Barnett, N. L. (2014). Medication adherence: where are we now? A UK perspective. *European Journal of Hospital Pharmacy: Science and Practice*, 21(3),181-184.
- Barry, C., Stevenson, F., Britten, N., Barber, N. and Bradley, C. (2001) 'Giving voice to the lifeworld. More humane, more effective care? A qualitative study of doctor-patient communication in general practice' *Social Science and Medicine*, vol53(4),487-505.
- Britten, N. (2001). Prescribing and the defence of clinical autonomy. *Sociology of Health & Illness*, 23(4),478-496.
- Cameron, L. D., & Leventhal, H. (2003). *The self-regulation of health and illness behaviour*. Psychology Press
- Centre for Postgraduate Pharmacy Education (2014) *Consultation skills for pharmacy practice*. University of Manchester: Manchester.
- De Simoni, A., Mullis, R., Clyne, W., & Blenkinsopp, A. (2012). Medicines optimisation in primary care: can community pharmacies deliver?. *British Journal of General Practice*, 62(601),398-399
- Dean, M. (2010) *Governmentality*, London: Sage
- Department of Health (2003) *A vision for pharmacy in the new NHS*, London: TSO
- Department of Health (2008) *Pharmacy in England: Building on strengths – Delivering the Future*, London: TSO
- Dingwall, R., & Wilson, E. (1995). Is pharmacy really an incomplete profession. *Perspectives on Social Problems*, 7,111-28.

- Elliott, R. A., Barber, N., Clifford, S., Horne, R., & Hartley, E. (2008). The cost effectiveness of a telephone-based pharmacy advisory service to improve adherence to newly prescribed medicines. *Pharmacy World & Science*, 30(1), 17-23.
- Elliott, R., Boyd, M., Waring, J., Barber, N., Mehta, R., Chuter, A., Avery, A., et al (2014) *Understanding and Appraising the New Medicine Service in the NHS in England*, London: Department of Health.
- Foucault, M. (1980) *Power/Knowledge*, London: Harvester
- Foucault, M. (1982) 'The Subject and Power' *Critical Inquiry*, vol.8(4),777-95.
- Foucault, M. (2012). *The Birth of the Clinic*. London: Routledge.
- Foucault, M. (2008) *Security, Territory, Population: Lectures at the Collège de France 1977--1978*. Vol. 4. London: Macmillan
- Freidson, E. (1970). *Profession of medicine: a study of the sociology of applied knowledge*, Chicago: University of Chicago Press.
- Golder, B. (2007) 'Foucault and the genealogy of pastoral power', *Radical philosophy review*, 10(2),157-76.
- Harding, G. and Taylor, K. (1997) 'Responding to change: the case of community pharmacy in Great Britain' *Sociology of Health and Illness*, vol.19(5),547-60.
- Hassell, K., Rogers, A. and Noyce, P. (2000) 'Community pharmacy as a primary health and self-care resource: a framework for understanding pharmacy utilization' *Health and Social Care in the Community*, vol.8(1),40-9.
- Haynes, R. Brian, et al. (2008) "Interventions for enhancing medication adherence." Cochrane database vol.2.2.

- Hibbert, D., Bissell, P. and Ward, P. (2002) 'Consumerism and professional work in the community pharmacy' *Sociology of Health and Illness*, vol. 24(1),46-65.
- Ho, P., Rumsfeld, J., Masoudi, F., McClure, D., Plomondon, M., Steiner, J., & Magid, D. (2006) 'Effect of medication nonadherence on hospitalization and mortality among patients with diabetes mellitus', *Archives of internal medicine*, 166(17),1836-1841.
- Jamie, K. (2014). The pharmacy gaze: bodies in pharmacy practice. *Sociology of health & illness*, 36(8),1141-1155.
- Lemke, T. (2011). *Foucault, governmentality, and critique*. Paradigm Publishers.
- McDonald, R., Cheraghi-Sohi, S., Sanders, C., & Ashcroft, D. (2010) 'Professional status in a changing world: The case of medicines use reviews in English community pharmacy', *Social Science & Medicine*, 71(3),451-458.
- Miller, P., & Rose, N. (2008). *Governing the present: Administering economic, social and personal life*. Polity.
- Mossialos, E., Courtin, E., Naci, H., Benrimoj, S., Bouvy, M., Farris, K. & Sketris, I. (2015). From "retailers" to health care providers: Transforming the role of community pharmacists in chronic disease management. *Health Policy* (in press).
- Nettleton, S. (1997) 'Governing the risky self', in Bunton, R. and Petersen, A. (eds.) *Foucault, health and medicine*. London: Routledge,207-222.
- Nuffield Committee of Inquiry in Pharmacy (1996) *Pharmacy: a report to the Nuffield Foundation*, London: Nuffield Foundation.
- Petersen, A. (1997) 'Risk, governance and the new public health' in Bunton, R., & Petersen, A. (eds.) *Foucault, health and medicine*. London: Routledge, pp.189-206

- Petrakaki, D., Barber, N. and Waring, J. (2012) 'The possibilities of technology in shaping healthcare professionals: (Re/De-)Professionalisation of pharmacists in England', *Social Science and Medicine*, vol.75,429-437.
- Pound, P., Britten, N., Morgan, M., Yardley, L., Pope, C., Daker-White, G., & Campbell, R. (2005). Resisting medicines: a synthesis of qualitative studies of medicine taking. *Social science & medicine*, 61(1),133-155.
- Pharmaceutical Services Negotiating Committee (PSNC) (2014a) *Advanced Services (MUR & NMS)*, PSNC Briefing 016/14, London: PSNC.
- Pharmaceutical Services Negotiating Committee (PSNC) (2014b) *Improving Health and Patient Care through Community Pharmacy – a Call to Action*, London: PSNC.
- Reichertz, J. (2007) 'Abduction: The logic of discovery of grounded theory' in Bryant, A. and Charmaz, K. (Eds.) *The Sage Handbook of Grounded Theory*, London: SAGE.
- Rose, N. (1990) *Governing the soul: the shaping of the private self*. London: Routledge.
- Rose, N. (2007) *The politics of life itself: Biomedicine, power, and subjectivity in the twenty-first century*. London: Routledge
- Ryan, K., Bissell, P., & Traulsen, J. M. (2004). The work of Michel Foucault: relevance to pharmacy practice. *International Journal of Pharmacy Practice*, 12(1),43-52.
- Smith, J., Picton, C. and Dayan, M. (2013) *Now or Never: shaping pharmacy for the future*, London: Royal Pharmaceutical Society
- Strauss, A., & Corbin, J. M. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. London: Sage.

- Tinelli, M. and Bond, R. (2009) 'Patient preferences for an increased pharmacist role in the management of drug therapy, *Int J Pharm Pract*, 17 (2009),275–282
- Waring, J. and Martin, G. (2016) 'Network leadership as pastoral power: the governance of quality improvement communities in the English NHS' in Bevir, M. (ed.) *Governmentality after Neoliberalism*, London: Taylor Francis
- Whyte, R., van der Geest, S. and Hardon, A. (2003) *The Social Lives of Medicines*, Cambridge: Cambridge University Press.
- Williams, K. F. (2007) 'Re-examining 'professionalism' in pharmacy: A South African perspective' *Social Science and Medicine*, vol. 64,1285-96

Pastoral power in the community pharmacy: a Foucauldian analysis of services to promote patient adherence to new medicine use

Table 1: NMS Interview Schedule

1. Have you had the chance to start taking your new medicine yet?
2. How are you getting on with it?
3. Are you having any problems with your new medicine, or concerns about taking it?
4. Do you think it is working? (Prompt: is this different from what you were expecting?)
5. Do you think you are getting any side effects or unexpected effects?
6. People often miss taking doses of their medicines, for a wide range of reasons. Have you missed any doses of your new medicine, or changed when you take it? (Prompt: when did you last miss a dose?)
7. Do you have anything else you would like to know about your new medicine or is there anything you would like me to go over again?

Table 2. Patients participating in observations

	Patients (n=20)
Gender	
Male	11
Female	9
Age mean (Range)	57.1 (15-84)
Condition	
Hypertension	8
Asthma/COPD	5
Diabetes	4

Anticoagulants/antiplatelets	3
Reported ethnicity	
White (English/Welsh/Scottish/Northern Irish/British)	9
White (Irish)	2
White (Other – Polish)	1
Black (African/Caribbean/Black British)	-
Asian/Asian British (Indian)	1
Asian (Other -Sri Lankan)	1
Not reported	6

Highlights

- Pharmacists increasingly involved in the surveillance and disciplining of patients
- Pharmacists expected to foster self-discipline amongst patients
- Advanced services highlight the extension of 'pastoral power' within community pharmacy
- Study undertaken in the London, Midlands and South Yorkshire regions of the English NHS between 2012-13