UNIVERSITY OF SOUTHAMPTON

FACULTY OF HEALTH SCIENCES

Challenging the physiotherapy-medical boundary through NHS workforce modernisation policy: a Foucauldian-informed interpretive discursive account.

by

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<u>ABSTRACT</u>

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CHALLENGING THE PHYSIOTHERAPY-MEDICAL BOUNDARY THROUGH NHS WORKFORCE MODERNISATION POLICY: A FOUCAULDIAN-INFORMED INTERPRETIVE DISCURSIVE ACCOUNT

Nicky Wilson

Skill-mix change and task shifting among the healthcare workforce has become a key mechanism for the continued provision of effective public healthcare within funding constraints. However, decoupling the healthcare professions from their traditional professional work tasks is not straightforward. Previous research has shown that in some contexts jurisdictional boundaries remain resolute.

This thesis uses two case studies to explore the mechanism and effect of challenge to the physiotherapy-medical professional boundary, precipitated by policy to modernise the English National Health Service workforce. The first examines the socio-political events which accompanied the publication of a national clinical guideline that proposed a reconfiguration of healthcare professionals managing people with non-specific low back pain. The second investigates the practice of physiotherapist non-medical prescribing in a musculoskeletal outpatient service in a single NHS Trust in England. The methodology adopted is interpretive policy analysis, informed by Foucault's writings about power/knowledge and governmentality.

Through the identification and analysis of policy-related symbolic languages, objects and acts holding meaning for the communities studied, and examination of the system of relations between them, the discursive and extra-discursive constituting and shaping the physiotherapy-medical boundary are revealed. A 'grid of intelligibility' is employed as a framework to discern the circuits of power and the technologies governing physiotherapy practice. 'Medical professionalism' – the pre-eminence of specialist physicians in this field of healthcare – emerged as a dominant discursive formation and the case studies show the significant professional and institutional work required to maintain this.

The findings of this thesis suggest that despite the strong policy rhetoric of workforce modernisation, medical professionalism at the physiotherapy-medical boundary continues to thwart jurisdictional change. The historically contingent discourses at the heart of this power struggle mean that both meso-level policies and local-level practice change, directed to workforce reconfiguration, have only limited impact.

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DECLARATION OF AUTHORSHIP

I, NICKY WILSON declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

Challenging the physiotherapy-medical boundary through NHS workforce modernisation policy: a Foucauldian-informed interpretive discursive account.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. Parts of this work have been published as:

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Definitions and Abbreviations

A&E	Accident and Emergency
BMA	British Medical Association
BMJ	British Medical Journal
CATS	Clinical Assessment and Treatment Services
CG88	Clinical Guideline 88
CMP	Clinical Management Plan
CSP	Chartered Society of Physiotherapy
DHSS	Department of Health and Social Security
DoH	Department of Health
EWTD	European Working Time Directive
GP	General Practitioner
GPwSI	General Practitioner with Special Interests
MRI	Magnetic Resonance Imaging
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
WHO	World Health Organisation
18-week RTT	Eighteen-week referral to treatment target

Chapter 1: Modernising the National Health Service workforce: Policy and the professions

1.1 Introduction

Just five months after the inauguration of the UK's National Health Service (NHS), Aneurin Bevan, the Minister of Health, warned colleagues that demand for healthcare had 'exceeded all expectations' (Bevan 1948a p2). Predicted spending on healthcare was 28% higher than originally anticipated, prescription medicines were being dispensed at a rate of approximately twice that foreseen, and the huge demand for optician appointments led Bevan to surmise that a 'most extraordinary proportion of the population has got bad eye sight' (Bevan 1948b para 5). An unstoppable financial escalator had begun (Klein 2013 p27).

Controlling fiscal spending on healthcare has concentrated the attention of successive governments ever since the foundation of the NHS in 1948. Over the last seven decades numerous top-down political reforms have been introduced, including: the introduction of new managerialism; a purchaser-provider split and a state-financed internal market; General Practitioner fundholding; a ten-year modernisation programme; and, more latterly, re-organisation and devolution, in the form of an NHS Commissioning Board and Clinical Commissioning Groups (Klein 2013). Yet despite these reforms, expenditure continues to rise, and if future predictions are realised, by 2062 spending on health and social care could be as high as one fifth of the UK's entire gross domestic product (Appleby 2013). Delivering high quality, cost effective healthcare with optimal efficiency and productivity therefore remains a key political concern.

At the start of the twenty-first century, New Labour's (1997–2010) 'third way' (Department of Health [DoH] 1997) heralded a ten-year policy programme of investment and modernisation of the NHS, with the healthcare professions and the wider NHS workforce a principal focus; in short, more staff, but working differently (DoH 2000a, 2002a). The hallmark of workforce modernisation policy was a loosening of the traditional work domains of the professions, skill-mix change (a term used to denote changing the mix of occupations, roles, levels of experience, proficiencies and skills to deliver a service) (Buchan and Dal Poz 2002) and 'task shifting', the reassignment of healthcare interventions and service delivery from more expensive to less expensive workers (Noyes 2012). To support this, new professional roles were created and jobs were redesigned beyond traditional professional ambits (DoH 2000a). The image of a skills escalator emerged in

the health policy literature: staff were to be supported and encouraged to move up the escalator 'renewing and extending their skills and knowledge', while delegating roles and workload down the escalator, thereby 'generating efficiencies and skill-mix benefits' (DoH 2002a p8).

Underpinning this rationale was an assumption that professional knowledge and skills could, and would, pass across professional boundaries. However, running counter to this were reports of resistance to skill-mix change and task shifting from professional organisations and their members (Anon. 2002a; Anon. 2003; Day 2005; Templeton 2006; Knight 2008), suggesting that professional boundaries might be less permeable than anticipated. An area of scholarship within the sociology of the professions literature offered an explanation for these responses, namely that this was a way of professional life founded on occupational closure and interprofessional competition (Larkin 1983; Abbott 1988; Macdonald 1995). At the heart of this lies a professional project, a collective endeavour to translate special knowledge and skills into social and economic rewards (Larson 1977). Key to this endeavour is boundary-work (Gieryn 1983), defined as activity to defend, maintain and expand professional jurisdiction and assert professional authority through practices of exclusion, demarcation and usurpation (Gieryn 1983; Abbott 1988; Witz 1992; Macdonald 1995; Scott 2008).

How these contrasting paradigms interact (on the one hand, professional collaboration and sharing of knowledge and skills and, on the other, policed professional boundaries and demarcatory practices) has been the subject of study across a number of healthcare professions and segments. Previous research has examined the boundaries between: nursing and medicine (Allen 1997, 2000, 2001; Salhani and Coulter 2009); midwifery and medicine (Foley and Faircloth 2003; Hunter and Segrott 2014); podiatry and orthopaedic surgery (Borthwick 2000; Borthwick and Dowd 2004); theatre nurses and operating department practitioners (Timmons and Tanner 2004); occupational therapists and occupational therapy assistants (Nancarrow and Mackey 2005); and medical specialists and generalists (Martin et al. 2009). However, one healthcare occupation that has received relatively little attention is physiotherapy, although Milligan's (2003) study of orthopaedic specialist registrars' opinions of physiotherapists working in extended roles and a study by Welsh et al. (2014) analysing the legitimacy claims of physiotherapists to undertake sickness certification, are notable exceptions. Physiotherapy was one of the core professions that was offered opportunities through New Labour's workforce modernisation policies (DoH 2000b), and as the largest of the allied health professions, its contribution to the NHS workforce is significant.

As indicated by the research above, many of the accounts about professional boundaries in healthcare involve the medical profession, in part reflecting medicine's premier position in the

division of healthcare labour and its influential role in the evolution of other healthcare professions (Johnson 1972; Armstrong 1976; Larkin 1978, 1981). Challenges to professional boundaries can take place within the legal (macro), public (meso) and workplace (micro) arenas (Abbott 1988), and their settlements reflect an interplay of both current and historical forces (Larkin 1988). While many studies of professional boundary reconfiguration (secondary to workforce modernisation policy) explore the rhetorical construction of boundaries by practitioners (Charles-Jones et al. 2003; Borthwick and Dowd 2004; Timmons and Tanner 2004; Nancarrow and Mackey 2005; Sanders and Harrison 2008; Welsh et al. 2014), some scholars have investigated the effect of jurisdictional challenge on the division of labour among the healthcare professions (Allen 1997; Salhani and Coulter 2009; Martin et al. 2009; Currie et al. 2012a; Kroezen et al. 2014a). While this is a less well-developed area of scholarship (Kroezen et al. 2014a), arguably it is a significant concern, for, as Colebatch (2009 p14) notes, 'the critical thing is what happens as a consequence' of policy.

This thesis brings these two strands – the physiotherapy profession and the effect of jurisdictional challenge – together, and focusses on the effect of workforce modernisation policy on the boundary between physiotherapy and medicine. I explore *how* the physiotherapy-medical professional boundary is being challenged by policies of skill-mix change and task shifting, and identify the *effects* of boundary challenges on the division of healthcare labour. Under this overarching aim are a number of subsidiary objectives:

1) At the meso-level of healthcare, to explore a challenge to the physiotherapy-medical professional boundary brought about as a result of national level workforce modernisation policy.

2) At the micro-level of healthcare, to explore a challenge to the physiotherapy-medical professional boundary brought about as a result of locally-enacted workforce modernisation policy.

3) To analyse the historically specific discursive formations emerging from these boundary challenges.

To address these objectives, I present two case studies. The first, a meso-level case study, centres on the response of healthcare professionals and their professional organisations to the publication of a national guideline for the early management of chronic non-specific low back pain. The guideline proposed a redistribution of work among healthcare professionals associated with managing persistent low back pain, and challenged professional boundaries between workers traditionally associated with this area of practice. Drawing on data captured in professional journals and fora, policy and professional association documents and interviews with key actors, I offer an interpretive account of the reaction of professional organisations and

professionals to the publication of the guideline and the socio-political events that accompanied it.

The second case study is at the micro-level of healthcare, with its locus in the workplace. In this case study the practice of non-medical prescribing (the prescribing of medicines by healthcare professionals other than a doctor) by physiotherapists is explored within a single NHS setting in England. Appropriately trained and qualified physiotherapists have been able to prescribe medicines since 2005, but to date little is known about their prescribing practices and the effect of this new jurisdiction on the physiotherapy-medical professional boundary. The data for this case study are derived from observations of clinical practice, national and local policy, and organisational documents and interviews with physiotherapist non-medical prescribers and healthcare professionals associated with local and national non-medical prescribing policy and practice. Analysis of this data gives rise to a second interpretive account focussed around a challenge to the physiotherapy-medical professional boundary in the workplace.

Framing both case studies is an interpretive philosophy, concerned primarily with meaning-making in relation to skill-mix change and task shifting (Crotty 1998; Yanow 2000). The case studies are approached through a lens of professional boundaries and boundary-work and the research methodology employed is discourse analysis, informed by the work of the French philosopher Michel Foucault (1926–1984). Foucault's conceptualisations of discourse, power/knowledge and governmentality provide the platform from which I sought to understand my findings (Foucault 1972, 1977a, 1978, 1979, 1981, 1983), although at the outset of this thesis, I acknowledge that the representations detailed in subsequent pages are shaped by my subjectivity, and the interpretations offered are, and can ever only be, partial.

1.2   The motivation for this research

My interest in skill-mix change and task shifting across professional boundaries was born from personal experience when working as a physiotherapist in the NHS at a time when New Labour's workforce modernisation policies were being cascaded. I was acting as an 'extended scope physiotherapist', a first contact practitioner seeing patients with musculoskeletal disorders. My role combined tasks and practices traditionally considered to be the work of a doctor – for example, requesting clinical investigations, making a diagnosis and undertaking treatment using pharmaceuticals, alongside more conventional physiotherapy approaches such as exercise and manual therapy. However, adopting tasks usually performed by others was, on occasions, problematic, and barriers to the development and expansion of my role in the workplace were evident. In relation to certain practices associated with the assessment and treatment of people

with musculoskeletal conditions, seemingly hermetic boundaries separated tasks that 'could' be done by a physiotherapist and tasks that 'could' be undertaken by a doctor, running contrary to the rhetoric of permeable boundaries and the dissolution of historical profession-specific working practices.

The stimuli for the case studies presented in this thesis came from events external to my doctoral studies, although they centre on the field of musculoskeletal disorders which forms my area of practice and interest. The conception of the first case study was opportune: a national back pain guideline was published in 2009 and debated in the public arena at a time when my interest in the professions and professional boundaries was growing. The guidance had implications for my clinical practice, and the debate and subsequent events brought to the fore a number of points for discussion among professional colleagues. The second case study emanated from a legislative amendment to the policy programme of non-medical prescribing when, in 2013, physiotherapists were granted rights to independently prescribe medicines following appropriate training and qualification. As a non-medical prescriber myself, I was interested to understand how the policy of physiotherapist non-medical prescribing was enacted in a different locality.

This thesis gets under way by briefly describing the challenging healthcare position facing New Labour on coming to power in 1997, and some of the government's pivotal reform policies introduced to address the situation. In section 1.5 of this chapter, I narrow the policy focus to the NHS professional workforce and describe workforce modernisation, including skill-mix change and task shifting, and some of the effects of this agenda on the professional healthcare workforce. Following this, I draw on the concept of occupational closure within the sociology of the professions to explore projects of professionalisation, professional boundaries and boundary-work. To conclude, I present an overview of the structure of the remainder of the thesis and a summary of this first chapter.

1.3   The need for modernisation

When Labour came to power in 1997, public satisfaction with the NHS was at its lowest since 1983 (King's Fund 2005): 1.3 million people were waiting for hospital treatment (Harrison and Appleby 2005), regional variation in access to care was problematic (Audit Commission 1990; Appleby et al. 2011), and variability in performance against key clinical outcomes was axiomatic (DoH 1997; 2010a). Contributing to this were a number of factors, including increased demand for healthcare, reduced supply of medical labour and fiscal prudence.

1.3.1 Increased demand for healthcare

Ever since the beginning of the twentieth century, England's population has been rising. In 1951 it stood at a little over 41 million. By 2001 it had reached close to 50 million, and by 2031 it is predicted to exceed 60 million (Office for National Statistics 2011). In conjunction with this, utilisation of public healthcare has increased. In the four years preceding 1996/97, first attendances at Accident and Emergency (A&E) departments rose by 1.49 million; from 1980 to the late 1990s doctor's consultations per capita increased by 17%; and between 2006/7 and 2012/13 the total number of hospital admissions went up by 16% (Organisation for Economic Co-operation and Development [OECD] 2001; Nuffield Trust 2013; Smith et al. 2014). Alongside this, England's population is ageing. The number of people over the age of 65 has increased by nearly 1.5 million since 2008 (Office for National Statistics 2016), and it is anticipated that by 2030, one in five people in England will be aged 65 years or over (House of Lords 2013 cited in Oliver et al. 2014). NHS health expenditure per capita is three times higher in this age group than for people aged between 5 and 64 years (Seshamani and Gray 2002), and the shift in the type of health conditions requiring care (diabetes, dementia and degenerative joint disease) poses a significant long-term health burden (World Health Organisation [WHO] 2011a). Many long-term conditions are more prevalent with age, although rising levels of obesity and reduced levels of physical activity in the UK are placing an additional burden on the healthcare system (WHO 2016).

1.3.2 Reduced supply of medical labour

The early 1990s saw the introduction of two key regulatory frameworks affecting the supply of medical labour within the NHS professional workforce. First, the Junior Doctors' Contract (the New Deal), introduced in 1991, led to a reduction in junior doctors' weekly working hours (DoH, Welsh Office, Department of Health and Social Services (Northern Ireland), Scottish Home and Health Department 1990). Historically, junior doctors worked in excess of one hundred hours a week (House 2009), but data highlighting risks to doctors' wellbeing and patient safety as a result of such practices (Orton and Gruzelier 1989), in combination with a sustained campaign for change by junior doctors (Hunter 1991), resulted in a settlement whereby weekly working hours were lowered from eighty-three to seventy-two (Anon. 1991). The New Deal was subsequently amended in 2000, with a further lowering of average weekly working hours (Collum et al. 2013).

Second, the European Working Time Directive (EWTD), a European working time health and safety initiative, came into force on 1 October 1998. The EWTD limits weekly working hours to a maximum forty-eight hour average working week, and mandates a daily rest period of at least eleven consecutive hours per twenty-four hour period (Council Directive 1993). For the NHS,

these mandatory restrictions posed not only a reduction in the supply of medical labour, but also a significant challenge to maintaining staffing (House 2009). Concern over the capacity and sustainability of the medical workforce in England was raised (Black 2009; Black and Jones 2010), at the forefront of which was continued provision of a high standard of patient care, patient safety and adequate training opportunities for junior medical staff within fewer working hours (House 2009; Richards 2009).

1.3.3 Fiscal prudence

Although spending on the NHS rose on average at a real annual rate of 3.2% between 1979 and 1997, outlay on healthcare, particularly during the Thatcher years, was stringently controlled (Crawford et al. 2009; Klein 2013). Thatcher's choice to tightly regulate NHS funding (King and Maynard 1999), in combination with an average annual increase in hospital sector spending of only 0.8% (compared to 6% in community health service funding), contributed to public perception of a 'parsimoniously funded health service' (Bloor and Maynard 1993 p4). In addition, it was felt that the creation and implementation of the internal market (a strategy to effectively eliminate the monopoly of public sector provided healthcare (Warwick 2007)) robbed NHS frontline services of essential funding and distorted clinical priorities (Blair 1997). General Practice Fund Holders could negotiate their own contractual arrangements with secondary care and also purchase from the independent sector, with the potential to destabilise traditional NHS funding allocations (Kay 2002; Warwick 2007).

In the next section, I outline some of New Labour's reform policies in response to the challenges laid out above.

1.4 New policies and potential solutions

Conventionally, policies are seen as answers to problems – signifiers of authoritative coherent action to guide human behaviour (Bacchi 2009; Colebatch 2009). In addressing the problems of the NHS in England, New Labour developed and implemented a significant and far-reaching policy programme of modernisation and reform of the health service. The policy programme was focussed on improving quality of health outcomes and reducing variation in access to and standards of healthcare (Vizard and Obolenskaya 2013). It included policies that mandated access times to healthcare, strengthened performance management around key targets, promoted patient choice, introduced new providers into the market place, new systems of governance and standardisation and effected organisational decentralisation (DoH 1997, 2000a, 2003a; Vizard and Obolenskaya 2013).

1.4.1   Tackling access

One of New Labour's first actions was to address waiting times for NHS treatment, having pledged in their pre-election manifesto to cut the number of people waiting for hospital treatment by one hundred thousand (Blair 1997). Waiting for NHS hospital treatment has been a cultural norm since 1948. On opening, the NHS inherited a waiting list of half a million people (Harrison and Appleby 2005); in 1988, a quarter of the people needing inpatient or day case treatment had been waiting longer than one year, and in 1997, 258,000 people in England waited more than thirteen weeks for an outpatient appointment (King's Fund 2005). In response, a 'war on waiting' was announced (Lewis and Appleby 2006).

The first phase of Labour's war on waiting was directed at reducing the total number of people waiting for hospital treatment. This was underpinned by new financial and organisational investment to support waiting list reductions. The second phase of the campaign centred around commitments to reduce the maximum waiting times experienced by patients, and to strengthen governance arrangements for compliance with target metrics. The NHS plan promised quicker access to: general practice (access to a General Practitioner (GP) within forty-eight hours and to a primary care professional within twenty-four hours); hospital specialists; four-hour maximum waiting times for patients seeking care in A&E; and an extension of the two-week maximum wait for suspected breast cancer to all types of suspected cancer (DoH 2000c). In the final phase of the war the focus shifted to the total waiting time throughout the patient journey. In 2004 a new target, set out in the NHS Improvement Plan (DoH 2004a), promised patients that by 2008 they would wait no longer than eighteen weeks from GP referral to consultant-led treatment. This eighteen-week referral to treatment target (18-week RTT) acknowledged the period patients spent waiting for diagnostic tests and between consultant appointments (Harrison and Appleby 2005).

Supporting the achievement of these targets were a number of measures and strategies, including: the provision of additional capacity and demand management; increased patient choice of provider; and the re-organisation of services. Additional supply came from increased diagnostic providers, higher levels of day surgery activity, and independent sector treatment centres that ring-fenced routine hospital surgery from emergency work, thereby mitigating the risk of cancelled operations (Harrison and Appleby 2005). Demand management strategies included the introduction of NHS walk-in centres, an increased role for community pharmacies as a place of community care and medicines management, and the development of practitioners with special interests by extending their roles to offer services closer to home, thus shifting activity away from secondary care into the community (DoH 2003b, 2006a; Thorlby and Maybin 2010). In addition,

the DoH offered technical support and set up a dedicated 18-week RTT website (www.18weeks.nhs.uk) to share ideas and resources for meeting the target. Historically, long waiting times have been associated with the specialities of orthopaedics, audiology, endoscopy and echocardiography, and these services were subsequently highlighted for intensive work around the 18-week RTT (DoH 2006b). Orthopaedics was considered the biggest offender (DoH 2006b) with only one in five pathways in 2006 ending in under eighteen weeks (King's Fund 2007).

1.4.2   Tackling variation and quality

Alongside tackling access to NHS treatment, New Labour also addressed variability in the quality of the healthcare being provided. This was facilitated by the genesis of National Service Frameworks and the National Institute for Clinical Excellence (now known as the National Institute for Health and Care Excellence) (NICE). The key was standardisation of care, informed by evidence-based medicine. Evidence-based medicine is defined as 'the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients' (Sackett et al. 1996 p71). In this model, evidence is ranked hierarchically, with level I evidence (large randomised controlled trials) at the top and level V evidence (case series with no controls) at the bottom (Sackett 1989)[1]. National Service Frameworks set out best practice service models for major health conditions such as coronary heart disease and diabetes, specifying how care should be delivered and by whom (DoH 2000d; DoH 2001a; Checkland 2004), while NICE, an organisation that provides NHS staff with 'clear and robust advice' about the best and most cost effective healthcare treatments (Rawlins 1999), develops clinical guidelines, quality standards, technology appraisals and public health guidance for dissemination to and implementation by healthcare professionals.

1.5   Modernising the NHS workforce

'Workforce underpins the modernisation agenda'

Alan Milburn (then Secretary of State for Health) (DoH 2002a p4)

For New Labour's reform policies to be successful, investment in and reconfiguration of the NHS workforce was considered essential – modernisation on a scale bigger than ever before. First, the government pledged a substantial increase in the number of professional workers within the NHS; 9,500 more medical doctors, 20,000 extra nurses and 6,500 additional therapists (DoH 2000a).

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[1] In 2011, the Oxford Centre for Evidence-Based Medicine (OCEBM) Levels of Evidence Working Group revised the levels of evidence. Mechanism-based reasoning now constitutes Level 5 evidence.

Second, in tandem with more staff went role redesign – staff working differently to deliver fast, high quality care, organised around the patient (DoH 2002b; Klein 2013). New professional roles were created, for example consultant therapists and general practitioners with special interests (GPwSIs) (DoH 2000a). Jobs for nurses, midwives, health visitors, pharmacists and allied health professionals were redesigned and extended (Read et al. 2001; Hyde et al. 2005), bolstered by a rhetoric of untapped potential among these workers (DoH 1999, 2000b; 2002c) and reports that between 25% and 70% of doctors' tasks, and duties constituting up to four hours of a junior doctor's day, could be done by other healthcare workers (Bulstrode et al. 1992; Richardson et al. 1998). Policy documents including the Chief Nursing Officer's Ten Key Roles for Nurses (DoH 2000a) and the Chief Health Professions Officer's Ten Key Roles for Allied Health Professionals (DoH 2003c) emerged, supporting these professions in laying claim to work tasks and practices not traditionally 'owned' by them. Staff were encouraged and supported to move up the skills escalator, while roles and tasks were passed down (DoH 2002b).

1.5.1   Skill-mix change and task shifting

With new and extended roles came the potential for skill-mix change and task shifting. As stated in the introduction to this chapter, skill-mix change refers to changing the mix of occupations, roles, levels of experience, proficiencies and skills to deliver a service (Buchan and Dal Poz 2002). In healthcare, this could include altering the ratio of senior to junior staff within a specific discipline, modifying the range of professionals constituting a healthcare team, or employing workers with specific competencies in roles to optimise service delivery (Sibbald et al. 2004).

Various typologies of role redesign have been implemented (Scholes et al. 1999; Sibbald et al. 2004; Hyde et al. 2005; Laurant et al. 2010) which, when examined, reflect movement of work that is either intra or interdisciplinary (Nancarrow and Borthwick 2005). Intradisciplinary movement is effected through diversification and specialisation, and results in boundary expansion for workers within a single discipline. Juxtaposed is interdisciplinary movement, where work transfers across professional boundaries (this can be consensual or contested), either via worker substitution or task redistribution (task shifting) (ibid.). In interdisciplinary movement, work can move vertically across disciplinary boundaries where 'the levels of training or expertise (and generally power and autonomy) are not equivalent between workers', or horizontally 'when providers with a similar level of training and expertise, but from different disciplinary backgrounds, undertake roles that are normally the domain of another discipline' (ibid. p909–911). The differential in status embedded in vertical substitution or vertical task shifting is commonly seen when a less expensive worker substitutes for a more expensive worker, such as nurses substituting for doctors in general practice (Kinnersley et al. 2000) or when radiographers

rather than radiologists report on clinical imaging (Brealey et al. 2003). This gives rise to the possibility of healthcare efficiencies and cost containment, although firm conclusions about the economic effects of substitution remain elusive (Laurant et al. 2010; Goryakin et al. 2011). At the same time, substitution or task shifting across professional boundaries has potential to increase the professional scope of practice for some groups, while threatening the jurisdiction of others (Nancarrow and Borthwick 2005; King et al. 2015). In the next section, I explore some of the reactions of the healthcare professions to New Labour's policies of workforce modernisation incorporating skill-mix change and task shifting.

1.5.2   The reaction of the healthcare professions to skill-mix change and task shifting

A policy mandate for a flexible NHS professional workforce underpinned by skill and knowledge transfer across traditional professional boundaries reduces reliance on any one individual or group to perform specific tasks or aspects of professional work (Desombre et al. 2006). As a result, claims to jurisdiction, based on tradition and historical practices no longer provide an assurance of work for a profession. In short, the policy of skill-mix change and task shifting posed a threat to the status and remuneration of the professions (Cameron 2011), and some have resisted its implementation.

In the substitution of nurses for doctors in primary care, arguments from the medical profession for patient choice and essential medical expertise in times of uncertainty have come to the fore (Knight 2008). There has been fierce opposition from doctors to the notion of nurses entering the surgical domain to perform routine operations and prescribe a wide range of medicines (Day 2005; Templeton 2006), and the introduction of non-physician anaesthetists to ease manpower difficulties in anaesthestics in the UK has encountered resistance (Kane et al. 2005). In the field of foot and ankle surgery within the NHS there is evidence of antagonism between orthopaedic and podiatric surgeons (Devlin 2008), and in NHS surgical theatres there are reports of conflict between practitioners about work roles (Anon. 2002a).

1.6   Professions, segments and professional projects

One explanation for these responses can be found in the concept of occupational closure, where the cognitions and actions of the professions are shaped by competition and rivalry (Macdonald 1995; Scott 2008). The professions are commonly thought of as occupational groups with special power and prestige (Larson 1977 px), set apart from other occupations through a combination of knowledge, skills and independence of formal control by others outside their own profession (Freidson 1984). They are recognised by cognitive, normative and evaluative domains: a relatively

abstract body of knowledge and skills used in professional work; a code of ethics and service norms that regulate certain behaviours such as 'handling consultations, acquiring and receiving clients … and relating to peers, superiors and subordinates' (Johnson 1972 p56); and a relative hierarchy (Larson 1977). In the organisation and delivery of healthcare, the medical profession is pre-eminent (Armstrong 1976; Larkin 1988), surrounded by other healthcare occupations in an inter-related fluid and contingent configuration that Abbott (1988) refers to as the 'system of professions' (p33). The medical profession was the first to obtain state registration and as such has been influential in directing and controlling the division of healthcare labour among other professions (Johnson 1972).

Within the system of professions, the axiom of professional life is inter and intraprofessional competition, as professions seek to extend their jurisdiction by taking on the work tasks of others (Abbott 1988). Each profession is bound to a set of core tasks by ties of jurisdiction 'established in the processes of actual professional work' (Abbott 1988 p33), although these ties are not permanent and are susceptible to change in response to political, societal, organisational and technological developments (Scott 2008; Muzio and Kirkpatrick 2011). As the number of full jurisdictions in healthcare is limited, each profession aims for 'a heartland of work' over which it has control (Abbott 1988 p71). Any attempt by another profession to colonise and take over its jurisdiction gives rise to potential conflict over territory and resources.

1.6.1 Segments

Nested within any given profession is an assortment of smaller conglomerations of professionals, commonly aggregated around shared areas of interest or specific areas of work (Bucher 1962). Bucher and Strauss (1961) refer to such groups as 'segments' (p326), each with its own distinct identity and unique sense of mission. Segments, like the professions from which they emerge, exist in a fluid and relational schema, shaped by the constant evolution of political, organisational, scientific and technical factors (Bucher 1962; Halpern 1990). They follow the same evolutionary processes as the professions themselves and are influenced by exogenous and endogenous factors (Bucher and Stelling 1969; Pawluch, 1983; Halpern 1990), with inevitable competition and conflict. In fact, Goode (1960) suggests that no segment can develop 'without antagonism' (p902).

1.6.2 Professional projects

The competition and conflict between professions and segments outlined above has its roots in occupational closure which, for the professions, is characterised by a 'professional project' – an enduring and organised, although not necessarily deliberate, process by which occupations

attempt to translate 'one order of scarce resources – special knowledge and skills – into another – social and economic rewards' (Larson 1977 pxvii). The aim of a professional project is to attain an exclusive and privileged position, founded on an economic monopoly of knowledge-based services within a market place and status, relative to other occupations and actors within a field (Larson 1977; Timmons and Tanner 2004; Kitchener and Mertz 2012). Embedded within this aim are the dual constructs of power and knowledge: a profession seeks market and social status monopoly, mediated by exclusive ownership of a body of relatively abstract knowledge (Larson 1977). Professional knowledge is, therefore, the primary construct in occupational closure. Drawing on the work of Jamous and Peloille (1970), professional knowledge is delineated by a high indeterminate-technical ratio, i.e. the amount of tacit knowledge, secondary to experience or 'know-how', is greater than the amount of activity that can be transmitted and enacted by following a rule-based system (Kroezen et al. 2013). Indeterminacy reinforces professional or segmental social cohesion and promotes unitary development (Larson 1977). The benefit of a high level of indeterminacy in a knowledge base is that it reduces the likelihood that it will be subsumed by other occupational groups or segments, although sufficient codification is necessary if market monopoly is to be achieved.

Professionalising commonly entails a series of processes, including the founding of a professional association, the development of a training institution and the adoption of a professional code of practice (Wilensky 1964). While these are often early steps in the professionalising process, the collective and enduring nature of a professional project leads to manifestations of occupational closure throughout a profession's lifetime, behaviours that are sometimes expansionary and sometimes defensive. Accounts of expansion by professions and segments have been offered by scholars such as Pawluch (1983), Halpern (1990), Mesler (1991), Anderson (2007) and Pickard (2009). Anderson (2007) recounts how community pharmacists in Great Britain in the 1980s galvanised the profession into reasserting its expertise in medicines when faced with the threat of marginalisation. Community pharmacists claimed new areas of work, populated new social spaces and created new professional identities for their members. In a similar manner, when faced with dwindling numbers of medically sick children as a result of advancements in public health, primary care paediatricians in America re-branded and revitalised in order to lay claim to a new jurisdiction – children's psychosocial problems (Pawluch 1983), although Halpern (1990) argues that it was not so much a shift in market forces that led to this expansionary activity, but rather the desire of primary care paediatricians to escape the routine nature of their professional work.

Antithetical to these expansionary accounts are more defensive narratives, with professions and segments adopting positions to protect and maintain their jurisdiction (Bucher 1962; Currie et al. 2009; Powell and Davies 2012). Bucher (1962), in a study of two segments within the speciality of

pathology, identified clear defensive and rejuvenative activities by the scientific segment in defence against a loss of position within the medical hierarchy (Bucher 1962). In response to encroachment by GPwSIs into the work domain of hospital-based geneticists, Currie et al. (2009) identified a reassertion of authority by hospital specialists to subordinate GPwSIs by controlling the work available to them. Powell and Davies (2012), in their study of role change as a means to improve post-operative pain management, highlight the resistive strategies employed by doctors and nurses when attempts to incorporate acute pain service tasks into their work were initiated.

The methods adopted for the expansion and defence of professional boundaries are multiple and varied, and are achieved through activities such as 'nurturing and mobilisation of strategic alliances', the 'deployment of material and ideological resources such as appeals to …public interest', and the 'fending off of jurisdictional challenge posed by competing groups' (Bolton and Muzio 2008 p285). Drawing on Witz's (1992) model of occupational closure (Figure 1), the expansionary aspects of a professional project can be accomplished by inclusionary and dual closure strategies. Inclusionary strategies are utilised as a means to gain entry to a social space from which a professional group was previously excluded, while dual closure strategies include devices of usurpation upwards and demarcation downwards as a means to consolidate and improve a profession's position within the hierarchy (Witz 1992). Side by side with expansionary aspects are exclusionary and demarcatory strategies, utilised to defend jurisdiction and subordinate or disbar other professions or segments from the professional field.
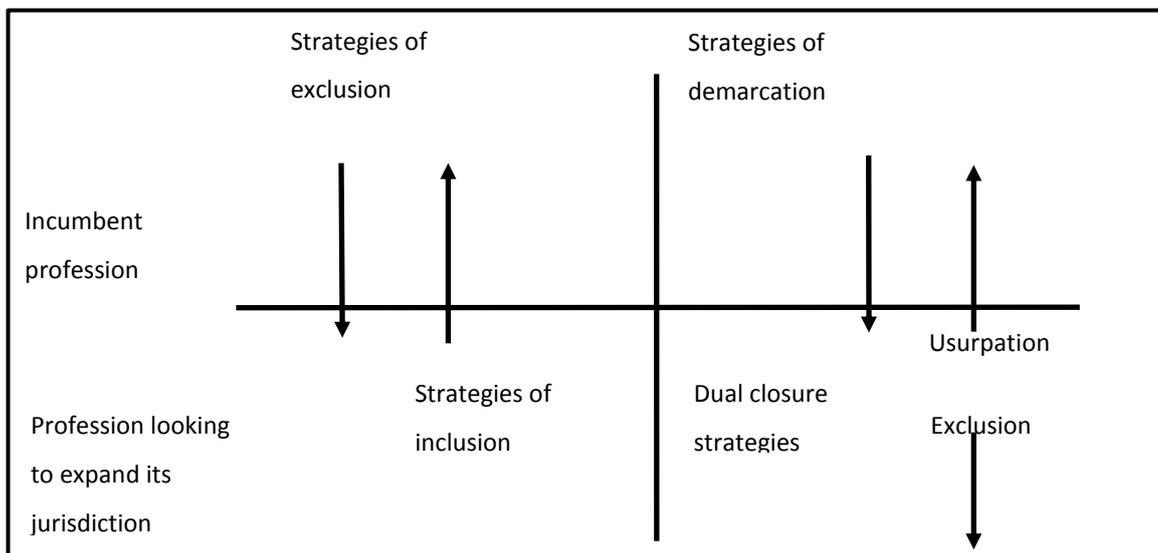
Figure 1 – A conceptual model of occupational closure (modified from Witz 1992 p45 and reproduced with permission from Taylor & Francis Group)

1.7 Professional boundaries

Montgomery and Oliver (2007) argue that all organisations have social boundaries that work to differentiate groups and individuals. Boundaries form from points of difference (Abbott 1995), subsequently melding into social borders that signal inequitable access to, and distribution of, resources and opportunities (Lamont and Molnár 2002 p168). Although sometimes appearing as static perimeters, boundaries are not pre-defined permanent entities (Gieryn 1983); they are social constructions that reflect the interests and goals of their creators, and as such they imbue new realities in times of political struggle (Stone 2002). Professional boundaries lay claim to the type of work undertaken, the practices employed, and the nature of working relationships (Norris 2001) and some have questioned their permeability (Cameron 2011). They are drawn and re-drawn through 'boundary-work', a term originally used by Gieryn (1983) to describe the demarcatory rhetorical strategies used by scientists to distinguish science from non-science.

1.7.1 Boundary-work

Methods of boundary-work are divergent. Macdonald (1995 p52) suggests that the professions deploy 'a hundred and one ways of self-presentation and behaviour' to enact occupational closure. Some scholars have identified multiple discursive constructions and reconstructions of boundaries by the professions, in particular claims about specialist knowledge and skills (Witz 1992; Allen 2001; Norris 2001; Sanders and Harrison 2008; Kroezen et al. 2013; Welsh et al. 2014; Borthwick et al. 2015; Bucher et al. 2016). For example, in the case of nurse prescribing in the Netherlands, doctors created a discourse of essential medical expertise and superior knowledge of polypharmacy and comorbidity to eclipse nursing's claim to legitimately prescribe medicines (Kroezen et al. 2013). Physiotherapists in primary care have claimed legitimacy in the practice of sickness certification by drawing on their specialist knowledge of musculoskeletal conditions, while General Practitioners made their case by asserting their monopoly as the providers of holistic patient care (Welsh et al. 2014).

Some claims to specialist knowledge and skills centre on the indeterminacy-technicality (I/T) ratio described by Jamous and Peloille (1970) (see page 13). For example, the boundary-work of secondary care specialist geneticists resisting the transfer of work to GPwSIs identified by Martin et al. (2009), focussed on the need for 'immersion' in the practice of genetics within a specialist genetics unit with a 'collegiate atmosphere' (ibid. p1195). Similarly, in a study of radiology, Burri (2008) observed rhetorical claims by radiologists that only they could see the 'hidden information' (p48) in images to enable full interpretation. Conversely, the routine and codifiable nature of nursing work (guideline or protocol-driven care) has been emphasised by doctors in the field of

heart failure as a means to legitimise their professional jurisdiction and subordinate nurses (Sanders and Harrison 2008).

Other discursive conformations are demarcatory in effect. Segments and professions highlight the perceived imperfections of others – from 'a lack of' a characteristic or practice (as highlighted by Norris (2001) in her study of legitimacy claims by multiple practitioners in New Zealand involved in the treatment of people with musculoskeletal conditions) – to 'risky' practices (as carried out by junior doctors (Allen 2001) and podiatric surgeons (Borthwick and Dowd 2004)).

In addition to rhetorical devices employed in the drawing and redrawing of professional boundaries, boundary-work can manifest as action, wherein 'actors mobilise …norms about how things should be done' (Bucher et al. 2016 p504). Scholars, recognising that what professionals say may not necessarily be representative of what they do (Allen 1997), have observed practice to identify how this boundary-work is enacted (Mizrachi et al. 2005; Burri 2008; Salhani and Coulter 2009; Currie et al. 2012a; Huby et al. 2014; Kroezen et al. 2014a). Some of the observed techniques include: practices and strategies to define and monitor the knowledge base of others (Currie et al. 2012a); controlling the referral and delegation of work (Mizrachi et al. 2005; Kroezen et al. 2014a), including the discarding of 'dirty work' (less prestigious tasks and roles); and the exclusion of other professions or segments, through inaction as well as action (Burri 2008; Huby et al. 2014). Juxtaposed are more inclusionary strategies to facilitate usurpation, for example, incorporating affiliations with other actors (Salhani and Coulter 2009; Huby et al. 2014) and isomorphic behaviour (Mizrachi et al. 2005).

1.8   Chapter summary

In this chapter I have discussed a difficulty for the healthcare professions as a result of NHS workforce modernisation policy. Skill-mix change and task shifting, while offering opportunities for some professions and segments to advance their professional projects and take on new areas of work, usurp the jurisdiction of others. In an inter-related system, incumbent professions challenged by encroachment, engage in defensive boundary-work, employing demarcatory and exclusionary strategies, with the potential for conflict and struggle. Previous research has been undertaken investigating the effect of boundary challenges among the healthcare professions as a result of workforce modernisation policy, but to date little has been written about challenges to the physiotherapy-medical boundary. This research sets out to address this gap in the literature, and in the following section I lay out an overview of the structure of the remainder of this thesis.

1.8.1 Thesis layout

Unlike a traditional thesis structure, this manuscript does not include a comprehensive review of the literature in an early chapter. Due to the diverse nature of the two case studies, the relevant literature is described and appraised in the appropriate chapters. Therefore, this thesis starts in Chapter 2 with an exploration of physiotherapy's professionalisation, from the genesis of the profession in 1894 to the emergence and development of a new professional segment, the extended scope physiotherapy practitioner segment, towards the latter part of the twentieth century. Drawing on archival data, I focus on four epochs within this period during which physiotherapy advanced its professional project: the emergence of the Society of Trained Masseuses, the granting of a Royal Charter, the issuing of Health Circular HC(77)33, and the ascendancy of the extended scope physiotherapy practitioner segment at the beginning of the 1990s. The value of historical enquiry in empirical studies about the professions has been demonstrated by Begun and Lippincott (1980) in their analysis of the professional control of optometry in the US. While not proposing that past events are deterministic of current phenomena in the socio-political world, they do highlight the connectivity between the past and the present.

In Chapter 3 I unravel the Foucauldian-informed interpretive discursive approach informing the development of the research, the collection of evidence, and the analysis of the data constructed through the case studies. The chapter begins by introducing an interpretive philosophy as the underlying approach to the policy-related phenomena that form the foci of the case studies. This is followed by the designation of discourse as a key heuristic in understanding the meaning of policy, and a description of some of Foucault's most well-known ideas upon which I draw to inform my interpretive accounts, in particular his conceptualisations of power/knowledge and governmentality (Dreyfus and Rabinow 1983; Foucault 1977a, 1978, 1979; 1983, 1988; Dean 2010). In the final section of the chapter I lay out the methodology of interpretive policy analysis, a form of discourse analysis via which I followed the essential steps of this research study.

Chapter 4 outlines the methods used in this research, and draws on interpretive reflexivity to make visible the micro circuitry coupling me, the researcher, to the interpretive accounts generated in the latter part of this thesis. The case study was my primary heuristic and provided the means to investigate my chosen phenomena within their socio-political contexts. Documents, qualitative interviews and non-participant observations were the vehicles for evidence gathering and provided the starting point for the co-construction of data. I end the chapter with a description of the approach I took to the analysis of my data.

In Chapter 5 I present the first of the two case studies, focussing on a debate that took place

between healthcare professionals in the public arena following the publication of a NICE guideline for the management of non-specific low back pain. The guideline, published in 2009, aimed to standardise the management of non-specific low back pain for adults in England and Wales. My interest centres on the divergent meanings that the guideline held for the interpreting communities involved in the treatment of people with non-specific low back pain, and the dominant discursive formation that emerged through the debate and the accompanying socio-political events. Within this interpretive account is evidence of boundary-work by specialist doctors in pain medicine in response to the reconfiguration of work proposed by the guideline.

In Chapter 6, the focus shifts to a different area of workforce modernisation policy – the policy programme of non-medical prescribing. I begin by situating the prescribing of medicines within a pharmaceutical regime and provide a brief overview of standpoints from which this can be explored. As actors are integral to a pharmaceutical regime, I focus initially on the multiplicity of practitioners using medicines in health and disease in sixteenth century England. I then trace the means by which the medical profession gained a monopoly on prescribing medicines, before exploring the development and expansion of non-medical prescribing in the NHS. The chapter ends with the introduction of independent prescribing of medicines for physiotherapists, a recent and further advancement to physiotherapy's professional project.

Chapter 7 details the second case study in which I investigate the non-medical prescribing practices of five physiotherapists working with people with musculoskeletal conditions in an NHS outpatient service in England. Influenced by Foucault's conceptions of government and empirical studies of governmentality in the field of healthcare, I offer an interpretive account of how non-medical prescribing by physiotherapists is being shaped and constituted. Within the emerging discursive formation are conformations of professional boundary-work.

To conclude, in Chapter 8 I review my research findings and situate them among other studies in the field. I offer some insights into the historically contingent discursive formation emerging through the case studies, before tendering some reflections on the contributions and limitations of this research. To finish, I propose a number of areas for future research and development.

Chapter 2: Physiotherapy: a professional project

2.1 Introduction

In the introductory chapter of this thesis I stated that characterising the development of a profession or segment is a professional project – an enduring collective affair epitomised by the occupational pursuit of a market monopoly of knowledge-based services and social mobility (Larson 1977). New Labour's policy of skill-mix change and task shifting offered professions such as physiotherapy an opportunity to advance its professional project through the instigation of new and extended roles. However, hand-in-hand with this development were responses suggesting that incumbent professions, threatened by jurisdictional encroachment and reconfiguration in the division of labour, were resisting these developments and engaging in defensive boundary-work, including demarcatory and exclusionary strategies and tactics.

Essential to explorations of the mechanisms and effects of workforce modernisation policy is an appreciation of the historical and contextual conditions framing a particular policy tension or puzzle, or as Dean (2010) suggests, the need to capture the role of the past in informing and constituting the present. This chapter therefore sets out some of the historical relations between the professions of physiotherapy and medicine (key groups in the case studies presented) through an examination of physiotherapy's professional project, from its conception in the late 1800s to the emergence of the extended scope physiotherapy practitioner segment in the last decade of the twentieth century.

2.2 A professional project

Analysing a professional project requires cognisance of both process and context, for example the behaviours and actions of a profession or its surrounding occupational groups and the interplay of these behaviours with organisational and socio-political forces. Context, Abbott (1988) suggests, determines the scope and reach of a professional project just as much as the efforts of the professions themselves. For example, Broadbent (1998) showed how the implementation of a new contract for UK GPs incorporating payment for health promotion activities provided the impetus for a practice nurse project of professionalisation. GPs, displaying ambivalence to health promotion activities, passed this unwanted but financially necessary work to practice nurses, who willingly took it on and subsequently laid claim to it (Broadbent 1998). Similarly, the publication of policy to move healthcare closer to home (DoH 2006a) opened up a new professional space in the market and incentivised the professionalisation of GPwSIs (Pickard 2009), while the segment of

geriatric medicine professionalised in response to a state discourse about the burden of an ageing population on healthcare services (Pickard 2010). In addition to external forces such as these, Anderson (2007) showed how in the 1980's, the stimulus for re-professionalisation of community pharmacy came from within the segment itself, emerging from workers' perceptions of dwindling prestige and a loss of position in the market place.

Kitchener and Mertz (2012) emphasise this notion of context and process in their analysis of the professionalisation of dental hygienists in America. Drawing on a model of contextualised professional agency (see Figure 4), they demonstrate through a number of key actions how dental hygienists brought a new alternative practice hygiene archetype to the fore as a means to claim independence from a patriarchal dental profession (Kitchener and Mertz 2012).

Context	• Occupational distinction • Objective of social closure (includes pursuit of economic monopoly of knowledge-based services granted by state; status and respectability granted by society) • Relations to other actors (market and status consequences) • Relations to social, cultural and political context
Process	• Relations with other actors (jurisdictional conflicts and alliances) • Development of sub-goals (specific strategies to advance social closure) • Jurisdictional maintenance

Figure 2 – Context and process in professional projects (modified from Kitchener and Mertz 2012 p373 and reproduced with permission from Elsevier)

I have chosen to adopt Kitchener and Mertz's (2012) model to illustrate physiotherapy's professional project in this thesis. Based upon four contextual epochs in physiotherapy's past – the emergence of the Society of Trained Masseuses in the late 1800s; the First World War and the granting of a Royal Charter; the introduction of Health Circular (77)33; and the emergence and expansion of the extended scope physiotherapy practitioner segment – I uncover the processes through which the profession pursued professionalisation.

2.3 The emergence of the Society of Trained Masseuses: an occupation of distinction

Foremost among physiotherapy organisations in the UK is the Society of Trained Masseuses (now entitled the Chartered Society of Physiotherapy [CSP]), established in London in the winter of

1894 to provide women with a recognisable and reputable occupation (Barclay 1994). Massage as a practice had become increasingly popular in England in the latter half of the nineteenth century, attributable in part to rising interest in treatment regimens based upon natural remedies. Massage was considered 'a curative proceeding of great promise' (Anon. 1883 p733) and reports of its success in particularly challenging cases, including alcoholism (Anon. 1877), neurasthenic disease (Playfair 1882) and chronic dyspepsia and sleeplessness (Eccles 1887), were documented in the pages of professional medical journals. Favourable reports such as these were supported by experts in the field including William Murrell, a lecturer in pharmacology and therapeutics at the Westminster Hospital in London, and WS Playfair, a professor of obstetric medicine at the London Hospital. Murrell proposed that massage was a 'scientific mode of treatment well worthy of attentive study at the hands of skilled physicians and surgeons' (Murrell 1886 p926), while WS Playfair promoted it for his patients with nervous disorders (Playfair 1882). Playfair introduced the 'Weir Mitchell' method into Britain, a scheme for managing disorders such as neurasthenia. Among other things, the method incorporated a twice-daily massage for up to ninety minutes (Mason 1992) carried out by a number of specially trained nurse-masseuses, some of whom later became founding members of the Society of Trained Masseuses (Barclay 1994).

Alongside this endorsement by doctors, the popularity of massage among the general public was also rising. Wicksteed (1948) describes the arrival of a massage craze, purportedly impelled by the publication of an article by Lady Manners in *Nineteenth Century* in December 1886. The article emerged at a time of growing acceptance of professional roles for middle and upper class women, and suggested that women might find the practice of massage to be profitable and useful employment. Sir William Bennett, a surgeon at the time, summed up the situation:

> A good deal of enthusiasm was excited among the public generally in the matter … Indeed, it became at one time almost a matter of honour for any lady of position in society to have a course in massage … Hence people began to crowd into this calling with extraordinary avidity.

(Extract taken from Wicksteed 1948 p22)

This extraordinary activity mentioned by Bennett, in combination with a large influx of Swedish masseuses from the Central Institute of Stockholm, led to a surfeit of massage practitioners (Wicksteed 1948) and concern among the medical profession that the practice might fall into disrepute (Murrell 1887). The nature of this disrepute was outlined by Dr Abraham Colles, who suggested that a fresh body of charlatans were seeking refuge under the system of treatment known as massage (Colles 1888). Colles also stated that although massage was a great field for 'experiment and research', not much had been done to reclaim it from 'ignorant pretenders' (ibid.

p175), a sentiment that also surfaced at a meeting of the Edinburgh Medico-Chirugical Society in May 1894. One author at the meeting wrote that although the discussion on massage was 'disappointing', some speakers did well to call attention to the method 'falling into the hands of the lamentably large number of charlatans, quacks and humbugs that […] carry on a precarious existence on the fringes of the medical profession […]' (Anon. 1894a p1149).

It wasn't long before this concern transferred from individual practitioners to the wider medical profession. In the summer of 1894 the British Medical Journal (BMJ) published *Immoral "Massage" Establishments*, an article alleging that many massage shops were little more than 'houses of accommodation' (Anon. 1894b p88). The author(s) of the article declared their belief that the legitimate massage market was 'overstocked' and that no women (unless they had private connections) 'had the slightest chance of getting a living by massage alone' (Anon. 1894b p88). The story was picked up in the national press who focussed on a young lady (and her mother) who had complained to the police about her experiences of events associated with the tuition of, and employment in, the practice of massage (Anon. 1894c; Anon. 1894d). On replying to an advertisement for lady massage pupils in a daily newspaper, the young lady had subsequently discovered that there were expectations of a *service* beyond any definition of medical massage. On complaining to the proprietor, she was allegedly advised that if she wished to remain in employment, she 'must make herself agreeable' (Anon. 1894c para 2).

In response to these reports the medical profession convinced Scotland Yard that it needed to investigate (Anon. 1894e), which Nicholls and Cheek (2006) suggest was a likely outcome given increased public sensitivities about prostitution and the need for 'proper conduct' between the sexes (Hall 2000 p2345). While the enquiry by Scotland Yard found little to substantiate the allegations of immoral massage and the BMJ was reproached for causing 'a perfect ferment in the newspapers' (Anon. 1894f p33), the controversy resulting from the affair laid the foundations for the professional masseuse, as the following quote highlights:

> We most decidedly need to form an association both for our own protection and that of the public, but it must be a body representing the generality of good Masseuses […], supported by the medical profession, and under a President and Council of well-known people, connected directly and indirectly with Massage practice …
>
> *(Allinson 1895 para 1)*

Medical patronage for a massage society was sought and agreed, and in 1894 the Society of Trained Masseuses was formed by Miss Rosalind Paget, Miss Lucy Robinson, Miss Annie Manley and Mrs Margaret Palmer, founding members who worked to create an organisation that would

ensure suitable and morally proper employment for women of the day (Wicksteed 1948). An occupation of distinction had emerged (Kitchener and Mertz 2012).

The new Society subsequently developed and laid down rules of practice for its members (Figure 5), including the establishment of a referral pathway that would control the flow of work to the profession for many years to come.

I.	No massage to be undertaken except under medical direction.
II.	No general massage for men to be undertaken. Occasional exceptions may be made at a doctor's special request for urgent or nursing cases.
III.	No advertising permitted in any but strictly medical papers.
IV.	No sale of drugs to patients allowed.

Figure 3 – Rules of the Society of Trained Masseuses (modified from Barclay 1994 pp26-27 with the permission of The Chartered Society of Physiotherapy)

An event confirming the organisation's status as an occupation of distinction occurred shortly after the Society of Trained Masseuses came into being. In January 1895 another organisation, the British Massage Association, was founded by a masseur and hypnotist from London, Mr Thomas Maltby (Maltby 1885). Maltby's aim was for a society that would protect male and female masseuses and establish the practice of massage on a 'sound, systematic and scientific basis' (Maltby 1885 p47). However, Maltby's organisation was short-lived; it lacked medical influence, as one Mr E. Luke Freer FRCS, writing in the Hospital Nursing Supplement in February 1895, pointed out. Freer noted that although he had been supplied with a copy of the rules of the British Massage Association, he could not see the names of any leading medical men or laymen connected with the organisation and therefore concluded that 'such an association [could not] secure confidence' (Freer 1895 p156).

2.4   The First World War and a Royal Charter: objectives of social closure

The newly formed administrative council officially adopted the title 'Society of Trained Masseuses' at its meeting in January 1895 and became incorporated in 1900 (Barclay 1994). A key objective of the Incorporated Society was 'to improve the status and training of Masseuses' (Barclay 1994 p31). Standardised training is a feature that promotes occupational unity, both within a profession and to the public. It ensures the provision of a distinct and recognisable service in the market place and is an essential facet in gaining market control (Larson 1977; Begun

and Lippincott 1980). In February 1895, the new Society held its first examination in the theory and practice of massage, with seven candidates gaining the Society's certificate. Wicksteed (1948) recounts events following the examination: a visit to the trained nurses' club to receive certificates, subscription to the rules of the Society, and an address from the founders about the integral nature of mutual support between the Society and its members. Following the emergence of the Society's first certificate holders the Council sent a circular to various parties, including medical men, matrons of hospitals, surgical homes and private friends, stating the following:

> The Society of Trained Masseuses has been formed for the purpose of improving the training of, and organising an independent examination for, competent masseuses. It is hoped this may establish a more uniform standard of proficiency and qualification.

> **(Extract taken from Wicksteed 1948 p35)**

Newly qualified masseuses were eligible to practice within certain parameters and had their details maintained on a register. This register was later replaced by something Barclay (1994 p32) describes as 'the little red book', a book sent to London doctors and later those in the provinces to facilitate work for future masseuses. In the early 1900s, training institutes for massage emerged in London and an increasing discourse about the need for exercise among the population enabled the Society to lay claim to a new area of work, Swedish remedial exercise, with the Council of the Society introducing examinations and a core syllabus in 1912 (Barclay 1994 p28).

Although advancements within the profession were moving apace locally, it was the First World War (1914–1918) that contributed to the fulfilment of the Society's ambition for public respectability. At the outbreak of war an Almeric Paget Massage Corps was established. The corps was recognised by the War Office and was initially made up of fifty trained masseuses, one of whom, DP Russell, recalled her experiences of working at that time:

> The work was very strenuous; it was of course massage and movement, and many patients had very serious circulatory troubles, as they had been sometimes a long time in transit… We were called 'rubbers' at first by the QAIMNS[2] personnel, but in a little while our professional status was assured, and we were treated with the greatest consideration by all.

> **(Extract taken from a letter written by DP Russell in 1971 cited in Anon. 1994a)**

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[2] Queen Alexandra's Imperial Military Nursing Service

By the end of the First World War physical therapy had gained significant prestige. It was anticipated that the qualified masseuse would be in demand in situations that aimed to arrest the deterioration of the population, develop the national physique and establish school clinics (Barclay 1994). This prestige was further enhanced when Queen Mary agreed to become the Society's patroness in July 1916, and the names of about one hundred members were brought to the attention of the Secretary of State for valuable services connected with the First World War (Wicksteed 1948; Barclay 1994; Anon. 1994b).

Following the First World War, the Society turned its attention towards a Royal Charter. Emanating from the crown, a Royal Charter is a document that sets out the rights, functions and constitution of an organisation. It enhances the prestige of the professional body concerned and is a key symbol in occupational closure as only one organisation in any field can hold one (Anon. 1994c). For the Society, a Royal Charter was a means to protect itself from rival organisations and give it pre-eminence in the field (Wicksteed 1948; Barclay 1994). With the help of the Society's medical patrons, the newly amalgamated Incorporated Society of Trained Masseuses and Institute of Massage and Remedial Gymnastics was awarded its Royal Charter on 11th June 1920. This acknowledgement by the state provided a public guarantee of 'objectively' superior competence for the organisation (Larson 1977 p70) which subsequently went on to become The Chartered Society of Massage and Medical Gymnastics.

2.5 Autonomy in practice: formalising relations with other actors

The instigation of the NHS in 1948 brought with it a need to assess the position and function of its new professional workforce, so that assurances about provision of suitable and comprehensive healthcare could be given (Armstrong 1976). One of the first committees to form in response to this need was the Cope Committee, which set out to formalise arrangements for the supply and demand, training, qualification and registration of medical auxiliaries (Ministry of Health and Department of Health for Scotland 1951). Medical auxiliaries, defined as 'persons who assist medical practitioners (otherwise than as nurses)' (ibid. p1) had since 1935 been registered with an independent board set up by the British Medical Association (BMA). However, with the formation of the NHS, this was no longer seen as adequate, since registration of the different para-professions was not compulsory (Ministry of Health and Department of Health for Scotland 1951). The Majority Report of the Cope Committee therefore recommended statutory registration and a common register for all medical auxiliaries controlled by the medical profession by virtue of a majority representation on the new Council for Medical Auxiliary Services in the NHS (Armstrong 1976). In addition, the report emphasised that the final responsibility for training, training institutions and examinations should rest with the medical profession and not with the

paramedical professional associations themselves (Ministry of Health and Department of Health for Scotland 1951), a position vigorously opposed by the auxiliary professions, including physiotherapy. The Chartered Society of Physiotherapy,[3] following significant networking with some of the other professional associations, particularly occupational therapy and the Society of Remedial Gymnasts, rejected the proposal for a council that had only a minority medical auxiliary presence (ibid.). They also objected to the term 'medical auxiliaries' in the light of 'its possible association with the term "Nursing Auxiliary"' (CSP 1952 para 28), and dismissed suggestions that responsibility for the general direction of studies at physiotherapy training schools should sit with the medical profession (CSP 1951 para 4). Ongoing discussion during the 1950s, within government, among the professions and with professional bodies, led to the introduction of the Council of the Professions Supplementary to Medicine, and in 1962 state registration was granted to physiotherapy, giving the profession more control over its training and qualifications (Øvretveit 1985).

In subsequent years the physiotherapy profession continued to pursue greater control of its work and independence from the medical profession through changing social relations (Øvretveit 1985). One bye-law that accompanied the Royal Charter of 1920 was the subject of recurrent debate as it significantly affected access to work for some members of the profession (Robinson 1994). Ethical rule 46(1) stated that no person would be placed on the massage or physiotherapy register without first signing an agreement not to undertake any case except under the direction of a registered medical practitioner. This was a position vigorously defended by the medical profession. Dr James Mennell, who was vice chair and then chair of the Council of the Chartered Society of Massage and Medical Gymnastics between 1929 and 1938, had argued for the maintenance and strengthening of the prescriptive role of the medical practitioner, highlighting the possible dire effects of masseuses diagnosing conditions (Wicksteed 1948; Robinson 1994). This stance was still apparent in 1962 when the Ministry of Health stated that 'Doctors should prescribe physiotherapy with the same precise therapeutic indications in mind as they have when prescribing drugs' and not leave decisions about the frequency and progression of treatment to physiotherapists (Ministry of Health 1962 cited in Lane 1992).

In an effort to mitigate the rising tension created by such an approach, Sir Keith Joseph, Secretary of State for Social Services, invited representatives from the Association of Occupational Therapists, the Chartered Society of Physiotherapy and the Society of Remedial Gymnasts to join a working party in order to make recommendations on the future role of the remedial

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[3] In 1943, the Privy Council consented to a name change for the Society from The Chartered Society of Massage and Medical Gymnastics to the Chartered Society of Physiotherapy, as the old name no longer represented the scope of the work being undertaken by the profession.

professions. Representing physiotherapy was Lois Dyer, who campaigned for greater autonomy on behalf of the profession. In 1973, the McMillan Report was published (Department of Health and Social Security [DHSS] 1973). The report identified a wider role for the remedial professions than previously and made a number of recommendations on career structure, training, research and relations with other professions. It proposed that the remedial professions 'coordinate, organise and administer their own services' (ibid. p13), and that one or more of their members be appointed to the DoH to advise on such matters. Concerning relationships between the remedial professions and doctors, the report advocated for greater 'responsibility and freedom' for therapists to manage the care of patients as they saw fit following a referral from a doctor (ibid. p11). This position was subsequently set out in the DHSS (1977) health circular HC(77)33, albeit following considerable delay, largely due to opposition from consultant doctors (Clews 2007). HC(77)33 recommended that:

> In referring patients to therapists doctors should give the diagnosis, where possible, and set out the aims of treatment with a note of limitations and contra-indications to a particular form of treatment if there are any. […] Within this framework therapists may decide upon the nature of the treatment if this has not been agreed with the doctors previously. They should also be expected to advise curtailment or prolongation of the treatment if they consider this necessary.

(Extract taken from HC(77)33, DHSS 1977)

While HC(77)33 gave physiotherapists greater freedom in the provision of treatment, the referral pathway remained firmly under medical control. For some within the profession the circular did not go far enough in granting autonomous practice to physiotherapists (Clews 2007), especially as in other parts of the world the profession had already taken steps to rescind medical authority over its work (Galley 1977). Lois Dyer, the first physiotherapy representative at the DoH, lobbied hard for the profession although the legacy of ethical rule 46(1) was hard to break. Nonetheless, despite the perceived limitations of the circular the document made it clear that in referring for physiotherapy the therapist should be able to determine the nature and frequency of treatment, and in 1978, a bye-law change in the Society's statutes finally allowed physiotherapists to treat patients without prior medical referral (Clews 2007).

2.6 The emergence of the extended scope physiotherapy practitioner segment: social, cultural and political relations

The final epoch chosen to demonstrate physiotherapy's project of professionalisation is the emergence and development of the extended scope physiotherapy practitioner segment. As described in Chapter 1, segments are collections of professionals who share specific interests and practices and commonly a sense of mission. They spring up and fade in response to contextual change and follow a similar pattern of development to the professions from which they originate. Within physiotherapy, the extended scope physiotherapy practitioner segment emerged in response to the instigation of new roles in secondary care hospital outpatient services in which physiotherapists performed 'extended scope' activities, including making a diagnosis, requesting clinical investigations and formulating treatment plans. Lengthy waiting times in musculoskeletal secondary care outpatient services, in conjunction with evidence suggesting that not all patients referred to hospital outpatient services required consultant-led treatment (Ross et al. 1983; Roland et al. 1991), led to experienced physiotherapists being substituted for doctors or added to existing medical clinic staff to manage outpatient demand (Durrell 1996).

Early archetypes of the extended scope physiotherapy practitioner role centred on physiotherapists working as first contact practitioners in outpatient orthopaedic clinics, seeing patients referred to orthopaedics from general practice and other sources (Byles and Ling 1989; Hourigan and Weatherley 1994; Hockin and Bannister 1994; Daker-White et al. 1999). The first record of such a role in the UK is described by Byles and Ling (1989). A senior physiotherapist was employed as an 'orthopaedic assistant' within an outpatient orthopaedic clinic in England, assessing and managing patients referred from general practice (ibid. p436). The outcome of the eighteen month pilot suggested that the scheme was broadly acceptable to stakeholders and created surgical capacity. The physiotherapist independently managed the majority of her caseload, with only 33% of cases referred on to the consultant orthopaedic surgeon.

Following this initial study, other services began to employ extended scope physiotherapy practitioners, some of whom were based in primary care. These roles were developed to triage patients with musculoskeletal conditions seen in general practice and filter work to secondary care (Hattam and Smeatham 1999; Hattam 2004). Early studies reported favourable outcomes, reduced patient waiting times and appropriate standards of care and safety. The core additional skills considered necessary for these extended roles included the ordering and interpreting of diagnostic investigations, for example, clinical imaging and blood tests, the administration of intra and peri-articular corticoid steroid injections, the prescription of orthotics, and onward referral to other services (Durrell 1996).

Models of the role in consultant-led orthopaedic clinics were based on traditional relations and service structures; routine filtering of referrals ensured a suitable caseload for the physiotherapist, and the consultant took responsibility for the physiotherapist's actions (Byles and Ling 1989; Daker-White et al. 1999). Many physiotherapists undertaking these roles were provided with 'on-the-job' training, learning a 'craft version' of consultant orthopaedic knowledge (Abbott 1988 p65), thereby enabling them to effectively act as orthopaedic assistants as outlined below:

> …for the purposes of the assessment and initial management of new referrals, the aim is to train the physiotherapist to function as a surgeon would – that is, to take a case history, perform a clinical examination, order appropriate investigations, make a provisional diagnosis and arrange appropriate management and treatment interventions.

(Daker-White et al. 1999 p643)

2.6.1   The Extended Scope Physiotherapy Practice Network: establishing a jurisdiction

Colonisation of new intellectual and economic spaces is a key mechanism for the advancement of a professional project (Suddaby and Viale 2011), and in response to increasing numbers of physiotherapists working in new and extended roles, the professional affairs department of the CSP issued a briefing paper entitled *Physiotherapists working outside the scope of physiotherapy practice* (CSP 1994). The paper defined physiotherapy's scope of practice as those modalities of treatment directly related to the core skills of the profession: massage, electrotherapy, exercise and movement, and, additionally where a responsible body of opinion within the profession asserts that the modality in question is used by chartered physiotherapists (CSP 1994). Some practices undertaken by extended scope physiotherapy practitioners, for example giving injections and aspirating joints, taking X-rays and prescribing medicines, fell outside the usual scope of physiotherapy, requiring supplementary guidance and, for some tasks, additional insurance (Durrell 1996).

Of interest here is that although augmented roles for physiotherapists were considered a new practice at the end of the twentieth century, evidence of developments in this field can be traced to the 1920s. Sir Cooper Perry, one of the Chairmen of the Chartered Society of Massage and Medical Gymnastics, stated the following in an annual general meeting of the Society held in 1927:

…it struck those of us at Guy's Hospital who were watching developments, that there was a very good field of employment for women, who, knowing anatomy and physiology in the way our members do, should also possess a knowledge of diagnostic X-rays and of apparatus used for the purpose. Practically every man in consulting work nowadays must provide himself with an X-ray apparatus, and he is bound when he uses this method for diagnosis for his female patients to have some woman in attendance. If he can find someone who knows medical electricity, who has the combined certificate, and who also knows something about X-ray apparatus and how to use it, that is exactly what he wants. If in addition to that, she can do typewriting and is capable of functioning as a secretary, then she becomes scarcely less important to the success of the practice than the physician himself.

(Extract taken from the Chartered Society of Massage and Medical Gymnastics Annual General Meeting 1927 p71)

Increasing enquiries to the CSP about guidelines for extended scope physiotherapy practitioner roles led to the organisation of a consensus conference in 1995, attended by fifteen UK physiotherapists. An inaugural meeting of specialist physiotherapists working in these roles followed in March 1996, one outcome of which was an agreement to form a professional interest group whose purpose would include the 'evaluation and promotion of this role' (Durrell 1996 p212).

The extended scope physiotherapy practitioner segment soon progressed to publishing its own journal, organising conferences and holding study days. In 1999, it was recognised as a Clinical Interest Group by the CSP, thus legitimising its position within the wider profession. However, uncertainty about the professional status of its members persisted, primarily in relation to their scope of practice. Begun and Lippincott (1980) note that one concern of a professional segment is its employment situation. Social activity is motivated by a desire for self-enhancement and uncertainty reduction about one's place in the world and resulted in ongoing correspondence between the officers of the extended scope physiotherapy practitioner segment and the CSP (White 2009 per comm). In 2008 the Society published an information paper in which the scope of practice for the profession and that of an individual extended scope physiotherapy practitioner was redefined (CSP 2008). Based on the Royal Charter of 1920, a new scope of practice was brought to the fore, albeit somewhat fortuitously (White 2009 per comm), which situated the segment within the boundaries of the profession. Among the objects for which the Chartered Society was established and incorporated was the following aim:

...to foster and develop the use of Manipulative, Gymnastic, Electrotherapeutic, and kindred forms of treatment.

(Extract taken from object n from The Chartered Society of Massage and Medical Gymnastics Royal Charter and Bye-laws (n.d.)).

The term *kindred forms of treatment*, although not previously appropriated by the profession, was awakened from its eighty-eight-year slumber to become the 'fourth pillar' of the physiotherapy profession under which extended scope activities could be situated and other practices added, thereby enabling the profession to expand according to patient, professional and political need (CSP 2008 p5). This new scope of practice of the profession now includes 'any activity undertaken by an individual physiotherapist that may be situated within the four pillars of physiotherapy practice where the individual is educated, trained and competent to perform that activity' (CSP 2008 p6).

2.6.2   Evidence and efficacy: developing a body of knowledge

The production of theoretical knowledge accelerates the development of a segment's cognitive base and is a commodity essential for market control and public confidence (Larson 1977). For the extended scope physiotherapy practitioner segment, literature detailing the efficacy and efficiency of its practitioners started to emerge. Studies detailing comparable levels of accuracy between extended scope physiotherapy practitioners and doctors in the diagnosis of patients with musculoskeletal conditions were published (Gardiner and Turner 2002; Dickens et al. 2003; Oakes 2009); high levels of patient satisfaction with extended scope physiotherapy practitioners were emphasised (Daker-White et al. 1999; Oldmeadow et al. 2007; MacKay et al. 2009; Rabey et al. 2009) and reports of doctor satisfaction with physiotherapy's new role by and large emphasised the favourable nature of the development (Ellis and Kersten 2002; Milligan 2003). The extended scope physiotherapists' clinical interest group published a competency manual (Syme 2009), thereby contributing to standardising the production of producers.

2.6.3   Moving centre stage and new jurisdictions: the introduction of Clinical Assessment and Treatment Services

As stated at the start of this chapter, the demand for new services is a catalyst for the expansion of professional boundaries (Abbott 1988; Halpern 1990; Broadbent 1998), and in 2006 the publication of the Musculoskeletal Service Framework (DoH 2006c) heralded an opportunity for further growth of the extended scope physiotherapy practitioner segment. Interest in the redesign and delivery of services closer to home and a mandate to meet key performance metrics

(DoH 2001b, 2006a, 2006b) led to a shift in emphasis from secondary to primary care and the introduction of new models and locations for healthcare work. One model, Clinical Assessment and Treatment Services (CATS), was developed at the interface between primary and secondary care within a range of specialities, including orthopaedics. Musculoskeletal CATS, staffed by a range of professionals triaging, investigating and signposting patients with musculoskeletal conditions to appropriate conservative or operative services, was a way to meet the 18-week RTT. Extended scope physiotherapists were mentioned specifically in the CATS workforce (DoH 2006c), thereby affirming their position not only within secondary care but also within the community and wider healthcare workforce.

A preliminary evaluation of CATS demonstrated favourable outcomes: reduced waiting times for appointments; increased ease of access to services; positive evaluations by patients; and no evidence of adverse quality impacts (National Primary Care Research and Development Centre and Health Economics Facility 2007). In 2009 an audit carried out by the Arthritis and Musculoskeletal Alliance (ARMA) found that 79% of Primary Care Trusts in England (now replaced by commissioning consortia) operated a Musculoskeletal CATS (ARMA 2009), a figure which subsequently increased by 6% in a re-audit in 2011 (ARMA 2012). Other evaluations have highlighted the benefits of such services (Sephton et al. 2010; Ferguson and Cook 2011), and the growth in the number of extended scope physiotherapists within the Society highlights an expanding segment (du Bois 2009 pers comm), reflective of a project of collective mobility and distinction.

2.7   Chapter summary

This chapter has charted physiotherapy's professional project across four epochs in the profession's history. Drawing on both process and context, I have explored the profession's dual ambitions of market control and higher social status, and have brought to light particular historical relations between the professions of physiotherapy and medicine that inform our present. In the pre-filled social space of massage workers in England in the late 1800s, an occupation of distinction emerged, the product of a confluence of discourses embedded in which was a publication in the BMJ about *Immoral "Massage" Establishments*. By the start of the twenty-first century a new physiotherapy professional segment, the extended scope physiotherapy practitioner network, was born, a product of shifting socio-political discourses, professional inter-relations and jurisdictional expansion. The BMJ re-emerges as a focal point in my first case study of a policy-related tension, brought about by an external stimulus to the system of professions. However, preceding it are Chapters 3 and 4, in which I unpack the methodological approach I adopted, and the methods I employed, in carrying out this research.

Chapter 3: A Foucauldian-informed interpretive discursive approach to analysing professional boundary challenges

3.1 Introduction

In Chapter 1, I laid out the tension between modernisation of the NHS workforce through skill-mix change and task shifting, and the projects of professionalisation pursued by individual professions and segments. Subsequently I focussed on the professionalisation of physiotherapy in Chapter 2, a profession that to date has received relatively little attention within the sociology of professions literature. In this chapter I unpack the Foucauldian-informed interpretive discursive approach that I adopted in the formulation, development and undertaking of the research to explore how the physiotherapy-medical professional boundary is being challenged by workforce modernisation policy. I begin by focussing on the interpretive theoretical perspective from which I chose to advance my research aim and the subsequent objectives laid out in Chapter 1 (see p3). I then reflect on the opportunities for understanding that such an approach offers when thinking about policy development and implementation. Subsequently, I turn to discourse as the substance of interpretive studies and discourse analysis as a primary instrument for investigating the socio-political world, predicated on the ideas and theories of the French philosopher Michel Foucault. To end this chapter I outline the practical steps of my investigation, drawing on the work of Dvora Yanow, an interpretive methodologist researching policy and organisational settings (Yanow 2000, 2006, 2007; Schwartz-Shea and Yanow 2012).

3.2 Approaches to evaluating healthcare policy

Accounts of healthcare policy are multifarious and variably represented within the literature. Authoritative choice accounts, considered the dominant approach in policy writing, largely as a result of the way in which they 'structure[s] the action and facilitate[s] acceptance of outcomes' (Colebatch 2009 p45), are concerned with 'authorised' individuals and groups, selecting informed courses of action to achieve specified objectives, to be implemented by 'subordinate officials' (Colebatch 2009 p24). These accounts stress the rational production-like model of policy making (Stone 2002), interspersed by a series of 'decision nodes' into which 'evidence' is fed (Greenhalgh and Russell 2006 p36). From this logical and stepped process a solution emerges, along with subsequent strategies for successful enactment (Rawlins 1999; NICE 2013). Finally, outcomes are

evaluated by a neutral set of objective standards applied from outside the policy process (Stone 2002), commonly employing tools such as microeconomics and decision analysis (Yanow 2000).

However, such accounts say little about *why* and *how* certain health policies (for example, tobacco control and cancer screening) have been successfully implemented in some regions of the world and not in others (Mackenback and McKee 2013). Certainly the limits of scientific biomedical evidence in the formulation of some areas of health policy, for example public health, have been recognised (Kelly et al. 2010), and models that acknowledge the messiness and complexity of the socio-political world are recommended as a means to increase understanding about policy generation and effect (Wagenaar 2007; Russell et al. 2008).

One alternative to the authoritative choice account is a more critical and situated explanation of policy formation, implementation and evaluation, advocated in the writings of scholars such as John Forester (Fischer and Forester 1993), Dvora Yanow (2000, 2007), Deborah Stone (2002), Frank Fischer (2003) and Hendrik Wagenaar (2007, 2011). Accounts of this nature are grounded in an interpretive theoretical perspective within the constructionist epistemology, where knowledge and therefore 'all meaningful reality' is constructed by humans interpreting the world with which they engage (Crotty 1998 p42). In these accounts, policy and policy issues are perceived to be socially constructed by actors (Berger and Luckman 1967; Fischer 2003; Colebatch 2009), running counter to the scientific rationalist framing of policy in which particular socio-political phenomena are considered to have an objective truth about which 'value free assessments' can be made (Yanow 2000 p5). The central point of departure in interpretive explanations of public policy is that the units of analysis (policy components) are not hard-wired into social reality, and therefore different constructions and (consequently) accounts of the world become possible (Wagenaar 2011). This social construction of 'facts' (where truth and meaning are constructed and not discovered) and the social phenomena they delineate are, for Fischer, the 'stuff of policy politics' (2003 p14).

Interpretive policy analysis is a form of discourse analysis (Glynos et al. 2009) commonly employed with the aim of making sense or deepening understanding of a particular policy-related tension or puzzle (Yanow 2000). It encompasses post-modern and post-structural sensibilities, inter-relating approaches to thinking about culture, society, history, knowledge and language (Agger 1991). These approaches recognise and value 'plurality, fragmentation and multi-vocality' (Cheek 2000 p40). Postmodern thought embraces reality as known from multiple positions. Here no single representation is afforded primacy over another. Juxtaposed is post-structural thought, which rejects the notion that language (conveyed in text, images and symbols) is a neutral and

value-free expression of objective reality (Cheek 2000). From this viewpoint, reality or 'truth' can only ever be partially represented.

The benefit of interpretivist accounts of healthcare policy is their potential to challenge dominant health ideologies (Greenhalgh et al. 2013; Russell et al. 2014; Shaw et al. 2015) and to question the normal and taken-for-granted practices and regimes of healthcare (Cheek 2000; Nicholls 2012). While interpretive accounts are always provisory and incomplete (Wagenaar 2007), they can nonetheless provide new insights and explanations for the often unintended consequences of a policy or policy programme by uncovering the complexity of the social interaction and human practices that accompany policy generation and interpretation (Yanow 2000). However, accounts of this nature are not without criticism, with charges of interviewer bias, relativism and a lack of validity levelled at those adopting an interpretivist methodology (Garrick 1999). As a rejoinder, Schwartz-Shea and Yanow (2012) propose that evidence supporting the centralisation of researcher reflexivity, data sense checking via a continual re-examination of initial interpretations and 'member checking', if appropriate, enable confidence in interpretive accounts of social action (p106).

3.3   Meaning in interpretive accounts

At the centre of all interpretive research approaches is a focus on meaning (Yanow 2007; Wagenaar 2011; Schwartz-Shea and Yanow 2012) – for example, the meaning that a policy has for particular communities (Yanow 2000), meaning that shapes actions, practices and institutions (Bevir and Rhodes 2004 p130), and meaning that is specific, deeply situated and intimately related to historical and cultural context through local knowledge (Geertz 1972; Schwartz-Shea and Yanow 2012).

The connection between meaning and context is clearly displayed by Wagenaar (2011) in his text *Meaning in Action: Interpretation and Dialogue in Policy Analysis*, in which he describes a cultural upset broadcast on Dutch television. A Moroccan-Dutch imam refused to shake hands with the female Dutch Minister of Immigration. The ensuing debate in the media brought to the fore different ways of interpreting the actions of the imam. For those with an appreciation of the practices and values espoused by the Koran, the refusal to shake hands signified the imam's respect for the Minister, while for others, whose values were more aligned with Dutch secular society, the act was interpreted as defiant of a particular social convention (Wagenaar 2011 p15-16). Regardless of position, the integral nature of context to interpretation and sense making of the world is apparent in this example, and highlights the need for an appreciation of context not as an 'organisational or cultural container' (Wagenaar 2004 p648) but as a dynamic integrated

system of relations, between 'people and people, people and things, [and] people and events' (Rose et al. 2006 p87).

The different constructions of meaning in Wagenaar's example reflect the 'ambiguity and plasticity' of meaning making and the 'system of symbols' through which we express and communicate meaning to both ourselves and others (Schwartz-Shea and Yanow 2012 p46). Multiple meanings, generated through interpretation of human behaviour (in the above example, a hand shake at a particular political meeting), gives rise to the possibility of numerous realities (Cheek 2004). In these realities, both subject and object (or act) are inseparably intertwined in the meaning making process, and form the basis of contested claims about the generation of 'objective' knowledge and any 'true' explanation of an event (Sandberg 2005).

Although contextual interpretations of events, people and things shape human actions and behaviours, these actions and behaviours are only loosely bound (if at all) to intentionality (Yanow 2000; Wagenaar 2011). Therefore, to understand meaning we have to grasp both the conscious explanations that people give for their actions (the subjective meaning), and the implicit and less readily accessible meaning (often unrecognised by authors) (Yanow 2000; Crotty 1998 p91) conveyed through human behaviour (the objective meaning) (Yanow 2000). As Wagenaar (2007) points out:

> There is always a surfeit of meaning in what we do, a plenitude that we can never hope
> to grasp in its entirety.

(Wagenaar 2007 p319)

Thus, access to human meaning requires a focus on the 'concrete behaviours of concrete actors' (Wagenaar 2011 p21), what people say and write, what they do and the objects they employ to make and convey meaning. Interpretive approaches commonly draw on methods from the phenomenological and hermeneutic traditions to access meaning and are described in the following section.

3.3.1   The roots of interpretive approaches and understanding meaning

Phenomenology and hermeneutics are the major arteries sustaining and giving rise to interpretive approaches and accounts (Yanow 2000; Crotty 1998; Wagenar 2011). The former is primarily concerned with how individuals experience and understand particular phenomena in the life world, situated within a template of prior personal knowledge and experience (Yanow 2000). As such, individuals, their subjective experiences and the intersubjective meanings that they construct through these experiences are the portal to interpretive accounts (Wagenaar 2011).

Hermeneutics, traditionally understood as the study of biblical science, is an approach to understanding meaning through textual exegesis (Klecun-Dabrowska and Cornford 2000; Crotty 1998), although it can be applied to other human artifacts including objects, built spaces and works of art (Burrell and Morgan 1979; Crotty 1998; Yanow 2006). The purpose of hermeneutics is to bring human symbols or texts 'into understanding' (Geanellos 1998 p154), to retrieve, reconstruct and reveal meaning not readily accessible on the surface of human existence, a meaning that extends beyond both the author's own understanding and the pre-understanding of the reader (Yanow 2000; Charalambous et al. 2008). Such is the nature of hermeneutics that some postulate an association with Hermes, the fleet-footed messenger in Greek mythology who acted as a translator of the messages of the Gods, conferring their intended meaning to humans in the mortal underworld (Crotty 1998; Jahnke 2012). Hermeneutics can lead to the development of new understandings through an iterative process of engaging with the text as a whole and with its parts (Geanellos 2000); as Wagenaar (2011) points out, the 'part obtains meaning from the whole and …the whole is explained by the individual parts' (p47). Through this hermeneutic circle the *matter* of the text is exposed, although this *matter* is neither the intention of the author nor a representation of any true state of affairs (Charalambous et al. 2008).

3.3.2   Types of meaning

Wagenaar (2011) proposes three distinct 'faces' of meaning accessible to interpretive researchers, hermeneutic, dialogical and discursive, although he notes their frequent overlap as a result of the 'pragmatic choices' taken by researchers when constructing accounts (Wagenaar 2011 p40). The first 'face', termed hermeneutic meaning, is the meaning that individual agents make within a context of shared practices, routines and understandings. The second 'face', termed dialogical meaning, is constructed as a result of interaction between agents and between agents and their social worlds. Finally, the discursive 'face' emphasises the way that meaning is shaped and made by 'large linguistic-practical frameworks' that make certain beliefs and behaviours possible, while at the same time marginalising others (Wagenaar 2011 p40). It is this last 'face' that is the focus of this research.

3.4   Discourse as a key unit of analysis

Focusing on the concrete behaviours of human subjects provides interpretive researchers with a number of heuristics: language (spoken or written), acts (such as gestures), and objects employed in human practices – for example, the use of surgical instruments in an operating theatre (Yanow 2000; Needham 2009; Bezemer et al. 2014). Emanating from these heuristics is discourse, a conceptually elusive term (Foucault 1981; Garrity 2010; Wagenaar 2011) characterised by a

multiplicity of meanings across and within different disciplinary structures and systems (Mills 1997; Howarth 2000; Hook 2001; Hajer and Versteeg 2005). These meanings are predicated on different ontological and epistemological presuppositions about the world and the status of knowledge (Wetherell et al. 2001). In this thesis, I am conceptualising discourse as a collection of statements homologous with a particular knowledge system (Foucault 1972; O'Farrell 2005). A statement is a group of utterances, sentences or material object(s) that share a common assumption and have a similar force – components of the social world that have effect and provide the basis for conscious knowledge (Mills 1997; Foucault 1972; Cheek 2004). They can take a multiplicity of forms, including a conglomeration of sentences, a graph or a growth curve, an accounts book or a built-up environment (Foucault 1972; Garrity 2010), although they are not reducible to the level of a day-to-day language system or material object. Instead, statements can be thought of as functions (Foucault 1972), discursive 'junction boxes' within which 'words and things intersect and become invested with particular relations of power' (Graham 2011 p668).

Discourse as a component of the meaning making system is invariably contextual; it is 'self-referential' (Ricoeur 1971 p531), always about something and addressed to someone, although its audience is created by the text itself and any association with its author is soon lost (Ricouer 1971; Garrity 2010). When spoken, it is momentary, unlike the language system that exists outside of time (Ricoeur 1971). Discourse is the place where ideas are expressed and struggled over (Stone 2002 p11), meaning is made and *truths* are shared (McCloskely 2008). In and through discourse, subjects and objects of the social world are constituted, identities and practices are created and particular realities are brought into being (Mills 1997; Wetherell et al. 2001). However, discourses do not exist in isolation. They can juxtapose, superimpose, exclude or be unconscious of other discourses (Foucault 1981), and can exist relative to non-discursive elements which Foucault describes as 'institutions, architectural forms, regulatory decisions, laws, [and] administrative measures' (Foucault 1980c p194). Together, the discursive and non-discursive form the scaffolds of an organising framework, a 'grid of intelligibility' (Dreyfus and Rabinow 1983 p121) made up of 'cultural practices, beliefs, understandings, aspirations, and materials in their particular cultural-historical context' (Wagenaar 2011 p118). Although these grids of intelligibility manifest as relatively stable, dominant natural phenomena, they can change as a result of relational shifts between discourses and discourses and between discourses and non-discursive practices (Howarth 2000; Wagenaar 2011).

3.5 A Foucauldian-informed discourse analysis

Given the range of meanings of the term discourse, it is not surprising that there exist multiple and individualistic approaches to its analysis (Wetherell et al. 2001; Bacchi 2009; Glynos et al.

2009; Fairclough 2010). In line with my adoption of discourse as a collection of statements with a particular force, I draw on the seminal writings of the French thinker Michel Foucault (1926-1984) to provide the theoretical underpinnings of my discourse analysis about the effect of NHS workforce modernisation policy on the physiotherapy-medical professional boundary (Foucault 1972, 1977a, 1978, 1979, 1981, 1983, 1988; O'Farrell 2005). By advancing a number of philosophical suppositions on matters of order, history, truth, power and ethics, Foucault developed theoretical ideas to challenge more orthodox understandings of the social world (Nye 2003; O'Farrell 2005). Particularly relevant to interpretive policy analysts, who see discourse as a contextualised 'political commodity' (Gordon 1980 p245), is Foucault's intertwining of knowledge, power and truth, a configuration captured in his archaeological and genealogical works (Foucault 1972, 1977a, 1979, 1983).

Foucault's archaeology, most commonly associated with publications prior to *Discipline and Punish* (Foucault 1977a), lays bare the discursive formations that produce subjects and objects and the conditions of possibility that give rise to particular forms of knowledge (O'Farrell 2005). In his seminal text *The Archaeology of Knowledge* (1972), Foucault describes a discursive formation as a system of dispersional regularity between 'objects, types of statement, concepts, or thematic choices' (Foucault 1972 [2002 p41]). These four categories – objects (such as homicide, madness and mental illness) (Dreyfus and Rabinow 1983; Foucault 1972); enunciative modalities (concerned with how statements referring to such objects are made) (Garrity 2010); concepts (produced by the organisation of statements in a particular way) (Fadyl et al. 2012); and strategies (the grouping of objects and subjects with a particular consistency of theme) (Nicholls 2009a; Fadyl et al. 2012) – provide the means to locate and describe the discursive formations constituting a particular 'truth'.

On the other hand, geneaology (most closely associated with Foucault's texts published after 1977a) was the medium through which Foucault sought to extend his archaeological project and address the production and workings of discursive formations. Geneaology is concerned with 'relations of power, knowledge and the body in modern society' conveyed through discourse (Dreyfus and Rabinow 1983 p105), as Foucault states:

> …discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it.

(Foucault 1979 [1998 p101])

In *The Order of Discourse* (1981), Foucault postulates a number of systems, rules and principles controlling the generation of discourse. Which statements are accorded the right to emerge,

Foucault argues, necessitates an appreciation of who it is that is speaking and by what means they are qualified to speak, what position they hold in the information networks and what relations permit this, and from which institutional sites particular statements are uttered and legitimised discourses emerge (Foucault 1972). As a starting point, he describes a number of systems of exclusion: one that organises and orders what 'might be considered truthful and what is seen as false' (Nicholls 2009a p35), one that separates and makes distinct the division between reason and madness, and one that controls *which* subjects have the right to speak and *what* they are permitted to speak about (Foucault 1981; Hook 2001). Second, he characterises a number of regulatory rules internal to discourse: commentary, the author, and disciplines (Foucault 1981 p56–61). These rules regulate discourse production by governing the beliefs of individuals, a belief that subjects are the 'instigators of new knowledge' (Nicholls 2009a p34) rather than the product of discourses which 'over and above their formulation, are said indefinitely, remain said, and are to be said again' (Foucault 1981 p57). Finally, Foucault proposes a set of philosophical rules (rituals, societies of discourse and doctrines) that determine which subjects (speakers and listeners) can access discourse and the limits of its effect (Foucault 1981). O'Farrell (2005) argues that the rules regulating discursive practices and consequently discourse are specific to 'time, space and cultural' setting (p79), but are often obscured from view (Nicholls 2009a). These rules operate through a principle of control, the effect of which is to make it virtually impossible to 'think outside of them' (Hook 2001 p2), although they can also work in productive ways (Foucault 1981) that enable challenge through subjective agency and the formation of different discourses.

In *Discipline and Punish* and *The History of Sexuality (Volume One)*, Foucault sets out the workings of discursive formations, unveiling an interlacing of certain types of knowledge or truths (discourses) with a capillary network of power within the social body. He highlights the 'processes, procedures and apparatuses by which truth and knowledge are propagated within specific historico-cultural contexts' (Tamboukou 1999 p202), bringing to the fore a 'history of the present' (Foucault 1977a [1991 p31]), a cartograph of our 'now' that is representative not of tradition, influence or evolution, but instead reflects 'discontinuities, recurrences and play' (Tamboukou 1999 p207) informed by the 'faint traces and hints of colour …seen by an historical eye' (Foucault 1977b p145).

The relevance of genealogy to health policy development and implementation is that it directs attention to the inter-relations between 'practice, power, and knowledge' (Wagenaar 2011 p119). Via a detailed excavation and mapping of specific socio-political concepts, a focus on the historical conditions of possibility and the rules for the production, circulation and transformation of discourse in society, Foucault shows how individuals (such as policy actors) establish relations 'between research, specialised knowledge and political struggles' (Gordon 1980 p233), and how

social power and its interaction with knowledge underpins, and at the same time explicates, 'how both scientific objectivity and subjective intentions emerge together in a space set up not by individuals, but by social practices' (Dreyfus and Rabinow 1983 p108). Significant here is Foucault's minimisation of human agency:

> …no one is responsible for an emergence; no one can glory in it, since it always occurs in the interstice.

(Foucault 1977b p150)

In the next section I briefly explore Foucault's conceptualisation of social power and its intimate connection with knowledge (power/knowledge), before turning to the technologies that govern human conduct within the large grids of intelligibility in the social world.

3.5.1   Power/Knowledge

Foucault's notion of power is considered by some to be his greatest contribution to social science (Wagenaar 2011; Kelly 2013). In contrast with traditional Western ways of thinking about power as hierarchical and repressive, exerted by empowered agents over non-empowered agents, Foucault conceptualises power as situated 'sets of relations' between individuals and groups (O'Farrell 2005 p99); a 'multiplicity of force relations' (Foucault 1979 [1998 p92]) that penetrate the social body. Formed in 'every relation from one point to another' and 'from one moment to the next' (Foucault 1979 [1998 p93]), this 'micro-physics of power' works on and through human subjects to the very 'depths of society' (Foucault 1977a [1991 p26–27]), exercised through social norms and distinctive forms of knowledge that regulate human thought and action (Jessop 2007). Foucauldian power is therefore seen as 'fundamentally productive' (Rawlinson 1987 p387), and while forces of domination (repression is one type of force and not power per se) are among the multiplicity of constantly changing force relations, alternative and counter forces with a diversity of direction and effect coexist (Rawlinson 1987) (see Figure 2).

Traditional conception of power
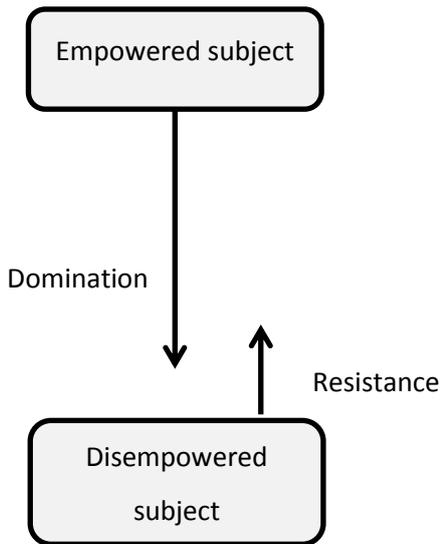
Foucauldian power (actions on actions)
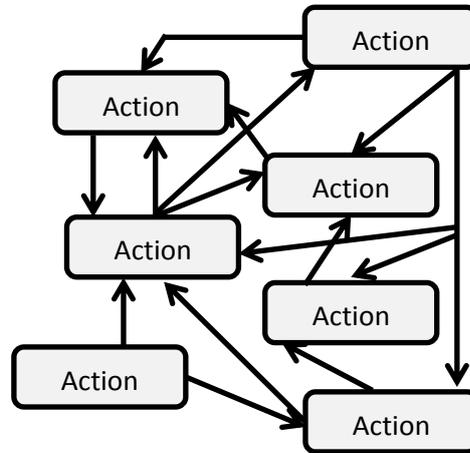
Figure 4 – A model of Foucauldian power (modified from Schwan and Shapiro (2011 p118 and reproduced with permission from Pluto Press [www.plutobooks.com]).

Juxtaposed with power is knowledge, which in Foucault's framework forms an inseparable nexus that governs human conduct in new and productive ways (Foucault 1977a [1991 p27]). The 'mutual enwrapping, interaction and interdependence' of power and knowledge (Gordon 1980 p233) is captured in Foucault's assertion that:

…there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations.

(Foucault 1977a [1991 p27])

Thus, power/knowledge joined together in discourse and effected through disciplinary technologies and subjectifying techniques (Foucault 1977b; Lacombe 1996), constrain and enable subjects, leading to the constitution of new discourses and discursive formations. These techniques are coterminous with the conditions of social relations (Gordon 1980 p246) and can be made visible through detailed study, as Jessop (2007) suggests:

One should study power where it is exercised over individuals rather than legitimated at the centre; explore the actual practices of subjugation rather than the intentions that

guide attempts at domination; and recognise that power circulates through net-works

rather than being applied at particular points.

(Jessop 2007 p36)

In the next section, I describe the key Foucauldian technologies governing human subjects.

3.5.2   Technologies of discipline and liberation

Foucault theorises that all free subjects are 'bound within power' (Schwan and Shapiro 2011 p32), governed to think and act in particular ways by technologies of discipline. These technologies include the distribution and visualisation of individuals in space and time, hierarchical observation to render individuals comparable, normalising judgement that leads to a homogeneity of behaviour and approach, and the examination, a space in which subjects are judged, ranked and codified before being positioned on a pathway of personal development aimed at making them more productive and useful (Foucault 1977a). From this assemblage, efficient and productive 'docile bodies' are constituted (Foucault 1977a [1991 p138]), specific to a particular socio-political moment in which subjects are instilled with the *right* beliefs and affective states to 'act well and follow certain kinds of behaviours' (Schwan and Shapiro 2011 p118), fashioned by the struggle to imagine otherwise. However, while these technologies deployed on human subjects produce a disciplinary society, Lacombe (1996) argues that Foucault's notion of power should not be 'reduced to a claim for the production of social control' (p334), because within all relations, subjects have a range of choices concerning behaviour and reaction which makes resistance, inscribed with power, possible.

3.5.3   Governmentality

Running alongside and interacting with technologies of discipline are technologies of the self, through which subjects 'produce the ends of government by fulfilling themselves rather than being merely obedient' (Rose et al. 2006). Foucault's interest in technologies of the self emerged in his later writings (Foucault 1988; Petersen 2003) and represent his growing interest in the role of individual agency within the 'large anonymous' frameworks that govern the social world (Wagenaar 2011 p109; Hanna 2013). He describes technologies of the self as those techniques:

> which permit individuals to effect by their own means or with the help of others a
> certain number of operations on their own bodies and souls, thoughts, conduct, and

way of being, so as to transform themselves in order to attain a certain state of
happiness, purity, wisdom, perfection, or immorality.

(Foucault 1988 p18)

The self-governing subject is apparent in Foucault's writings about *governmentality* (O'Farrell
2005), a term that combines the words government (any activity that seeks to shape human
conduct) with mentality (collective thought about how things are or ought to be) (Dean 2010).
Foucault introduced his notion of governmentality in a lecture given at the Collège de France in
1978, in which he proposed an alternative to the government of populations by a centralised
state, suggesting instead a continuum of multifarious micropractices effected by a profusion of
organisations, groups and individuals throughout society, which he described as:

> The ensemble formed by the institutions, procedures, analyses and reflections, the
> calculations and tactics that allow the exercise of this very specific albeit complex form
> of power, which has as its target population, as its principal form of knowledge political
> economy and as its essential technical means apparatuses of security.

(Foucault 1978 [1994 p219–220])

Thus, implicit in the notion of governmentality is the connection between subjects,
power/knowledge and government (Wagenaar 2011), which studies of governmentality look to
unveil through questions such as who is being governed and under what rationalities, who is
doing the governing and with what techniques (Rose et al. 2006). In the field of healthcare,
scholars such as Waring (2007), Nicholls (2009b) and Martin et al. (2013) have employed this form
of analysis to explore *how* particular rationalities or policies are 'acted into being' at a particular
moment in time (Wagenaar 2011 p 126), bringing to the fore new insights about how the state
and autonomous individuals co-constitute and 'co-determine each other's emergence' (Lemke
2007 p44).

3.6   A methodology of interpretive policy analysis

Despite Foucault's significant contribution to advancing understanding of social and ideological
phenomena and his wish for his books to be 'a kind of tool box' for researchers (Foucault 1974,
cited in O'Farrell 2005 p50), he left no methodological blueprint from which to conduct empirical
investigations into matters in the socio-political world (Hook 2001; O'Farrell 2005). Some scholars
have extrapolated key concepts directly from Foucault's texts and used them in scholarly activity
(Nettleton 1992; Nicholls 2009a; Fadyl et al. 2012), but I was uncertain how to proceed through
the essential steps of a research study without a clear structure or framework. In my search for a

solution to this problem I came across a number of publications by Dvora Yanow, a policy and organisational ethnographer and interpretive methodologist (Yanow 2000, 2006, 2007). In contrast with Foucault, Yanow (2000) lays out a clear methodological approach for researchers wishing to engage in interpretive policy analysis as a means to explore a particular policy tension or puzzle (see Figure 3).

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1. Identify the policy-related symbolic artifacts (languages, objects, acts) that carry significant meaning for the communities interpreting them.
2. Identify the different interpreting communities for each policy-related symbolic artifact.
3. Identify the discourses emerging through the policy-related symbolic artifacts.
4. Identify the points of struggle reflecting the different meanings interpreted by the different communities.

Figure 5 – Yanow's steps of interpretive policy analysis (modified from Yanow 2000 p22 and reproduced with permission from Sage Publishing)

The preliminary step in Yanow's approach involves a detailed excavation of the policy landscape and the identification and mapping of policy-related artifacts that carry significant meaning for the individuals and groups interpreting them. Yanow (2000) proposes that human artifacts are the 'concrete manifestations' of human meaning, and stand in 'a symbolic relationship to the meaning(s) they embody' (p14–15). These artifacts exist in three formulations – languages, objects, and acts – and express the values, beliefs and feelings of human actors as they engage and interpret the social world. However, these artifacts are not pre-filled with meaning, since meaning is only formulated through interaction between actor and artifact in the social world (Howarth 2000; Yanow 2007), and as such is contingent and dependent on context.

The second step in Yanow's approach requires the analyst to explore, through a recursive process, the existence of different interpretations for each artifact made by the various communities of interest – how objects appear to and are constructed by individuals and groups endowed with a set of proper understandings, beliefs, dispositions and values. Third, from this cartographic approach to the policy landscape the analyst identifies the discourses circulating within and belonging to the communities of interest, 'how they talk and act with respect to the policy issue' (Yanow 2000 p20), how policy related practices and events are framed, and the points of struggle between different interpretive communities. Following these three steps, multiple investigative threads can be employed in data analysis including genealogy, governmentality, critical discourse analysis and post structuralist political theory (Wagenaar 2011).

Projects that align with interpretive policy analysis take on an abductive logic of enquiry (contrasted with, and differentiated from, both deductive and inductive logics of enquiry). Here, the researcher is 'led away' by his search for explanations that render the tension or puzzle less perplexing (Schwartz-Shea and Yanow 2012). The path taken is inextricably intertwined with the subjectivity of the researcher (although the import of seeing all views as valuable, with no single view accorded supremacy over others, is key in this approach), the contextual setting of the policy issue, and a concern with the premise of meaning (Glynos et al. 2009; Wagenaar 2011). In this endeavour, the analyst is not removed from the policy tension being researched (Yanow 2000; Wagenaar 2007), but comes with a pre-understanding, formulated through history, experiences and expectations, that is both necessary and valuable (Fischer 2007; Jahnke 2012). It is this pre-understanding that provides a starting point for an interpretive investigation, giving the research direction while at the same time reinforcing a critical stance towards developing interpretations (Wagenaar 2011). As such, laying out what 'resides within' is fundamental to interpretive accounts (Geanellos 1998 p158), although the processes of seeking understanding bring with them deeper awareness and self-transformation (Wagenaar 2007).

3.7   Chapter summary

In this chapter I have described the Foucauldian-informed interpretive discursive approach I adopted to investigate the effect of NHS workforce modernisation policy on the physiotherapy-medical professional boundary. It is an approach that sets out to understand not only *what* a policy or policy-related issue means to interpretive communities, but also *how* it means something to them. Yanow's interpretive steps for policy analysis provide the vehicle for my Foucauldian-informed discourse analysis which draws on Foucault's archaeological, genealogical and governmentality texts. This will provide the means through which the discursive formations governing human thought and behaviour can be brought into view, thereby enabling a questioning of everything natural and taken for granted. In the next chapter I set out the methods I employed during this research, and bring to the fore the interconnections between myself as the researcher and the knowledge claims I seek to advance.

Chapter 4: Methods and interpretive reflexivity

4.1 Introduction

In the previous chapter of this thesis I laid out the theoretical and methodological foundations for the empirical studies through which I investigated the effect of NHS workforce modernisation policy on the physiotherapy-medical boundary. In this chapter, I provide a description of the methods I employed to anchor these foundations to the forthcoming interpretive accounts. However, at the outset, I acknowledge that the idea of a 'methods' chapter per se, is antithetical to a Foucauldian-informed interpretive discursive analysis of public policy. First, as already highlighted, Foucault didn't leave a methodological blueprint for other researchers to follow and there is certainly no general method associated with Foucauldian studies (O'Farrell 2005). Second, singling out an 'object of description called "research methods"' is somewhat at odds with studies that draw on interpretive policy analysis, as Wagenaar (2011) explains:

> Methods cannot be seen apart from finding a good subject, becoming aware of your specific interest in the topic, formulating an interesting question about it, becoming aware of the presuppositions with which you approach your subject, collecting data on your subject, and formulating ideas and concepts that respond to the question. Articulation of one of these elements informs and suggests articulation of the other.

> **(Wagenaar 2011 p241)**

With these caveats in mind, my aim is to bring to the fore this interconnectedness through 'interpretive reflexivity' (Lichterman 2017); to exteriorise the underpinning links between myself as the researcher, the heuristics that I employed in the gathering, construction and analysis of data, and the knowledge claims I advance (Mauthner and Doucet 2003). Interpretive reflexivity shows *how* particular interpretations are arrived at, the 'lucky guesses' and 'mistakes' that were made along the way to capturing meaning making (Lichterman 2017 p38) and the biographical, interpersonal and institutional influences that inevitably shape data analysis (Mauthner and Doucet 2003). It requires researchers to make known their assumptions about how the world works, and the steps taken or lessons learnt from scrutinising those assumptions as a means to enhance the trustworthiness of their interpretive accounts (Schwartz-Shea and Yanow 2012).

4.2   The case study: a multipurpose tool

The case study was the primary heuristic through which I chose to explore the physiotherapy-medical boundary in contemporary health care. As a technique, it offers opportunities for in-depth study of contextualised complex socio-political phenomenon over time (Marinetto 2012; Harrison et al. 2017) and, as such, has been widely applied in analyses of health policy (Exworthy and Peckham 2012). But case study is a broad church (Stake 1995; Yin 2014; Russell et al. 2015; Harrison et al. 2017). Its ontological and epistemological fluidity and uncertain status as a method or methodology (Hyett et al. 2014; Harrison et al. 2017) has led scholars to adopt a variety of approaches to investigative 'the particular' in health policy and practice. For example, Checkland et al. (2016), using case study as method, illuminate the structural and operational complexity of NHS Clinical Commissioning Groups (CCGs) in England. Extensive organisational mapping was accomplished through analysis of online surveys, observations of meetings and interviews with CCG staff, general practitioners and others drawn from eight study sites.

Juxtaposed is the single case study offered by Shaw et al. (2017), in which the authors explore the implementation of a global positioning system "geo-fence" with a gentleman with dementia prone to wandering. Through a lens of social practice, Shaw et al. (2017) unveil the network of actors, contingent practices and situated knowledges that led to implementation success and 'Rahim' maintaining his freedom to walk in his community.

Ancillary to this is the critical methodological approach adopted by Philip (2009) in her case study of the popular self-help book for depression – 'Feeling Good – the New Mood Therapy', written by a leading professor of psychiatry, Dr David Burns. Through an analysis of texts within the pages, she brings to the fore a dominant discourse of active citizenship through which individuals with depression are governed towards effective productivity in line with neoliberal values.

While case study is often concerned with contemporaneous organisations, individuals or events, it can also provide the means to explore historical phenomenon relevant to current policy and practice and, to this end, chimes with Foucault's genealogies about human madness, punishment and sexuality (Foucault 1961, 1977a, 1979). The value of this approach is seen in Cutler's (2011) study about performance management of the NHS. Cutler (2011) demonstrates the presence of both financial and non-financial techniques to control costs and wait times long before the emergence of the New Public Management public sector reform programme in the mid-70s and early 80s. Via a case study of acute NHS hospitals between 1942 and 1960, he shows how familiar metrics and processes were prevalent in the 1940s and 1950s, and suggests that repression of this historical knowledge limits opportunities for wider debate about public management. In a similar vein, Tomes's (2006) case study critiques the influence of consumer/survivors in the field of

mental health through a historical narrative. Tomes (2006) argues that growth of the movement is a consequence, and not a cause, of mental health service restructure in the USA.

4.2.1 Selecting my cases

I selected my cases for empirical study to broadly advance understanding of the professional boundary between physiotherapy and medicine. As the research was underpinned by an interpretive paradigm, I was aware that the decisions I made about *which* people to study and *what* events to attend would influence my discursive accounts (Schwartz-Shea and Yanow 2012). Unquestionably, my personal biography featured highly in the process. I stated early on in this thesis that my interest in professional boundaries emerged from my experiences working as an extended scope physiotherapist in the NHS in the field of musculoskeletal conditions, and the barriers I encountered to skill mix change and task shifting despite the strong policy rhetoric. These experiences caused me to approach my research with particular presuppositions (only some of which I had access to at the time), vis-à-vis my position in relation to other professionals in the division of healthcare labour, the contextually contingent nature of professional relations and the effects of professional boundary work on patients, practitioners and services. My cases resonated with these experiences at the outset.

The first case came to my attention rather serendipitously in the summer of 2009, when I was considering avenues for empirical studies. The National Institute for Health and Care Excellence (NICE) published a guideline for the management of non-specific low back pain. The guideline interested me for two reasons. First, it related directly to a large area of my daily clinical practice as adherence to evidence based treatment and national guidelines for people with musculoskeletal disorders was, and is, expected by clinical commissioners. Second, at the centre of the socio-political turbulence that followed the publication of the guideline, was a well-known and respected UK physiotherapist. The publication of NICE CG88 and the events surrounding the physiotherapist, sparked unrest between professionals and organisations concerned with the management of NSLBP, and sent ripples through a number of the professional segments to which I belonged. It was this controversy that handed me, in Wagenaar's words, my research question 'almost on a silver platter' (2011 p244). I aligned the boundaries of the case loosely with the chronology of NICE CG88 at the meso-level of healthcare; a four year period [2005-2009] during which a rich tapestry of texts associated with the initiation, development, publication and dissemination of the guideline were generated.

The selection of my second case was also somewhat fortuitous. About halfway through my PhD, I trained and qualified as a non-medical prescriber. At that time, physiotherapists could qualify and

practice as supplementary prescribers (a dependent model of prescribing medicines) and I was keenly following developments in the profession and at the Department of Health to enable physiotherapists to train and qualify as independent prescribers. I had found implementation of my new prescribing skills far from easy in my work setting. Local policy and protocol appeared distant from my practice and restrictive rather than enabling. Finding the 'right' physicians to support my practice required the use of organisational and strategic knowledge, and multiple systems and governance structures demanded navigation. My experiences seemed to echo feedback from other physiotherapist prescribers, and I was interested to know how physiotherapist non-medical prescribing was working in different practice settings. A favourable outcome to a public consultation into independent prescribing by physiotherapists in 2012, followed by subsequent approval from the Commission on Human Medicines, provided the springboard for the study.

To identify a potential case study site I sought NHS organisations in England employing four or more physiotherapists who were qualified as non-medical prescribers and working with people with musculoskeletal disorders. Due to the timing of my research, I anticipated that the primary mechanism of physiotherapist prescribing of prescription only medicines would be supplementary, as the first cohort of graduates from conversion programmes preparing physiotherapist supplementary prescribers as independent prescribers were not expected in practice until summer 2014.

A freedom of information request to the Health and Care Professions Council (HCPC) in May 2013 identified 261 physiotherapist supplementary prescribers on the HCPC register, suggesting that the number of non-medical prescribing physiotherapists would be low. The directory rendered the names of these physiotherapists but not the physiotherapist's work locations, so I searched non-medical prescribing news items and articles published in 'Frontline' (the news magazine of the CSP) and on websites for contacts. In addition, I emailed colleagues in an advanced practice national network to help identify sites.

The return from these search strategies was low, but in August 2013 a conversation with a colleague led to the identification of a non-medical prescribing network in one region in England. On contacting individuals within the network I identified two NHS Trusts that met the study inclusion criteria. Both agreed to participate in the research and my original intention was to gather data first from one site and then the other. However, preliminary dialogue with a key contact at one of the sites and a subsequent scoping visit, brought to light significant past and on-going professional workforce change for the physiotherapists. This, and evidence of accompanying professional tensions, suggested that a single case study in this particular setting

might offer novel and rich insight into skill-mix change and task shifting at the physiotherapy-medical boundary. Early fieldwork confirmed this and consequently I decided to focus on a single site in order to maximise depth of exploration and analysis. This time, the boundaries of the case were influenced in part by the time available for fieldwork (as I was working while studying for my PhD), and the number of healthcare professionals willing to participate in the research.

4.3 Evidence gathering and data generation

Just as interpretivism informed my case study perspective and a discursive lens influenced the phenomena I chose to focus on, so an interpretive discursive approach shaped the types of evidence I gathered and the methods I used in data generation. Ethnographic techniques, such as document analysis, in depth interviews with subjects, and observations of actors in their organisational settings are commensurate with interpretive discursive approaches (Parker-Jenkins 2016). They provide the means to identify the historically specific linguistic-practical matrices, imbued with meaning making and the 'polymorphous techniques of power' (Foucault 1979 [1998 p11], that constitute and shape social reality. Yet, data are not 'out there' just waiting to be collected (Schwartz-Shea and Yanow 2012). Data are co-generated through interaction between the researcher and the evidence, as Schwartz Shea and Yanow (2012) point out:

> ...evidence […] [is] brought into existence through the framing of a research question and those actions in the research setting that act on that framing. […]. In selecting things and people, events and acts to attend to […] the researcher may be said to "generate" data through research processes.

(Schwartz-Shea and Yanow 2012 p79-80)

4.3.1 Documents

Texts, commonly in the form of documents, are the primary analytic medium of discursive approaches (Wagenaar 2011). Foucault's genealogies involved the collection and meticulous inspection of a wide range of historical documents to trace the emergence of particular objects, knowledges, practices and the discourses that constitute them (Dreyfus and Rabinow 1983). Other discursive approaches place less emphasis on historical texts and focus instead on contemporary documents. For example, policy reports and websites can act as portals to an official state discourse (Broer and Pickersgill 2015), while institutional emails enable the detection of an organisations hierarchical 'pulse' (Panteli 2002). Whether historical or contemporary, documents are firmly coupled with societal structure and provide a 'nonintrusive approach' to investigating aspects of the socio-political world (Freeman and Maybin 2011; Michaud 2017 p40).

Like the case study however, researchers engage with documents as sources of evidence in different ways (Prior 2008; Freeman and Maybin 2011). Some treat documents as things - containers of material that enable a particular phenomenon to be counted, characterised and classified (Prior 2008). When conceptualised in this way, documents exist objectively and possess a certain stability in time and space (Boell and Hoof 2016). For others, documents are 'vehicles of discourse', embedded within which are texts that convey performative effects (Farchi and Salge 2017) and constitute certain subjectivities (Russell et al. 2014). Additionally, documents can be thought of as actors in the field '…that can be recruited into schemes […] and regarded by others as allies, enemies or perhaps simply instigators of further action' (Prior 2008 p828).

The documents that I gathered during my case studies emerged from all three delineations outlined above. First, newspaper articles and historical records containing details and pictures of people, places and events acted as receptacles of material and provided background to my cases. Second, documents as agents in the field, manipulated and used by human actors to achieve specific ends, were of interest to my enquiries. Third, organisational policy and process documents, letters, meeting minutes annotated with the names of distinct actors conveyed and constituted particular realities, and were central in the co-generation of my data. Identifying communities associated with the policy issue was aided by an understanding that documents 'create groups', shoring up boundaries around communities of people who 'think, do and want similar things (Freeman and Maybin 2011 p163). All three types of document also contained whispers of other archives in footnotes and margins, which I traced. My selection of documents was guided by my search for policy related symbolic artifacts (languages, objects and acts), although on occasions my choice was motivated by a strong visceral reaction to a particular text and I was unaware of its particular meaning and relevance.

4.3.2   Interviews

While documents are foundational to Foucauldian discourse analysis, the use of interviews in discursive studies investigating healthcare policy and practice is commonplace (see for example Ferlie et al. 2012; Cook and Brunton 2015; Lancaster et al. 2017). Interviews can be the single source of texts (Payne and Nicholls 2010; Cook and Brunton 2015), provide the context and foundations for other texts (Wagenaar 2011), or occupy a dual role in enquiries into the socio-political world (Shaw and Greenhalgh 2008; Jones and Exworthy 2015). Irrespective of role, interviews informed by interpretivism pivot around an interactive dialogue between interviewee and researcher through which data are co-produced (Fujii 2018). Yet, exactly *what* is co-produced is the outcome of dynamic interrelations between actor agency, researcher attributes, context, and researcher beliefs and values.

4.3.2.1   Identifying and approaching potential participants

The participants I approached for interview in both studies were purposively selected although they emanated from multiple sources. Yanow's (2000) initial steps of interpretive policy analysis enabled me to locate actors entwined with my cases. In the first case study I sought access to individuals associated with the debate surrounding the publication of NICE CG88. I attended national and local meetings about the guideline to identify subjects and gain an overview of the varied perspectives about CG88. I made an initial request to the Council of the British Pain Society, a professional organisation central to the socio-political events surrounding the guideline, to approach members and invite them to participate in the research. However, my request was declined (see Appendix A) and this led to a minor amendment to the study protocol. Thereafter I sought the names of individuals associated with the debate from information in the public domain and via intertextuality, and approached each individual independently. In the second case study, I sought potential participants among actors in the clinical setting. The lead physiotherapist at the site, with whom I shared commonalities in role and practice, identified field actors potentially of interest to my study and facilitated my access to the site.

However, as Schwartz-Shea and Yanow (2012) point out, identifying actors and gaining access to a setting does not guarantee interpersonal access, and a number of potential interviewees in both studies either declined to participate or did not respond to my requests. Despite my attempts to emphasise my researcher status in preliminary communications (and in effect de-emphasise my identity as a physiotherapist), my professional label seemed to precede me, shaping interactions with potential or actual participants. Professional identity provides one explanation for the silences and refusals associated with invitations to participate, and becomes understandable if we accept MacDonald's (2015) assertion that case study research is 'about identifiable individuals and events, and is always likely to have consequences for those it portrays' (p21). Being refused interpersonal access resulted in two interrelated effects. On the one hand, it limited my understanding of the meanings made by particular individuals and communities as explanations for their actions. On the other, it augmented the discursive framing of my cases, and offered me insights into policy/practice configurations and action landscapes in which power was operating.

4.3.2.2   The co-construction of data

Perhaps because I sensed that my interviewees viewed me first and foremost as a physiotherapist, I purposively set out the intentions of my research at the start of each interview, emphasised protection of anonymity, and invited participants to work with me to co-produce data that would advance understanding about the effect of workforce modernisation on the physiotherapy-medical boundary. Wagenars (2011) core principles of interviewing - establish a

relationship with the interviewee, monitor the quality of the interview material and help the respondent develop the material - formed the foundations of my interactions with participants. I drew on the tenets of effective communication (asking open questions, offering affirmations, reflections and summarising) that I use in my everyday clinical consultations to co-construct what I hoped would be detailed and rich material (Miller and Rollnick 2013). Fujii (2018) suggests that learning the language of interviewees is fundamental to deep understanding. While I had worked with colleagues from both physiotherapy and medicine for many years, I felt more attuned to the melody of physiotherapy than medicine. To address this I arranged coffee and conversation with local orthopaedic and pain consultant colleagues as a way to gain insight (albeit partial) into their experiences of skill-mix change and task shifting associated with workforce modernisation.

For the most part, my interviews were detailed and rich, although at times an anxiety about the need to gather 'quality' data came to the fore and I led the conversation more than I would have wanted, thereby potentially biasing a participants response. One or two interviewees exerted agency during dialogue and refused to be drawn on specific details about events or interactions, choosing instead to frame their responses in broad terms. I interpreted these 'silences' as symbols, which subsequently informed my emerging discursive webs. I recorded these instances in my journal, and made use of my reflections to guide further evidence gathering and data analysis.

On other occasions, context rather than selfhood or agency was the primary force shaping the co-construction of data. One interview in particular, threatened by time pressures, saw me abandon my topic guide and focus instead on specific aspects where I wanted a deeper understanding. The encounter in question was with an orthopaedic surgeon who had kindly agreed to talk to me as part of the research after a morning clinic. At the appointed meeting time it became obvious that the clinic was badly overrunning. Eventually, when the last patient departed, the surgeon appeared and offered a fifteen minute chat (the interview was scheduled to take between forty and fifty minutes), as the afternoon clinic, which was in a different location, needed to be reached on time. I had stopped to pick up a variety of sandwiches and drinks as refreshments en route to the interview venue (I don't know what prompted me to do this, perhaps a subconscious familiarity with clinics running late and missed lunches) and consequently our chat took place over lunch. Whether or not those sandwiches helped assuage the urgency to leave on time I don't know, but the net effect was thirty valuable minutes (instead of the offered fifteen) that provided fresh insights and enabled me to advance my understanding about the case.

4.3.3   Observations

Observations of participants formed the third strand of my evidence gathering strategy and were undertaken during the second case study. Proximity to participants as they go about their daily lives provides unique opportunities for gathering distinct evidence about how things work, including spatial arrangements of people and objects (Nettleton 1992), practices and nuanced interactions (Allen 1997), and gestures, silences, postures and facial expressions irrefutably entwined in meaning making (Geertz 1972). I planned at the outset of the research to undertake non-participatory observations of physiotherapist prescribing practices, but in reality, I became entangled in interactions between professionals, and professionals and patients, reflecting my biography and the contextual nature of the fieldwork (Van Maanen 2011). I escorted patients from the waiting area to the consulting room and engaged them in conversation about their lives during 'down' periods in the consultation, for example if the physiotherapist left the room. I tidied up the assessment area between patients to facilitate the flow of the clinic, looked at pictures of clinical imaging alongside the physiotherapists and shared informal conversations about clinical and non-clinical matters. My role as a physiotherapist and a non-medical prescriber seemed to offer a legitimate platform for these interactions, and I was permitted to hear, and indeed was included in, conversations between patients and practitioners. A commonality of language, work experiences and socialisation facilitated my acceptance at the site and gave me access to privileged information that I may not have been offered otherwise.

I captured my observations of clinical consultations and interactions via audio-recordings and detailed field notes, and made use of several notebooks and two recorders, one static in the consulting room and another that travelled with me as I moved around the site. While my case was physiotherapist prescribing practices, my earlier readings about Foucauldian power as sets of relations commonly hidden from view (Brenner 1994), led me appreciate that I could not 'ring fence' prescribing practices as in other studies about non-medical prescribing (Latter et al. 2010, 2012). This developing understanding shaped my observational focus towards the 'unsaid' and the 'unpresent' constituting part of the network of relations.

I was aware that my own biography could constrain as well as expand my worldview and aimed to mitigate for this by recording as much as I could in fieldnotes, from the point of entry to the study site to the point of departure. I made notes about the arrangement of objects and people in space, human behaviour, including non-verbal communication, and nuanced interactions between human subjects, even though these did not always have meaning for me at the point of capture. On one occasion, while waiting to collect my visitor identification badge prior to commencing my fieldwork, I made notes about an event I observed, the relevance of which only

became apparent some weeks later: a site worker entered the small portacabin in which I was waiting, carrying a large pile of brown envelopes and handed them to the receptionist seated behind the desk. The workers joked together that the envelopes contained P45s. This event came to have significant meaning some time later as I began to understand the depth of the Trust's financial difficulties and the dark shadow of staff redundancies.

4.4 Analysing texts

Yanow's (2000) steps to an interpretive policy analysis provided the foundations for my textual analysis. I read and re-read the documents I had gathered in relation to my cases and the transcripts of interviews and observations undertaken at the study sites. I listened repeatedly to audio-recordings gathered from interviews and periods of observations, and crosschecked the transcripts for accuracy, annotating them with material from notes I had made during fieldwork or following interviews. Returning repeatedly to the materials helped me to discern the 'whole' of the texts as well as the parts more closely connected to my cases.

I imported and organised my evidence in NVivo (QRS International Pty Ltd) and began by open coding of texts, initially line by line to identify concepts and categories, and then more specifically in relation to the policy-related symbolic artifacts (languages, objects and acts) imbued within the sources. Sometimes I didn't recognise symbols on a first or even second pass (on a number of occasions a document itself was the symbolic artifact, shaping and constituting reality in a particular way), although I often had an intuitive sense of their presence. I created annotations as a way to anchor my thoughts to aspects of texts, and reflected regularly in my NVivo journal throughout each project.

I explored my texts and artifacts from a number of perspectives. I asked who was speaking (and who was silent), what position were they speaking from and what were they speaking about; indeed, how was it possible to speak at all about that particular thing at that precise time. I considered the meanings that each policy related artifact could have for the different communities interpreting them and their effect in the world and interrogated sources to refute or support my developing ideas. When analysing texts from interviews and the informal conversations that took place during observations, I questioned the circumstances that led up to the identification of symbolic languages and asked how, and to what extent, I had been influential in their construction. Mautherer and Doucet (2003) suggest that interpersonal and institutional contexts are influential in the way in which we analyse data and I challenged my interpretations in the light of my background and experiences. Coding to nodes in NVivo (Bazley 2007) helped me to aggregate artifacts (languages, objects and acts) that shared a common force and effect, and

identify 'statements' (Foucault 1972), providing the basis for conscious thought and action. I constructed models in NVivo as I worked with the texts to help me see the connections between symbolic artifacts and communities, and bring to life the networks of relations between 'people and people, people and things, [and] people and events (Rose et al. 2006 p87). In short, the discourses and configurations of power operating within the social spaces I was exploring.

I oscillated between my emerging interpretations and the literature and drew in particular on writings about the sociology of the professions (for example, Larson 1977, Abbott 1988, Sanders and Harrison 2008; Saks 2016); health policy and practice in relation to workforce change (Timmermans and Berg 2003; McDonald and Harrison 2004; Russell et al. 2014) and organisational change (Fulop et al. 2002, 2005), to understand the meaning of my data within my conceptual framework (Wagenaar 2011). Additionally, I discussed my findings and emerging interpretations with colleagues familiar with the field, and or with an appreciation of Foucault's ideas and writings.

4.5   Conclusion

In this chapter I have situated the tools I employed to explore the effect of workforce modernisation policy on the physiotherapy-medical boundary within a template of interpretive reflexivity. Pivotal in this template is a coupling of the methodology/methods/researcher matrix with the narratives produced. Throughout the chapter I have sought to show my embodiment within each stage of the research process, and how this shaped the construction of my interpretive accounts and the knowledge claims I advance in the subsequent chapters of this thesis. In the next chapter, I set out my first empirical case study.

Chapter 5: Challenging the physiotherapy-medical boundary: A case study of NICE CG88

5.1   Introduction

In Chapter 2 of this manuscript I charted the advancement of physiotherapy's professional project, from the birth of the Society of Trained Masseuses in 1894 to the emergence and development of the extended scope physiotherapy practitioner segment in the last decade of the twentieth century. I suspended physiotherapy's professionalisation at the point of increasing growth and activity of the segment within musculoskeletal Clinical Assessment and Treatment Services (CATS), operating at the interface between primary and secondary care. These services were instigated to deliver care closer to home and reduce referrals to consultant-led hospital-based secondary care services. In Chapter 3 I outlined the pivotal role of power (conceptualised by Foucault as a 'mode of action upon actions' (Foucault 1983 p222)), and its association with knowledge in the construction, maintenance and circulation of discourse, constituting subjects and objects and generating new realities (Fadyl and Nicholls 2013). As specialist knowledge is a central tenet in the construction of professional boundaries (Macdonald 1995), and boundary-work is an essential component of a professional project, analysing the microphysics of power in jurisdictional challenges and settlements can offer insight into the effect of NHS workforce modernisation policy on the division of professional labour. I explore these ideas in this chapter through a single case study investigating the response of professionals to a national guideline that proposed a reconfiguration of work associated with the treatment of people with non-specific low back pain.

Musculoskeletal conditions constitute a significant socio-economic burden. They are a major cause of years lived with disability (Murray et al. 2013), and of the range of presentations, low back pain is the most common. Low back pain has an estimated global mean lifetime prevalence of 39% (Hoy et al. 2012) and is a perplexing and costly condition for health professionals and services. It is a primary reason for work absence and healthcare spending (Bevan 2012; Hong et al. 2013; Murray et al. 2013) and occupies between 6% and 9% of general practice consultations annually (Dunn and Croft 2005; Picavet et al. 2008). Approximately one third of individuals affected by an episode of low back pain will not have recovered after one year (Henschke et al. 2008), and for the majority a specific cause for their low back pain is never identified and their condition is therefore classified as non-specific low back pain (NSLBP) (Deyo and Weinstein 2001; Airaksinen et al. 2006). This lack of an easily identifiable lesion and specific cause for low back

pain, combined with a myriad of treatments with research evidence indicating modest effects at best (Balagué et al. 2012), hinders the distribution and redistribution of responsibility among healthcare providers, such that a range of practitioners including physiotherapists, osteopaths, chiropractors, pain physicians and spinal surgeons all have a role in the management of this condition (Prior 2003).

In this chapter, I explore a challenge to the physiotherapy-medical professional boundary that took place at the meso-level of healthcare. Antecedent events disturbing professional boundaries can be internal or external to the system of professions, and the stimulus for this perturbation was the publication of a national clinical guideline for the management of non-specific low back pain (NICE CG88). As outlined in Chapter 1, NICE was established to reduce variability in the provision of healthcare and provide NHS professionals in England and Wales with tools to deliver high-quality cost effective clinical care (Rawlins 1999). One way that this is done is through the development and publication of national clinical guidelines, defined as 'systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances' (Field and Lohr 1992 p2).

Clinical guidelines are tools of governance, political instruments with the potential to shape practitioner behaviour and transform the social world (Timmermans and Berg 2003). Although not mandatory, the adoption of NICE guidance is strongly encouraged as a means to standardise healthcare practice. However, its implementation is known to be highly variable (Sheldon et al. 2004) and there is a large literature which shows that the generation (McDonald and Harrison 2004; Moreira 2005) and adoption of clinical guidelines (Gabbay and le May 2004; Rashidian et al. 2008; Mickan et al. 2011; Spyridonidis and Calnan 2011) are highly problematic, leading some to conclude that clinical guidelines often fail to improve practice (Rashidian et al. 2008).

In the following section I describe the background to the development of NICE CG88 and the ensuing debate and socio-political events that followed the publication of the guideline in May 2009. Subsequently, I set out the aims of the case study and describe the specific techniques I used in evidence gathering and data construction and analysis before presenting my findings in Section 5.5. To conclude, I offer some insights about my findings and a summary of the chapter.

5.2   Background to the case study

In November 2005 the DoH requested that NICE produce a clinical guideline for the early management of patients with chronic (>6 weeks) low back pain (NICE 2006). The development of the guideline occurred over a two-year period, and culminated in publication in May 2009. The guideline affirmed the non-specific nature of most low back pain and recommended that spinal

imaging (X-ray and Magnetic Resonance Imaging {MRI}) should not be performed unless on the grounds of suspected serious medical pathology (cancer, infection, fracture, inflammatory disorders) or where a surgical opinion was to be sought (Savigny et al. 2009). Although MRI enables the identification of spinal anomalies which are not visible externally, spinal anomalies have been found in a large number of individuals without symptoms (Jarvik et al. 2001; Brinjikji et al. 2015), thereby reducing the diagnostic value of this procedure in people with non-specific low back pain (Rhodes et al. 1999). However, the significance of a spinal anomaly and its correlation with pain can be explored, for example by injecting the spine with therapeutic substances, but secure diagnosis resulting from these procedures has not been demonstrated (Manchikanti et al. 2009). Given the lack of evidence to support the use of these injections, this practice was also not recommended. However, the guideline did recommend increased provision of exercise, manual therapy and acupuncture as first line interventions – treatments typically offered by physiotherapists, chiropractors, osteopaths and acupuncturists, some of whom historically work outside the NHS in the private healthcare sector. For people resistant to initial treatments and presenting with high disability and/or psychological distress, a combined physical and psychological treatment programme of up to one hundred hours (termed CPP) was to be offered, while for the small group unresponsive to all conservative treatments, and who were willing to consider surgery, an opinion on spinal fusion was recommended (Savigny et al. 2009).

Reactions to the guideline were mixed; some healthcare organisations welcomed it (British Acupuncture Council 2009; British Osteopathic Association 2009; Chartered Society of Physiotherapy 2009; General Chiropractic Council 2009) while others openly contested the recommendations (Hester 2009; Royal College of Anaesthetists 2011). The guideline challenged a number of common practices and traditional professional boundaries. For some healthcare workers (for example, manual therapists and acupuncturists) there was the potential for work gain, while for others (notably medical doctors working in pain medicine) there was a perceived role reduction. Specialist doctors in pain medicine were particularly concerned about the recommendation that injections of therapeutic substances into the spine should no longer be offered to patients with non-specific low back pain (Munglani 2009).

Significant debate about CG88 took place in the British Medical Journal (BMJ), in blogs and on other websites targeted at health professionals. Disquiet about the guideline recommendations and the process of guideline development was expressed. Both the British Pain Society, the largest multi-professional organisation in the field of pain care within the UK, and the Faculty of Pain Medicine of the Royal College of Anaesthetists called for the guideline to be withdrawn (Hester 2009; Royal College of Anaesthetists 2011). In July 2009 the British Pain Society held an Extraordinary General Meeting during which the President of the Society signalled his resignation

following a vote of no confidence. The President, a consultant physiotherapist, had worked on the development of the guideline since 2007 when he was appointed clinical advisor to the Guideline Development Group. In spring 2009 he was elected President of the British Pain Society, the first non-medical doctor to hold this role. Following the Extraordinary General Meeting further correspondence and debate among groups representing healthcare professionals took place, much of which centred on whether the President's role in the development of and support for CG88 was in direct conflict with his role as President of the Society.

The aims of the case study were:

1)   To undertake an exploratory critical analysis of texts produced by professionals and organisations responding to the publication of NICE CG88 in May 2009 and the socio-political events that followed.

2)   To identify and explore the discourses surrounding the publication of the guideline and the subsequent socio-political events that occurred within the British Pain Society in the summer of 2009.

5.3   Approach and methods

Permission to conduct the case study was granted by the ethics committee at the School of Health Sciences, University of Southampton (Appendix B). As laid out previously, I adopted a Foucauldian-informed interpretive discursive approach towards the collection of evidence and the construction and analysis of the case study data, drawing on Yanow's (2000) steps to guide me. To sensitise myself to the debate and issues of interest, I reviewed a wide range of material in which discussion about the publication of CG88 occurred. In addition, I attended two professional events in which the guideline was a focus of debate: Britspine 2010, a biennial scientific conference of the UK spine societies, and a local seminar for healthcare professionals hosted by a primary care network. Attendance at these sessions gave me insight into emerging issues in the debate and enabled me to identify a number of actors who were integral to the socio-political events of interest.

5.4   Evidence collection and sources

The evidence for this study originated from two data sources: first, texts located in medical journals and documents produced by NICE and the professional societies; and second, a series of semi-structured interviews with key informants drawn from the health professions represented in the debate.

5.4.1 Texts

Texts relating to the development, production and publication of the guideline were gathered from a wide variety of sources including professional journals, professional and organisational websites, blogs, emails and other fora. From these, I purposively sampled forty-three rapid response letters published in the BMJ between 28th May and 10th August 2009 in response to the publication of the guideline [L 1–43], nine documents produced by NICE (available at www.nice.org.uk) relating to the development and publication of CG88 [D 1–9], and fourteen documents relating to the organisational processes of the British Pain Society (including the Extraordinary General Meeting) [D 10–24], some of which were publically available and some that were given in confidence.

5.4.2 Interviews

Eleven semi-structured interviews with health professionals involved in the debate (ten face-to-face and one by telephone) were undertaken between December 2010 and November 2011 [I 1–11]. As stated in Chapter 4, sampling of potential interviewees was purposive. I sought to include individuals named in the debate and associated with the socio-political events within the British Pain Society, and healthcare professionals holding formal positions within the organisations involved. Potential participants were emailed a letter of invitation (Appendix D) and a participant information sheet (Appendix E). Individuals willing to be interviewed gave signed consent to participate in the study (Appendix F) and protection of their identity was assured. A topic guide (Appendix G) informed the interviews and included questions about: participant views on skill-mix change and task shifting; clinical guidelines and their effect; and NICE CG88. Interviews took place at a convenient location for participants, were audio-recorded and lasted approximately one hour. They were subsequently transcribed verbatim and anonymised. Documents and transcripts were imported into QSR NVIVO 9 (QSR International Pty Ltd) to enable data management and recording of codes. All data were stored securely and kept separate from participant identifiable information.

5.4.3 Data analysis

Data analysis began with multiple readings of the texts and a mapping exercise to identify key actors in the debate, including their professional background, roles and associations. Line by line coding (Charmaz 2006) facilitated the identification of the policy-related symbolic artifacts – the languages, acts and objects carrying significant meaning for the different communities interpreting the guideline. In the following section these artifacts and the communities

interpreting and creating them are chronicled across the development and publication of the guideline, the debate and the subsequent events within the British Pain Society.

5.5 Findings: the signifiers of meaning

5.5.1 Symbolic languages

The data revealed four discrete but inter-related languages manifesting the meaning of the guideline for the communities interpreting it: legitimisation of practice, diagnostic expertise, the individual patient, and the evidence-base.

5.5.1.1 Legitimisation of practice

The publication of NICE CG88 was seen by professionals as a tool that would shape practice, alter the distribution of resources among professional services and legitimate practitioners working with individuals and groups affected by persistent low back pain. The guideline was of huge importance to some professional groups, individuals and organisations (as indicated by correspondence within the BMJ and on professional websites), with groups focussing on what the guidelines would mean for them, their role and their practice with patients. One figure involved in the development of the guideline reflected on this:

> *[What] …was very enlightening to me …about the guidelines …was that when people read them they automatically went to see …where am I in this guideline? They never look at the guideline as a piece of work; they look at where am I? [I, 2]*

For those professions already providing treatment interventions recommended within the guidance, CG88 had the potential to strengthen their position:

> *...for physiotherapy, if you look at what was recommended, [the physiotherapy profession] was written all over [the guideline]… [I, 6]*

and provide opportunities for further work:

> *[The Osteopaths and Chiropractors] were very very good at promoting [the guideline] … looking at it from a marketing perspective …for example, the Chiropractors ...lobbied every PCT [Primary Care Trust] in England. [I, 6]*

For others, however, particularly specialist doctors, the recommendations were perceived as constraining of their practice, as indicated by this interview extract from one specialist doctor in pain medicine:

...most pain specialists spend most of their time treating people with low back pain –
that's what we do. And a guideline comes out that says, you're not needed. Full stop. …It
can be managed without any reference to you whatsoever; you don't need injections;
you don't need TENS [Transcutaneous Electrical Nerve Stimulation]; GPs can give all the
drugs; the manipulation therapists and the physios can do all the manipulation and
acupuncture; oh, and we have a little bit of rehab. …And it was like, hey, hang on, this is
what I do! [I, 11]

The reconfiguration of work and workers proposed by the guideline was accompanied by a redistribution of finances, as laid out in the costing report. This led to a perception in some communities that pain clinic funding would be a potential casualty if the guideline was adopted:

Funding to Pain Clinics will be stopped, to provide acupuncture and chiropractic and also
the more useful, but less well-funded options, of exercise and CPP (Combined
Physiotherapy and Psychology) - no need for doctors and nurses. [L, 34]

The *no need for doctors and nurses* at the end of this extract hints at the perceived potential disruption to the customary positions occupied by the different professions assessing and managing persistent low back pain.

5.5.1.2   Diagnostic expertise

The guideline recommendations against spinal imaging and interventional pain medicine techniques attacked the core diagnostic tasks of pain physician practice. This led to rebuttals from specialist pain doctors and claims about the potential for missed diagnosis:

In order to make a diagnosis patients need an MRI scan and specific nerve blocking or
structure stimulating techniques … [L, 12]

…if imaging isn't allowed, how are those specific conditions to be diagnosed or excluded?
[L, 25]

The legal implications of missing serious pathology of the pelvis, urinary tract, bowel or
bone presenting as "non-specific LBP" will become a time bomb waiting to explode. [L,
36]

Some specialist doctors in pain medicine expressed misgivings when individuals with low back pain were under the care of non-medical practitioners, signalling perceived shortcomings in other healthcare professionals:

> *…adherence to these guidelines will result in prolonged treatments by non-medical*
> *professionals without proper assessment of the patient. [L, 25]*

Diagnosis can be considered as both a category and a process that structures the healthcare field (Blaxter 1978). It demarcates providers and technologies (which speciality *owns* the patient or can have access to the patient at particular times), and allocates rights to particular resources (Jutel and Nettleton 2011). Jutel (2009 p284) proposes that medicine's authority is embodied in diagnosis at 'both institutional and individual levels'. Yet the guideline threatened to make obsolete the tools of interventional pain medicine for the management of non-specific low back pain, and to reduce the gap between illness and disease (Jutel 2009; Schubert 2011), thereby potentially de-legitimising the role of the interventional pain specialist physician, and more widely, specialist doctors in pain medicine.

5.5.1.3   The individual patient

The guideline was publicised as a means to benefit millions of people in the UK seeking help for low back pain, although this sentiment was not shared by the British Pain Society, who wrote in response to the guidance:

> *Application of these guidelines to all those with persistent low back pain will result in a*
> *major change in clinical practice, which in the opinion of the Council of the BPS [British*
> *Pain Society], will not represent good or appropriate patient care. [L, 10]*

The 'patient' began to be conceptualised and presented in the debate as both individualised (requiring specific, tailored treatment) and agentic (able to make choices about their own care). Robust classification systems for surgical and non-surgical management of people with non-specific low back pain have yet to be realised (Fairbank et al. 2011; Foster et al. 2011), and the heterogeneity of symptom presentation allowed clinicians to argue about the contingent nature of this condition:

> *...we've tried to lump them [patients with non-specific low back pain] all together and*
> *not found that possible, so what we have to do is find a route, [a] way through [so] we*
> *can manage this individual, manage them physically, psychologically and socially,*
> *through to some sort of …agreed end point where they are better, or they are managing*
> *it better, or they're coping a bit better with what they have got. [I, 8]*

The language of the individual patient was rationalised as a means to resist the proposed re-organisation of care, as the quotes below indicate:

…the treatment has to be tailored to patients' needs, and prescriptive guidelines promoting "one size fits all" is not acceptable. [L, 12]

…the treatment of low back pain is complex and has to be individualised. [L, 10]

This aspect of the debate has strong parallels with the findings of a UK study of GP prescribing practices for depression (Armstrong 2002). Following the introduction of a new anti-depressant medicine, individual practitioner clinical autonomy and a resistance against 'formalised systems of control' was reasserted through the promotion of patient individualism and the need for specificity (Armstrong 2002 p1776). In the debate about the guideline, the essential nature of patient individualism was overlain by calls for patient choice, particularly in relation to treatment with injections:

…we are most concerned that a significant number of patients will be denied this choice of treatment in the interim. [L 10]

There's a population out there who manage and cope, and it [injections] is their preferred way of managing their back pain, and doctors accede to that; we do lots of things for patients because that's what they want. [I, 9]

Indeed, the tension between patients' rights to choose their treatment and the curtailing of choice through the guideline was embedded in the very language of CG88:

Offer one of the following treatment options, taking into account patient preference: an exercise program, a course of manual therapy or a course of acupuncture (Savigny et al. 2009 p2). [D, 8]

Patient 'choice' has been a consistent feature in UK health policy reform since the start of the twenty-first century (DoH 2000a, 2003a, 2004b, 2006d, 2010b), reflecting the introduction of a consumer-led market and patient-centred health services (Peckham et al. 2011). However, choice in the UK 'remains a limited concept' (Peckham et al. 2011 p200) with many systems restricting choice to enable waiting time management and efficient use of resources (Klein and Maybin 2012). Regardless of this, latterly patient choice has been extended to encompass not only choice of provider but also choice of treatment (DoH 2010b), although the extent to which this is being realised is, as yet, unknown. Within the NHS, choice of treatment is predicated on choice of professional provider, and the exclusion of pain physicians from the guideline treatment pathway effectively presaged a remapping of the provider landscape.

Objections to this were voiced not only through a direct call for patient choice but through the framing of a 'safe' choice for spinal injections delivered by pain physicians:

…target injection treatment is effective and safe. [L, 22]

Radiofrequency (RF) neurotomy when performed correctly in appropriately selected patients is a minimally invasive procedure with good outcome and no significant complications. [L, 23]

But these injections work as long as it's pain doctors who give 'em and not Orthopaedic surgeons… [I, 11]

This was set against the backdrop alternative treatment of spinal fusion, which was characterised as risky and harmful:

NICE has put patients at risk. Surgery is irreversible. What about the incidence and long-term costs of treating failed back surgery? [L, 33]

5.5.1.4   The evidence-base

NICE advocates that its guideline recommendations are unambiguous, independent and action orientated, formulated on the best available evidence for clinical and cost effectiveness (NICE 2006). In relation to CG88, language manifesting concern over the evidence-base underpinning the guideline recommendations was identified in both texts and interviews. A core tenet of evidence-based medicine is the hierarchy of evidence that is used to develop guidance, with large randomised controlled trials and systematic reviews considered level I evidence. This understanding of the 'evidence' was key in the debate. One interviewee explained:

I do think the Guideline Development Group, in an effort to not produce something totally wacky that everybody was just going to roll over and laugh at …set their level of evidence very high, i.e. only randomised controlled trials. [I, 9]

The exclusion of other types of evidence was seen as problematic, not just for those interpreting the guideline but for those developing it as well:

…a lot of the evidence that we've already got doesn't meet that criteria, and we're writing guidelines on things that really have been set up not to represent real life. [I, 2]

In cases where there was inadequate evidence, the Guideline Development Group derived their guideline recommendations via informal consensus methods, drawing on lower level evidence, 'expert opinion and formal consensus' (Savigny et al. 2009), which was seen as problematic by some:

So they had some evidence-based stuff, and then sixteen on personal recommendation. Now, once you start doing that, you've broken the rules, and you either have it all as evidence-based – in which case you'll have to come up with a very weak guideline – or you have it all on personal opinion, in which case you've got to be really careful how you pick your committee. [I, 11]

Naylor (1995 p840) draws attention to the many 'grey zones' of clinical work where current data is insufficient to guide practice, resulting in minimalism or experience and inference-based inventions (Naylor 1995). The language in this last quote reveals the perceived association between the experiences and inferences of the Guideline Development Group and the guideline recommendations, an association that McDonald and Harrison (2004) have evidenced as influential in the construction of local clinical guidelines for statin use in the management of heart failure.

5.5.2   Symbolic objects

Objects, like languages, are manifestations of meaning (Yanow 2000). The objects imbued with meaning throughout the period of the debate and events within the British Pain Society are chronicled below.

5.5.2.1   The blog

As the debate unfolded within professional organisations and in the BMJ, it also spilt over into other fora, creating additional forums for communication about the guideline. One of these, an internet site www.nicelbp.blogspot, was set up following the publication of the draft low back pain guideline. Initially publically accessible, the blog housed comments from those wishing to voice their opinions on the guidelines and the role of the Society's President as clinical advisor to the Guideline Development Group:

…there were comments around the individual, and there were comments around NICE is barmy. [I, 9]

The blog played an agentic role within the debate and provided a vehicle for mobilising activity on behalf of individuals who were against the guideline and those who wished to censure the President for his involvement in its development. The following extract exemplifies this:

I have put up a poll @ http://niceguideline.questionpro.com for anyone who is interested in registering their dissatisfaction with [the President's] behaviour and involvement with the NICE guidelines. In my view he has done our specialty and the Society an enormous

disservice, he does not deserve to be our president. If you agree or even if you don't

please vote so that the depth of feeling can be gauged.

(Extract taken from www.nicelbp.blogspot) [D, 11]

This led to other members of the Society writing to express the feeling that the interventionalist perspective was *probably a bit over the top [I, 8]* and should be tempered in view of the evidence available. One interviewee recalled feeling like he was *listening in on the …rioters in …Hackney [I, 9]*, referring to the public order disturbances that took place in London in 2011. The blog provided a temporary viewing gallery onto the activities of some of the membership of the British Pain Society who were against the guideline, and permitted other professionals to copy extracts from the blog and reproduce them in other media, thus widening the web of professionals caught up in the activity:

Our experience in handling very difficult cases counts as nothing now that we form part

of a merry band of PC 'health care professionals. We are led by a physiotherapist! A

[professional] who cannot even interpret straight forward evidence when it is presented

to him on a plate. Who's going to be the next BPS President? A hospital porter?

(Extract taken from www.nicelbp.blogspot [D, 16] Available from: www.csp.org.uk)

Over time access to the blog changed, with one member of the Society recalling the transition from general access to subscription only, where '*you were accepted into it in order to read it*' [I, 2]. It took on a new role following the Extraordinary General Meeting and became a focal point for campaigning for a new President, with activists against the guideline lobbying for a 'home grown' President. This provided members of the blog readership with knowledge of upcoming activity, enabling them to mount alternative forms of action:

when …somebody else was going …for …President, [I] then actively campaigned to keep

him out. [I, 1]

5.5.2.2   Guideline Development Group membership list

Stakeholders are key in the development and implementation of national health guidance and provide not only evidence of user involvement, but also an opportunity to influence the outcome:

Everybody who was registered as a stakeholder got the opportunity to consult on the

guidelines. [I, 3]

However, the British Pain Society was not listed among the stakeholders. They had not been represented at the stakeholder meeting and they did not submit comments on the draft scope, thus limiting the Society's involvement:

If we had been able to comment on the scope, we should have been able to …make a comment to NICE to say we think it's vital that you have these people on the development group. We missed that opportunity. [I, 7]

The reason that this key organisation failed to register as an initial stakeholder in the preliminary development of the guideline has its roots in another object – the Guideline Development Group membership list. The President (although not elected to the role at the time) had been appointed clinical advisor to the Guideline Development Group prior to the initial stakeholder meeting. This appointment was perceived by some as advantageous:

…because [the President] was the clinical lead for that particular guideline …there was a perception …in the Pain Society that he was representing the British Pain Society, which he wasn't. [I, 8]

The membership of the Guideline Development Group (as confirmed in the record of attendees at guideline development meetings) [D, 7] was drawn from nominations made by stakeholder groups. In addition to the chair and the clinical advisor, the professions represented within this group included a general practitioner, a physiotherapist, a chiropractor, an osteopath, a clinical psychologist, an occupational health physician, an orthopaedic surgeon, a nurse and an expert in non-surgical interventional procedures (i.e. a radiologist, a rheumatologist or an anaesthetist). There were also two patient representatives.

Responses to the low back pain scope consultation that ran between February and March 2007 highlighted anxieties from groups that were not represented on the Guideline Development Group, and enthusiasm from those who had secured a place:

…it would appear that practitioners of complementary and alternative therapy will have strong representation on the GDG [Guideline Development Group] when these therapies are not normally provided in the NHS. Is there a danger of these enthusiasts making unrealistic claims for treatments for which positive evidence from RCTs [randomised controlled trials] is scant or non-existent? This would be a pity especially if people who have a firm grasp of evidence-based medicine (e.g. from pain medicine and rheumatology) are not represented. (Royal College of Anaesthetists) [D, 3]

We welcome the creation of this Guideline and look forward to supporting NICE in its development through our involvement with both the GDG [Guideline Development Group] and the stakeholder consultation process. (Chartered Society of Physiotherapy) [D, 3]

Following the publication of the guideline, the membership list of the Guideline Development Group became a focus in the debate. Some professionals interpreted the constitution of the group as prejudicial:

That the guidelines …include as recommended treatment options every modality represented by panel members but, as no interventionalist has been accepted onto the panel, no injection treatment. [L, 14]

…the GDG [Guideline Development Group], whilst comprising honourable and scientific people, was actually a very biased group with pre-existing, strong beliefs in manipulation and exercise. [L, 34]

while others did not:

…who it is that's on the group …[is] a lot less relevant than what the evidence is saying. [I, 6]

The inclusion of an expert in non-surgical interventional procedures was a source of dissatisfaction with the membership of the Guideline Development Group, and was viewed as a key reason for the omission of injection therapy from the guideline. The appointee to the role was not seen as belonging to, or representative of, the interventional pain medicine segment:

…the biggest error the Guideline Development Group made …[was] that it didn't appoint an interventional pain medicine person to the group. It appointed someone who doesn't do it in that role. [I, 9]

Some of those dissatisfied with the guideline felt that the President, as the clinical advisor, needed to be an advocate for the Society. This was key in the acts that followed:

[The President] should have ensured that there was a relevant expert to advise and sit on the group. [L, 37]

5.5.2.3   Articles and Memorandum

The object enabling the calling of the Extraordinary General Meeting can be traced to the original Articles of Association of the British Pain Society, adopted with the incorporation of the Society as

a private limited company in January 2004. Article 50.1 permitted the convening of an Extraordinary General Meeting at the request of *not less than twenty-four Ordinary Members [D, 14]*, which subsequently had to be called within twenty-eight days of receipt of registration. The opportunities afforded by this object had not however been appreciated by all the members:

I don't think ...anybody quite realised how easy it was to call an EGM [Extraordinary General Meeting]. I think we suddenly said, what? Can they really do that? [I, 7]

Interestingly, these objects are seldom fixed, permanent entities as the history of Article 50.1 shows. Following its use in the summer of 2009, Article 50.1 was amended by special resolution to read:

50.1 The President or the Council may whenever he or it thinks fit call General Meetings and, on the requisition of 10 percent of Ordinary Members, shall forthwith proceed to convene an Extraordinary General Meeting. [D, 15]

5.5.3   Symbolic acts

The final artifacts identified through the data are two symbolic acts that are explored below.

5.5.3.1   The call for withdrawal of the guideline

Although the development of the guideline started in May 2007, disquiet with its contents surfaced after publication of the draft guideline in October 2008. One professional working within the speciality of pain recalled:

...we only picked it up ...in a big way …when the draft guideline came out. [I, 9]

As part of the guideline development process, NICE opened a consultation period encouraging stakeholders to submit comments between 1st October and 26th November 2008. One interviewee recalled that this produced a *huge amount [I, 9]* of responses, the greatest being from the Society's interventional pain special interest group:

clearly the interventional pain special interest group had the most to say about it. [I, 9].

Not everyone was dissatisfied with the guidance, however:

Overall, we welcome this guideline and agree with the underlying principles of encouraging activity, exercise and self-management in a context of appropriately prescribed analgesia. [D, 6]

…many individuals … felt that the guideline was in fact balanced and reasonable. [I, 9]

Following feedback on the draft there was a belief that the Guideline Development Group would make amendments based on stakeholder submissions, and that this would be reflected in the final guideline:

So, we were quite confident …that they wouldn't dream of bringing that out. [I, 11]

However, on publication it became clear that this hope was not to be fulfilled:

So we were really quite shocked and staggered when it didn't change. [I, 11]

and the British Pain Society Council called for withdrawal of the guideline on behalf of the Society's members:

...we couldn't do nothing; we had to say that we felt these Guidelines were wrong. [I, 7]

Although not all members of the Society were in favour of a call for withdrawal, the intense unease within the Society was influential:

…immediately afterwards [the call for withdrawal] the membership said, well we didn't ask the committee to make this decision but effectively …it …has historically always been ceded over to them because of the lack of engagement. [I, 1]

…there was concern that if that group …wasn't placated in some way, by the Society taking a fairly rigorous stance …there was a danger that the Society would fracture. [I, 7]

On the 12th June 2009 the BMJ published an official statement from the British Pain Society calling for the withdrawal of NICE CG88. The Faculty of Pain Medicine within the Royal College of Anaesthetists also recommended withdrawal of the guideline, placing emphasis on their perceived exclusion from the Guideline Development Group:

Neither the person nominated by the RCoA [Royal College of Anaesthetists] nor any other anaesthetist or pain medicine specialist was selected by NICE. (Royal College of Anaesthetists) [D, 24]

5.5.3.2 Extraordinary General Meeting

Five weeks after publication of the guideline, a letter signed by twenty-five members of the British Pain Society was received at the Society's London offices. The letter called for an Extraordinary General Meeting to debate the guideline and vote on a motion to remove the President from office due to:

> *...his involvement with and the continued endorsement of, the NICE Guidelines on Low*
>
> *Back Pain ... (British Pain Society 2009) [D, 22]*

One interviewee recalled the unprecedented territory that the Society found itself in, not just because it was the first time that an Extraordinary General Meeting had been called within the history of the British Pain Society, or its predecessor associations the Intractable Pain Society and the Pain Society, but because it was the first time that a President of the British Pain Society was the clinical lead for a guideline:

> *...whose recommendations ...threatened the practice of many of its members. [I, 9]*

The Extraordinary General Meeting took place at 10:00am on 21st July 2009 in London. Forty-five members of the British Pain Society were present, not counting the chair and the secretariat [D, 20]. Some members of the Society had written to the chair stating their objection to the vote and expressing their support for an alternate resolution to the crisis [D, 17; D, 18]. During the meeting a representative from NICE gave a short presentation, covering the role of the clinical advisor and the formation of the Guideline Development Group, offering to arrange a meeting between NICE and the British Pain Society to move forward with the guideline. One member of the interventional pain segment presented the rationale for the Extraordinary General Meeting, raising questions that were then responded to by the President. A proposal to move the vote to a secret ballot was presented to members at the meeting, but this was not taken up, with one interviewee recalling:

> *all hell broke loose at that point, and people were threatening to resign, and ...getting*
>
> *very, very angry. [I, 2]*

The vote ultimately went ahead and was carried by seven votes, with the total votes cast representing a quarter of the Society's membership. For some within the Society the vote was essential in resolving the situation and preventing further fragmentation of the organisation:

> *the Society may have ripped itself apart if it had been dragged on further ... [I, 2]*

although others saw the vote as a means to dismiss moves to have the President censured:

> *I think the feeling was that, well OK then, let's ...get it done, and get rid of it by voting it*
>
> *down. [I, 7]*

The timing of the vote (at the start of the summer holidays), combined with the mandate that it had to be held within twenty-eight days of calling, raised concerns that not all of the membership were fully aware of the situation:

…a minority of individuals has been able to force the resignation of our respected
President through a vote of no confidence at an Extraordinary General Meeting without
sufficient time for reflection and debate among the whole Society. [L, 38]

After the meeting the President duly resigned his position, having been in post for only three months. An interim President was appointed, an emeritus professor of psychological medicine who subsequently facilitated discussions between representatives of the Society and NICE. In November 2009 the interim President and four representatives from the British Pain Society met with NICE to discuss the Society's concerns over the guidance. One outcome of this communication was confirmation of an agreement between NICE and the British Pain Society, that on review of the guidelines in 2012, a:

refreshed or new Guideline Development Group would be established that would
'definitely include a pain medicine specialist'. (Bond and Littlejohns 2010 p20) [D, 23]

A new President of the Society (a consultant in anaesthesia and pain medicine) was subsequently elected restoring the role of medical practitioner as head of the Society. Having a medical practitioner back at the helm seemed to reassure some:

...doctors understand doctors. Other professions, I believe, don't have the same insight,
not for any reason than they're not doctors. …Traditionally, you know, doctors have led
teams of medics and of pain professionals. Why the doctor? Because the managers listen
to them more, um, and they're intelligent, motivated people. [I, 9]

5.6   Discussion

The case study findings presented above describe a series of symbolic artifacts mapped across the chronology of NICE CG88. These interconnected languages, objects and acts, at once the components of discourse and constitutive of new discourses, expressed the meaning of the guideline for those interpreting it (Tamboukou 1999; Nicholls 2009a), defining the nature of the work to be done with individuals affected by non-specific low back pain and crucially, who should do it (May and Fleming 1997).

The symbolic languages – legitimisation of practice, diagnostic expertise, the individual patient and the evidence-base – functioned collectively to identify and situate each patient affected by persistent non-specific low back pain in the hands of a designated healthcare professional, one with authority to request and interpret spinal imaging, and one with skills in specialised diagnostic interventional pain management techniques enabled through access to technologies such as imaging and injections. In these hands the individual patient could be managed holistically and

given a choice of 'safe' interventions such as injection therapy. Through the discourse other practitioners were marginalised, segregated from the patient through a lack of diagnostic and technical skill and identified with practices carrying 'risk'.

The symbolic objects – the blog, the Guideline Development Group membership list and Article 50.1 – coalesced to constitute, locate and give voice to particular subjects, while shadowing, silencing and constraining others. The list of those permitted to contribute to the formulation of the guideline represents particular organisations and professionals – not just names, but signals of expertise and association. From this object, tributary discourses flowed about Guideline Development Group member bias and specialist forms of knowledge. The blog gave voice to those disenchanted with the guidance and provided a means to identify and connect to networks defined by professional and social difference (Duke 2011). These two objects provided a platform for opposition to the Society's President, and Article 50.1 was invoked to enable action.

The symbolic acts – the call to withdraw the guideline and the Extraordinary General Meeting – gave rise to particular discursive spaces in which some could speak and be heard, while others could not. The call for withdrawal of the guideline by the British Pain Society, a society that could lay claim to represent a range of professionals involved in providing care for patients with non-specific low back pain, gave legitimacy to the claims of doctors in interventional pain medicine who were disenfranchised by the guidance, and provided an essential conduit for further action. The Extraordinary General Meeting identified and ordered subjects and events, while the vote of no confidence and the subsequent resignation of the President re-legitimised the position of doctors in the system of healthcare professions.

These symbolic artifacts joined together to bring a new reality into being, a discursive formation in which the guideline was resisted and a familiar professional order in the division of labour between physiotherapy and medicine was enacted. Embedded in this discursive formation is boundary-work by specialist doctors in pain medicine; rhetorical devices, techniques of demarcation and strategies of exclusion, to defend jurisdiction and maintain position in the market place and social hierarchy.

5.7   Chapter summary

In this chapter I have laid bare the divergent meaning making of professional organisations and their members in the interpretation of NICE CG88, and shown how, through the circulation and exercise of power/knowledge, new objects and subjects were constituted in a field of relations. Foucault's articulation of knowledge and power as co-constitutive (Foucault 1980a p52) provides the mechanism for the emergence of a historically contingent discursive formation surrounding

CG88. Integral in this discursive formation are particular objects, enunciative modalities, concepts and strategies that have parallels with the past – aspects visible in physiotherapy's struggle for professionalisation presented in Chapter 2. These traces and familiar threads highlight the enduring and recurrent nature of discourse, thus affirming Foucault's assertion that an awareness of history in our present circumstances is necessary (Dreyfus and Rabinow 1983). The generative effect of discourse and the intricate network of relations operating in this case study reflect Foucault's conceptualisation of power as essentially productive and polymorphous within the social body, and provide the theoretical foundations for my explanation about *how* a key national clinical guideline was rejected and a time worn professional order in the division of healthcare labour, restored.

> This is an extremely complex system of relations which leads one finally to wonder how, given that no one person can have conceived it in its entirety, it can be so subtle in its distribution, its mechanisms, reciprocal controls and adjustments.

(Foucault 1980d p62)

In the subsequent chapter I review the jurisdiction of prescribing medicines as the basis for my next case study which explores a challenge to the physiotherapy-medical boundary at the micro-level of healthcare.

Chapter 6: Prescribing medicines: a shifting jurisdiction

6.1 Introduction

The interpretive account described in the previous chapter illuminates the disruptive effect of policy on the system of professions. The response to NICE CG88 by professionals and their organisations unveiled a web of meaning that bestirred a specific socio-historical order among professions treating people with non-specific low back pain. But jurisdictional settlements enacted in the public arena are not necessarily mirrored in the workplace (Abbott 1988), as studies at the micro-level of patient and professional interactions show (Mizrachi and Shuval 2005; Kroezen et al. 2014a). Here the boundaries between the professions blur in response to the nuances of professional work routines, organisational systems and settings and worker heterogeneity (Allen 1997; Bonner and Walker 2004). Studying health policy enactment in the workplace therefore offers potentially new analytical insights into the effect of skill-mix change and task shifting on professional boundaries and the development of subsequent agendas (Swinglehurst et al. 2011).

The next case study in this thesis, presented in Chapter 7, is focused at the micro-level of healthcare and investigates the implementation of a policy of non-medical prescribing by physiotherapists in a single NHS setting in England. Prescribing medicines for the prevention and treatment of illness or disease is a thoroughly social act (Parish 1974). It is a key intervention in healthcare services and lies at the heart of a pharmaceutical regime, which Collin (2016) likens to Foucault's notion of a dispositif[4]. Constituted by 'networks of institutions, organisations, actors and artifacts', and assemblages of knowledge associated with the 'creation, production and use of new therapeutics' (Goodman and Walsh 1993, cited in Williams et al. 2011 p711), a pharmaceutical regime can be viewed and investigated from different standpoints (Williams et al. 2011; Gabe et al. 2015).

For example, Elbe et al. (2015), in an analysis of the role of governments within the regime, illuminate burgeoning state involvement in medical countermeasures as a way to protect populations from the global threat of bioterrorism and pandemics. Government strategies to incentivise the development of new pharmaceuticals for such purposes are uncovered, and include allocation of public money to support the market, protection from law suits for companies involved in the development of counter measures, promotion of procedures to enable emergency

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[4] The term dispositif is used interchangeably with a grid of intelligibility or apparatus in Foucault's own texts and those written by others (Foucault 1980c p194; Dreyfus and Rabinow 1983)

authorisation and widespread administration of medicines, and pathways, to facilitate rapid approval of pharmaceuticals such as antivirals and antibiotics.

Investigating the regime through a meso-level lens has led some scholars to focus on the pharmaceutical industry as the dominant actor in the field (Abraham 2009; Mulinari 2013). Through a detailed account of inter-relations between the pharmaceutical industry and the NHS, Abraham (2009) argues that the rate of advancement in the regulation and safety of medicines, independent drug pricing, ethical marketing and rationale prescribing in the NHS, has been significantly slowed by the fungal like penetration of the industry's commercial interests. However, juxtaposed is an account of countervailing forces against the industry. In a study about the introduction of EU legislation to allow direct to consumer information on prescription medicines by the pharmaceutical industry, Mulinari (2013) shows how multiple stakeholders countered the development, and thereby moderated pharmaceuticalisation at that juncture.

Finally, as an apparatus of interrelated nodes, the regime, or elements of it, can be explored at the micro-level of practice and everyday life. Empirical studies have examined how and why prescriptions of some pharmaceuticals continue to rise, despite questions about efficacy (Busfield 2015). Factors outside of clinical need are known to be important (for example in physician and nurse decision making about antibiotic prescribing (Butler et al. 1998; Horwood et al. 2016; Williams et al. 2017)), while incentivised case finding via simple screening tools, such as the PhQ9 to identify depression in people with long term conditions, has opened up new trajectories for increased medicines use (McLintock 2014). Other sociological factors such as patient income, habitation status (living alone, cohabiting etc) and skin colour (Ohlsson et al. 2010; Pollock and Jones 2015), have also been identified as influential in physician prescribing, and have been associated with inequitable access to appropriate medicines as a result of non prescribing.

Increasing patient access to essential medicines has been a key goal of UK health policy since the start of the NHS. One response has been the introduction of non-physician healthcare professionals trained and qualified to prescribe medicines via the policy programme of non-medical prescribing (DoH 1999). I review the background to non-medical prescribing in this chapter – material that is necessary to understand this emergent practice in the context of physiotherapy. Non-medical prescribing took root at the end of the 1980s (DHSS 1986; DoH 1989) and effected a transition in the jurisdiction of prescribing medicines. What had been an exclusive province held by the medical profession in England for many years became, at the start of the twenty-first century, a jurisdiction shared by an assemblage of professionals.

As a rationale for increasing health system efficiency and efficacy and the means by which autonomy in practice for non-medical professionals can be advanced, non-medical prescribing has been enthusiastically pursued by government officials and the non-medical professions, including

nursing, pharmacy and some of the allied health professions. Physiotherapists are one group to have been granted prescribing rights, but despite having jurisdiction since 2005, little is known about their prescribing practices. In August 2013 legislative change resulted in the extension of physiotherapist prescribing rights (The Human Medicines (Amendment) Regulations 2013), prompting the development of this study.

In this chapter I describe the backdrop to non-medical prescribing and the shift of jurisdiction in prescribing medicines. Studying the past offers perspicacity into the present (Dean 2010), and so the first section of this chapter characterises the melee of workers in England engaged in prescribing medicines from the sixteenth to the mid-nineteenth centuries. This was followed by a gradual transition, so that by the mid-twentieth century doctors were legitimised as the rightful prescribers of human medicines. The next section describes the context in which non-medical prescribing emerged, the key developments within the government's non-medical prescribing policy programme (up to the granting of physiotherapist independent prescribing), and the effect of this expanding policy programme on the profession of medicine. In the final section I explore some of the extant research investigating the implementation of non-medical prescribing in the workplace.

6.2   Prescribing medicines (sixteenth – mid-nineteenth centuries)

In England, between the sixteenth and the mid-nineteenth centuries, treating and preventing ill health using medicines was an activity undertaken by a plurality of practitioners: cunning folk who prepared lotions and elixirs from local plants to cure those thought to be bewitched; apothecaries and nascent general practitioners, who, in addition to dispensing medicines and attending lyings in, treated patients, practicing both physic[5] and surgery; physicians and apothecary surgeons who developed and dispensed their own medicines; and druggists and chemists who engaged in over-the-counter prescribing in addition to the sale of drugs and patent remedies (Kett 1964; Marland 1987; Davies 1999; Corfield 2009; Lindeman 2010). Largely unregulated, this multifarious workforce was free to respond to changing market demands (Britten 2008), and outside London in particular[6] a fluidity of practitioner function (and frequently nomenclature; see Kett 1964) was essential in meeting local need. But with so many practitioners in the field vying for business, claims of legitimisation and engagement in exclusionary practices by both individuals and groups

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[5] Physic was a term used to describe the practice of medicine in England in the Middle Ages (Colson and Ralley 2015)

[6] The Royal College of Physicians had laid claim to the practice of physic in London and its immediate environs following the granting of its charter in 1518 (Hill 1985).

of workers were commonplace (Cook 1990; Corfield 2009).

Practitioners prescribing medicines during this period were nominally divided into fringe practitioners (the largest group of which, by the mid-nineteenth century, were druggists and chemists) (Marland 1987) and those thought of as medical men – physicians, surgeons and apothecaries. Apothecaries had officially been recognised as medical men in 1695 after they claimed exemption from serving in minor parish offices in the London city government, on the basis of their professional role tending the sick (Cook 1990). Traditionally apothecaries had made and dispensed medicines (Kett 1964; Hill 1985), but had expanded their role into 'the full gamut of professional care' to include diagnosis and treatment of illness (Corfield 2009 p4). This was a jurisdiction that threw them into fierce competition with physicians, and in response to recognition of the apothecaries as medical men, equal in status with physicians and other professional men, the physicians engaged in exclusionary tactics. Members of the College of Physicians were ordered by its officers to give free prescriptions to the poor and subsequently established a London dispensary. The dispensary was staffed by members of the College of Physicians and provided diagnosis of medical illness without charge for all those who were registered poor. The subsequent selling of the appropriate remedies at cost encouraged many to use the dispensary rather than the apothecaries' shops, thus directing business towards the physicians (Cook 1990).

Other exclusionary strategies to restrict the practice of apothecaries were also employed. The officers of the College of Physicians imposed fines on unlicensed practitioners, including apothecaries found to be practicing physic. One London apothecary, William Rose, was accused of such an offence and prosecuted by the College of Physicians. The physicians argued that if apothecaries were permitted to practice physic then the sons of the gentry would be deprived of a viable profession (Jones 2006). The physicians were initially awarded the case, but an appeal to the House of Lords by the Society of Apothecaries led to the verdict being reversed. Rose won the legal right to prescribe medicines, assess and diagnose disease (Hill 1985), thus confirming his position (and that of all other apothecaries) as medical men, a role that later became the General Practitioner (Jones 2006).

In addition to competition between physicians and apothecaries, the number of trading druggists and chemists was a matter of concern for all medical men. Drawing on data from Wakefield and Huddersfield in the North of England, Marland (1987) notes the large number of druggists and chemists, outnumbering physicians, surgeons and apothecaries in the first half of the nineteenth century. The role of druggists and chemists was to make up physician prescriptions, but as this was an activity associated with limited revenue, these practitioners also engaged in developing

concoctions of their own to sell, along with retailing over-the-counter drugs and patent remedies (Marland 1987). The number of chemists and druggists prescribing 'behind the counter and out of doors' (Fosbroke 1842 p276) affected demand for the services of other practitioners, with Kett (1964 p28) noting that '[c]onstant pressure from below was working to destroy a system of gradations; each rank was pushing into the one above'.

Not only did the prevalence of druggists and chemists create unease among medical men, but that they provided an alternative (and cheaper) option to a consultation with a physician or general practitioner, was an additional and significant worry (Fosbroke 1842). Their use of patent medicines to quench the desires and requisites of the people generated alarm, as highlighted in one letter to the editor of the Lancet in March 1839:

> I am constantly hearing of, or being called to, persons in the last extremity, who might, in all probability, have been saved, had bleeding, or other proper remedies, been resorted to within the first day or two; but these pretended medical men go on physiking the patient till the regular practitioner is merely summoned to pronounce that he is dying.

This led naturally to the conclusion that the druggist should be:

> usefully occupied behind his counter, attending to the duties thereof, without stepping beyond its precincts to give advice, for which his education has not qualified him.

(Anon. 1839)

6.3   The medical profession: gaining a monopoly on prescribing

From the mid-nineteenth century onwards, practitioner roles and boundaries became more defined, and in 1858 the Medical Act split those associated with medicines into physicians and chemists and druggists; the latter had formed the Pharmaceutical Society of Great Britain in 1841 (Whittet 1983). The 1858 Medical Act stipulated that only those registered under it were entitled to recompense for 'any Medical or Surgical Advice, Attendance, or for the Performance of any Operation or for any Medicine which he shall have both prescribed and supplied' (The Medical Act 1858 p686). The Act had been introduced as a way to differentiate bona fide doctors from 'quacks', with entry onto the register based on location of training and payment of a fee. However, anyone practicing in England before 1st August 1815 could gain entry onto the register on payment of the fee, and as a result the register included the names of a wide variety of practitioners, many of whom were considered to be the very quacks that the Act had aimed to eradicate (The Medical Act 1858; Weatherall 1996). Also lacking was a clear framework stating

who could prescribe medicines, and with such a vibrant trade in drugs and patent medicines, it is of interest that prescribing became a task solely associated with doctors. Crelin (2004) suggests that a number of factors, including a campaign by the medical profession to build respectability, a war against advertising patent medicines, and the introduction of medicines legislation, all contributed to the growing association between doctors and prescription only medicines.

6.3.1   Building respectability

Making the profession of medicine respectable through the development of scientific knowledge was one response to patients deserting doctors for quack competitors (Weatherall 1996). The role of physician authority in building patients' confidence and faith was paramount and was closely linked to their specialist knowledge gained from 'proper education and long experience' (Weatherall 1996 p179). Reverence to the formulae of prescriptions used by physicians attached to famed London hospitals (Crelin 2004), and the exclusion of unwanted groups from debates about what was and what was not scientific medicine helped to establish certain types of treatment as credible and others as not (Weatherall 1996).

6.3.2   Regulating patent medicines

Hand in hand with building respectability was the medical professions public war on patent medicines. Although very few of the nostrums actually went through the patenting process, patent medicines had been in existence in England in the eighteenth century, but in the latter part of the nineteenth century their increasing availability and popularity led to rising sales (Loeb 2001). Commonly associated with quackery, patent medicines caused significant concern to the medical profession (Anon. 1882; Anon. 1894g). Not only were some over-the-counter nostrums potentially harmful (one 'Tucker's cure for asthma to be administered by aërizer was said to contain atropine, cocaine, hypo-nitrous acid and various balsamic extracts (Anon. 1903)), but regular indulgence in their use by all classes of society, fuelled by widespread advertising and ease of purchase, negatively affected business for the physicians and general practitioners (Fosbroke 1842; Marland 1987).

In the early 1900s the medical profession launched a campaign against patent medicines. The BMA commissioned a chemist to analyse the content and cost of a number of patent remedies and revealed the findings in a series of articles published in the BMJ between 1907 and 1912 (Newsom 2002). *The composition of certain secret remedies* brought to light ingredients such as lead, mercury and tannin in remedies advertised to cure multiple problems ranging from deafness to alcoholism and diabetes to rheumatism (Anon. 1908; Clifton 1908). Appeals to the government

to investigate followed the publications and a select committee on patent medicines was formed in 1912, leading subsequently to calls for legislative change (Newsom 2002). However, concern about double standards within the BMA emerged when the Journal of the American Medical Association published claims that the BMJ was advertising patent medicines to generate financial revenue (Loeb 2001). Individual physicians were also implicated in the furore as many who denounced the use of patent medicines both prescribed and promoted them to patients and commonly used them for their own purposes (Loeb 2001). Finally, in 1920 the BMA advised all registered medical practitioners that they should not recommend or use any remedy where the main ingredients were unknown to the profession (Loeb 2001).

6.3.3   Legislation

In addition to changes in the patent medicine trade, the introduction of new legislation controlling narcotics availability and use aided the medical profession in obtaining jurisdiction over prescribing medicines. At the start of the 1900s a series of high profile cases involving drug use, picked up and sensationalised by the press, fuelled the public health debate about the liberal use of opium in England, and provided doctors with a legitimate platform from which to express their involvement in the administration and control of these substances (Berridge 1999).

First, the medical profession voiced its concern about the easy availability of the drug, recommending that its sale should be restricted. In 1920 the Dangerous Drugs Act was passed which made it illegal for anyone to possess opium and cocaine (or products which contained 20% or more of morphine and 10% or more of cocaine, ecgonine or diamorphine), unless supplied by a medical practitioner or in accordance with a medical or dental prescription (Anon. 1923; Britten 2008).

Second, doctors laid claim to drug addicts, stating that addiction was an illness requiring medical intervention (Berridge 1999). In the early 1920s the medical profession opposed the Home Office's intention for penal management of addicts (an approach that would have largely excluded doctors' involvement with this group) and, via a series of moves, ensured their place at the policy-making table. The Rolleston Committee, with its predominantly medical membership, had been asked to advise on the management of persons suffering from addiction to narcotics. The committee report circumstantiated the role of the doctor in the care and management of the addict, effecting medical control of both the prescribing of controlled drugs and the management of excess (Crelin 2004).

Aside from events associated with controlled drugs, the regulation of medicines in the UK was patchy and limited until the passing of the Medicines Act in 1968 (Britten 2008). The Act was a

response to a tragedy in the early 1960s that resulted from the teratogenic actions of the drug Thalidomide (Anon. 1967) and categorised medicines into a general sales list, pharmacy and prescription only medicines, with only approved practitioners – doctors of medicine, dentists, veterinary surgeons and veterinary practitioners permitted to prescribe the latter category.

6.4   The emergence of non-medical prescribing: a subordinate jurisdiction

Legalised prescribing of prescription only medicines for human use remained a task solely undertaken by registered doctors and dentists until 1992, when, in response to the publication of two key reports (DHSS 1986; DoH 1989), registered nurses, midwives and health visitors were afforded the legal right to prescribe medicines (Medicinal Products: Prescribing by Nurses, etc, Act). The Cumberlege Report (the first of the two reports) outlined the state of community nursing services in England (DHSS 1986). One facet highlighted in the report was the time wasted by district nurses travelling to request prescriptions for patients from a GP (ibid.). The review team recommended, among other things, that community nurses, as part of their nursing care, be permitted to prescribe a limited range of items and simple agents to meet patient needs and, in well-defined circumstances, control drug dosage as a means to enhance patient care and make better use of resources (ibid.).

Unofficially, nurses had been prescribing for years (Anon. 1963; Burke-Masters 1986), 'telling' the doctor what medicine to prescribe (Bonner and Walker 2004), obtaining the doctor's authorisation after taking a prescribing decision (DoH 1989; Watterson et al. 2009) and recommending amendments to junior doctors' prescribing practices (Allen 1997), a position that had been brought to the attention of the Royal College of Nursing in 1978 by the Community Nursing Association (Jones 2004). The Cumberlege review now offered an opportunity to address the situation. Using the review team's report as a springboard, the Royal College of Nursing worked to manoeuver nurse prescribing up the political agenda. Jones (2004) recalls the blend of strategy and skill displayed by the Royal College in enrolling the BMA and the Royal Pharmaceutical Society of Great Britain, the 'right' politicians and the 'right' clinicians in support of nurse prescribing and, in so doing, facilitating the advancement of nursing's professional project.

In 1987 the health circular Community Nursing Services and Primary Health Care Teams signalled the government's backing of the Cumberlege review team's recommendations (DHSS 1987 cited in DoH 1989). Medical, nursing and midwifery and pharmacy advisory committees were all consulted about progressing community nurse prescribing, and as a consequence the Advisory

Group on Nurse Prescribing was set up to determine how the supply of medicines and appliances to people in the community might be improved as part of nursing care (DoH 1989). The Advisory Group, led by Dr June Crown, published its findings in 1989 (the second report) and, on the basis of 'wide agreement' that prescribing powers should be aligned with professional responsibilities, concurred with the Cumberlege Report recommendations (DoH 1989 p13). Community nursing's claim to prescribing and drug dosage adjustments within set protocols had been strengthened and looked set for implementation.

In January 1991, the Medicinal Products: Prescription by Nurses, etc. Bill to amend the existing legislation was introduced in the House of Commons under the ten-minute rule (HC Deb 30 January 1991), but the commission of a cost-benefit analysis of nurse prescribing delayed its progress (HC Deb 31 January 1992). The Bill was introduced again a year later as a Private Members' Bill by the MP for Chislehurst, Roger Sims, and subsequently taken forward by Baroness Cumberlege in the House of Lords (HL Deb 28 February 1992). Once passed, the Medicinal Products: Prescription by Nurses, etc, Act 1992 legally permitted community nurses to prescribe from a limited list of medicines, dressings and appliances, although it was another two years before the necessary secondary legislation was passed to enable actual prescribing practice (Watterson et al. 2009).

In October 1994 a one-year pilot scheme to evaluate the cost benefit and effect of nurse prescribing was launched, involving one GP surgery in each of the eight health regions in England (Ramsay 1994). It was soon realised, however, that the data generated would be insufficient to support national adoption and so the study was extended (Jones 2004). Included in the extension was one Community Trust in the north west of England, Bolton, which became the first Community Trust where all district nurses qualified as non-medical prescribers (Nolan and Bradley 2008 p25). Although nurse prescribing was celebrated by the profession as a major achievement, some questioned the benefit of such a development, especially as the majority of products listed could be purchased over the counter (Ramsay 1994).

Government support ensured the evaluation of the pilot schemes in England (Luker 1997), with the announcement of £14 million of new money underpinning the establishment of a national programme of nurse prescribing (HL Deb 20 April 1998). Concurrent with this announcement was a review of the prescribing, supply and administration of medicines, launched in March 1997 and led once again by Dr June Crown. The review team's remit this time included a report on the likely impact of a developed framework to enable health professionals to undertake new responsibilities in medicines prescribing, supply and administration (DoH 1999). New Labour's commitment to modernising nursing roles outlined in a white paper, The new NHS: modern and

dependable (DoH 1997), had set the scene for other developments in nurse prescribing. Furthermore, the NHS Plan: a plan for investment, a plan for reform (DoH 2000a), with its focus on modernising the workforce and breaking down traditional demarcations between the professions, provided a solid platform for prescribing by other groups of professionals, including allied health professionals.

6.4.1   Opportunities for other healthcare professionals

Inscribed in the second Crown report was a structure through which the prescription of medicines for human use could be extended beyond those already authorised; doctors, dentists and community nurses. The formation laid out by the review team incorporated practices to ensure the spread of non-medical prescribing – for example, procedures for putting forward and approving new groups of prescribers, recommendations for access to shared medication records and the naming of certain professional groups deemed suitable to apply for early rights to prescribe medicines, made eligible through a discourse of clinical expertise (DoH 1999). But coterminous were practices of constraint, such as limits to the type of medicines that could be prescribed by new professional groups and a new type of prescribing – dependent prescribing (later re-named supplementary prescribing) that was formulated around the valued activity of diagnosis (Blaxter 1978; DoH 1999).

Supplementary prescribing is characterised by a tripartite agreement between a qualified non-medical prescriber, an independent prescriber (a doctor or dentist) and the patient, to prescribe a medicine in accordance with a specific clinical management plan (CMP) (DoH 2005a). It enables the prescription of any medicine from the British National Formulary (including controlled drugs and unlicensed medicines) by a supplementary prescriber, provided the medicines are documented on the CMP following initial diagnosis and agreement by a doctor (or dentist) (DoH 1999; Bissell et al. 2008). Supplementary prescribing is considered most suited to the management of long-term conditions (DoH 2005a) but it has been heavily criticised due to its incompatibility with practice (Weiss et al. 2006; Courtenay et al. 2007). Nevertheless, it has been the primary route through which different professional groups seeking to prescribe medicines independently have advanced (DoH 2005a; Bissell et al. 2008; Courtenay et al. 2012). The Crown report (DoH 1999) had prised open the crack made by Cumberlege and her team; the doctors' monopoly on prescribing medicines had now become a focal point for challenge.

6.5   An expanding UK policy programme of non-medical prescribing and doctors' claims of legitimisation

Initially, nurse prescribing was limited to those working in the community. Although there was enthusiasm (particularly from the nursing profession) to expand the scheme to other areas (HC Deb 31 January 1992), the BMA opposed prescribing by hospital nurses on the basis that the nature of illnesses and corresponding drug treatment regimens in hospitals would necessarily be more complex and thereby require the skills and knowledge of a doctor (HL Deb 28 February 1992). However, in May 2001 the Health Minister Lord Hunt announced an expansion to not only the number of nurses engaged in prescribing practices but also the range of medicines that nurses could prescribe (DoH 2001c). By 2002 independent extended formulary prescribing had been introduced to allow nurses to prescribe independently from an Extended Nurses Formulary (Latter et al. 2005) and in 2003, at the request of the Secretary of State for Health, the Medicines and Healthcare products Regulatory Agency (MHRA) opened a consultation about proposals to further extend the range of prescription only medicines and conditions for which Extended Formulary Nurse Prescribers could prescribe (MHRA 2003).

The anticipated benefits of this expanding programme included improvement in patient care through reduced delay in patients accessing medicines, better use of professional skills and time, and task shifting from doctors to other professionals, to release doctors to undertake activities of greater complexity to which their skills were more suited (DoH 1999; Weiss et al. 2006). These benefits were included in policy statements and speeches made by DoH officials, making explicit the role of non-medical prescribing in the modernisation of the health service (DoH 2002c, 2003c, 2005b). The symbolic nature of these developments vis-à-vis the profession of medicine was also clearly signalled. In his speech at the chief nursing officer's conference in Brighton in 2003, John Reid, the then Health Secretary, announced that 'Nurse prescribing sends a powerful message to the public and others – that nursing is not subservient to medicine but an equal part of the healthcare team' (Reid 2003 para 22).

6.5.1   Supplementary prescribing for nurses, pharmacists and some allied health professionals

Following on from Extended Formulary Nurse Independent Prescribing, further developments in non-medical prescribing took place, and in 2003 supplementary prescribing was introduced for nurses and pharmacists. The CMPs underpinning supplementary prescribing agreements have to: specify the range of medicines that may be prescribed for a named patient; define the parameters for variation of drug dose, frequency and formulation; state the conditions for referral back to the

independent prescriber and be agreed and signed by both the independent and supplementary prescriber (National Prescribing Centre 2003). This framework of dependency on the medical profession, although acknowledged by medical organisations as key to the success of supplementary prescribing, was seen as burdensome and impractical (MHRA 2002). Of concern to medical organisations was the potential for an increase rather than a decrease in doctors' workloads as a result of the need to develop CMPs and have joint independent and supplementary prescriber reviews (Anon. 2002b; MHRA 2002). Nursing and pharmacy organisations also had reservations about CMPs and their implementation, and emphasised the importance of equal standing and a mutually supportive relationships between independent and supplementary prescribers.

Despite these concerns, supplementary prescribing was generally well received by stakeholders, including medical organisations, although the feeling that supplementary prescribing would be a transitional arrangement to prepare professionals for independent prescribing was palpable and caused anxiety particularly among medical bodies (MHRA 2002). When supplementary prescribing for the allied health professions (physiotherapists, chiropodists, optometrists and radiographers) was proposed several years later, it too was largely supported. Like the nurses and pharmacists before them, those allied health professionals seeking rights to extend their jurisdiction further made calls for expansion, with chiropody, physiotherapy and optometry claiming that independent prescribing was both necessary and beneficial to patient care (MHRA 2004). Little concern was raised this time about the use of CMPs and their implementation, although medical organisations emphasised the need for clear oversight by a doctor throughout the prescribing process (MHRA 2004).

6.5.2   **Independent prescribing for nurses, pharmacists and optometrists**

While the allied health professions were starting out with supplementary prescribing, nursing and pharmacy had advanced to the next stage – independent prescribing. An independent prescriber is defined as a practitioner 'responsible for the assessment of patients with undiagnosed conditions and for decisions about the clinical management required, including prescribing' (DoH, 1999 p39). Diagnosis is fundamental to the organisation of healthcare. It is foundational in medical authority, and is traditionally a key differential separating the doctor from other healthcare professionals (Jutel and Nettleton 2011). Notwithstanding this long-established boundary, the Ten Key Roles for nurses that emerged from the NHS Plan publically blurred this demarcation, offering diagnostic and prescribing privileges to other professionals, something that was certainly not anticipated when the Medicinal Products: prescription by Nurses, etc. Bill was introduced. As Mr Dudley Fishburn (MP) explained:

> The object of my Bill is not to involve nurses in the diagnosis of a disease or its
>
> treatment - none want that - but to allow them [community nurses] more responsibility
>
> in the long-term, continuing management of a patient's care.

(HC Deb 30 January 1991 col 944)

Although this was the stated case in 1991, fifteen years later the independent prescribing model offered a whole array of professionals direct access to specific client groups for provision of a diagnosis and holistic, comprehensive care, with the possibility that in some areas of work, the position of the doctor could be superseded.

In 2005 the MHRA issued two public consultations asking for views on future developments in nurse and pharmacist prescribing (MHRA 2005a, 2005b). A number of options were available to respondents, ranging from no change in rights to prescribe medicines to prescribing from the full formulary for any condition. Responding to the consultation, the BMA and the Royal College of General Practitioners voted for no extension of prescribing for pharmacists or prescribing for certain conditions from a limited formulary. The issue of non-medically trained professionals diagnosing disease was a key area of concern and was underpinned by perceptions of limited training of pharmacists and nurses, giving rise to worry about patient safety. However, patient safety was not the only concern. Disquiet about boundary encroachment was also evident. The Royal College of General Practitioners indicated that they considered independent prescribing by pharmacists a threat to the medical profession, with the potential to 'remove the central role of the GP' (MHRA 2005c p10).

Despite these tensions, opinion on independent prescribing for nurses and pharmacists was largely favourable, and suitably trained and qualified nurses and pharmacists were granted rights to prescribe 'any licensed medicine for any medical condition' within their own competence (DoH 2006e). Nevertheless, the announcement by Patricia Hewitt in November 2005 that nurses and pharmacists were to have access to almost the whole of the British National Formulary appeared to take the medical profession by surprise and proved highly contentious (Day 2005). The BMA called for an urgent meeting with the Health Secretary, publically stating their belief that only doctors had 'the necessary diagnostic and prescribing training that justifies access to the full range of medicines for all conditions' (Day 2005 p1159). Some pointed to the impending safety and financial disasters likely to result from the practice of professionals not skilled in the complex art of diagnosis (Keighley 2006), and Avery and Pringle (2005) questioned the wisdom of such an approach.

Despite anxiety about the possible effects of nurse and pharmacist independent prescribing, it commenced in May 2006. Medical opinion on the initiative remained circumspect and the result of an opinion poll published in Pulse, the UK GPs online magazine, revealed an undercurrent of feeling that the expansion of non-medical prescribing had gone too far (Anon. 2006); nearly 90% of doctors responding to the poll believed that the controls for independent nurse and pharmacist prescribing were insufficient to protect patients.

6.5.3   Independent prescribing for physiotherapists

By now the pattern for reaching independent prescribing status was established, although not altogether a given. The second Crown report (DoH 1999) had identified specialist physiotherapists, notably the extended scope physiotherapy practitioner segment, as one professional group eligible to apply for early authorisation to prescribe medicines independently, thought likely to be of particular benefit to patients with musculoskeletal problems and soft tissue injuries (MHRA 2004). Although the physiotherapy profession had been granted supplementary prescribing rights in 2005, uptake by practitioners was limited[7] with the profession arguing incompatibility between the way many physiotherapists work (providing first line independent care) and reliance on contact with a medical practitioner for authorisation of a CMP (DoH 2009a).

Despite the ambition for greater autonomy in prescribing, the physiotherapy profession was forced to wait another few years for an opportunity to pursue independent status. In 2008 the Allied Health Professions Prescribing and Medicines Supply Mechanisms Scoping Project Board was established to assess the need for extending medicines supply mechanisms and non-medical prescribing for the allied health professions (DoH 2009a). As a result of their review, the Scoping Project Board took the position that the existing mechanisms did not best serve patient needs or maximize the potential contribution of the allied health professions to services, and that there was a strong case for progression to independent prescribing by physiotherapists and podiatrists (DoH 2009a). The Scoping Project Board's argument centred on potential delays in patients accessing medicines, with subsequent safety concerns as a result of limited doctor availability to agree a CMP when physiotherapists worked alone as autonomous practitioners (DoH 2009a). In addition, supplementary prescribing was not seen as suitable for short-term care and was put forward as one reason why only 0.4% of the profession had registered as supplementary prescribers (Commission of Human Medicines 2012).

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[7] A freedom of information request to the HPCP in May 2013 highlighted only 261 physiotherapists registered as supplementary prescribers.

The findings of the Scoping Project Board (DoH 2009a) were submitted to the Department of Health Non-Medical Prescribing Board, who accepted the recommendation that there was a strong case for further work towards independent prescribing by physiotherapists (and podiatrists)[8]. A twelve-week public engagement exercise (DoH 2010c), between September and December 2011, was used to inform a full public consultation into independent prescribing by physiotherapists (DoH 2011). In a manner similar to previous consultations, the subsequent consultation laid out the options for independent prescribing by physiotherapists: Option 1 – independent prescribing for any condition from a full formulary; Option 2 – independent prescribing for specified conditions from a specified formulary; Option 3 – independent prescribing for any condition from a specified formulary; Option 4 – independent prescribing for specified conditions from a full formulary; and Option 5 – no change. In addition, agreement was sought for physiotherapists to prescribe from a limited list of controlled drugs and to mix medicines or direct others to mix medicines prior to administration (DoH 2011).

The consultation ran for three months and attracted 689 responses, with 99% of all respondents supporting some form of independent prescribing by physiotherapists (DoH 2012). The majority of respondents favoured Option 1, but some physiotherapists, the majority of medical organisations and some NHS Trusts supported Option 2 – independent prescribing for specified conditions from a specified formulary. The inherent difficulties of specific formularies and limited lists of conditions formed the basis of the argument for Option 1, but disquiet about perceived inadequacies in physiotherapist skills and knowledge to diagnose and prescribe safely from a full formulary, a desire to retain oversight and involvement in prescribing decisions and concern about practice creep, were arguments put forward for limiting physiotherapist prescribing jurisdiction. Some respondents stressed doctors' greater understanding of disease, conditions and individuals, gained through extensive medical training (DoH 2012).

The results of the consultation were taken forward, and in May 2012 approval from the Commission on Human Medicines was sought, with the Chief Allied Health Professions Officer presenting the case for independent physiotherapist prescribing for any condition from a full formulary. The Commission moved in favour of the proposal (although two commissioners abstained and one voted against) on the basis that physiotherapist prescribing would be 'within the overarching framework of physiotherapy practice in human function, movement and performance' (Commission on Human Medicines 2012, para 9). In addition, a small number of controlled drugs and permission to mix medicines were granted.

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[8] Independent prescribing for podiatrists went forward at the same time as physiotherapist independent prescribing, but from this point forward no further reference will be made to podiatrists.

On 20th August 2013 the Care and Support Minister, Norman Lamb, announced legislative change that would pave the way for physiotherapists to independently prescribe medicines. In a press release entitled 'Millions of patients to benefit from easier access to medication and fewer trips to hospitals' he proposed that independent prescribing would be more convenient for patients and would free up valuable time for GPs, as patients would no longer have to go back to their doctor to get medication after visiting a physiotherapist (DoH 2013). Phil Gray, the then Chief Executive of the CSP, also added that independent prescribing by physiotherapists would 'save money for the NHS' (CSP 2013).

Unlike on previous occasions, these announcements were met with relatively little response from medical organisations. Pulse was dispassionate in its reporting on the developments: 'Physiotherapists and Podiatrists gain independent prescribing rights' (Anon. 2012) and 'UK becomes first country to allow physiotherapists and podiatrists to prescribe' (Sterling 2013), although the latter article did attract comments from individual practitioners about the potential impact of independent non-medical prescribing by physiotherapists:

> There is a reason why other countries have not rushed to do this. Prescribing is both complex and potentially dangerous and indeed hard enough even after a decade of training. Hopefully, as this comes into force, there will also be a sizeable investment into endoscopy suites and C-Diff treatment facilities.

> **(Anon. 2013a)**

However, another respondent suggested that this perceived impact might be mitigated by restrictions on hospital fiscal spending:

> Don't worry. Hospital doctors can prescribe but are under pressure to send patients back to the GP so that the drug costs are footed by the GP budget. It sounds good for patients in principle but will come to nothing.

> **(Anon. 2013b)**

6.6   Implementation of non-medical prescribing in practice

Despite the medical profession's public claims that only doctors have the necessary knowledge and skill to prescribe medicines safely and effectively, national evaluations of non-medical prescribing in practice are favourable (Latter et al. 2005; Norman et al. 2007; Bissell et al. 2008; Guillaume et al. 2008; Watterson et al. 2009; Drennan et al. 2009; Latter et al. 2010). ePACT (electronic Prescribing Analysis and Cost) data suggests that the number of prescriptions issued by

non-medical prescribers (nursing and pharmacy) has increased over time (Guillaume et al. 2008; Drennan et al. 2014) and evaluations have shown the practice to be safe, effective and appropriate, reported positively by patients and non-medical prescribers and largely agreeable to stakeholders (Otway 2002; Norman et al. 2007; Bissell et al. 2008; Cooper et al. 2008; Guillaume et al. 2008; Drennan et al. 2009; Latter et al. 2010; Courtenay et al. 2012).

Juxtaposed, however, are reports of prescribing as 'patchy' either geographically or professionally (Bissell et al. 2008; Watterson et al. 2009 p7; Courtenay et al. 2012), with significant numbers of qualified prescribers not using their prescriptive authority in practice (Ryan-Woolley et al. 2007; Hacking and Taylor 2010; Courtenay et al. 2012; Drennan et al. 2014). Drawing on the results of a survey of Macmillan nurses, Ryan-Woolley et al. (2007) identified that half of the Macmillan nurses qualified as extended formulary independent nurse prescribers were not actively prescribing, and of those that were, there was marked variability in the number of prescriptions issued. This variability is echoed in a study by Kroezen et al. (2014a) in which contradistinctive prescribing practices by nurse specialist prescribers in Dutch hospital settings were observed. Moving beyond nurses, Courtenay et al. (2012) undertook a survey of qualified non-medical prescribers in one strategic health authority in England and found that 15% were not prescribing, the highest numbers of whom were pharmacists, allied health professionals and community practitioner prescribers. Regional and national level data echoes these findings; a survey of 628 non-medical prescribers in practice in the north west region of England (professionals who had achieved a nonmedical qualification in one of eight universities in the north west of England between 2004 and 2007) ascertained that 14% of the cohort had never used their prescribing qualification (Hacking and Taylor 2010) while only 43% of primary care nurses qualified and authorised by their employer to prescribe were actually doing so (Drennan et al. 2014).

Factors reported to affect non-medical prescribing in practice include intra and inter-professional relationships (Otway 2002; Avery et al. 2007; Bissell et al. 2008) and organisational factors, including access to the essential tools of prescribing – a prescription pad, full up-to-date medical records (Hall et al. 2006), software compatible with non-medical prescribing practice (Weiss et al. 2006; Bissell et al. 2008), and employer and peer support (Courtenay 2007; Ryan-Woolley et al. 2007; Watterson et al. 2009; Downer and Shepherd 2010). While some evaluations of non-medical prescribing have incorporated ethnographically informed case studies to explore implementation in practice (Latter et al. 2005; Weiss et al. 2006; Bissell et al. 2008; Watterson et al. 2009; Kroezen et al. 2014a), little has been written about *how* and *why* these factors affect prescribing practice.

6.7   Chapter summary

This chapter has reviewed the development of non-medical prescribing in the NHS in England across three decades, and has brought to the fore the rhetoric and drama associated with recurrent jurisdictional disputes over the practice of prescribing medicines. In contemporary healthcare, non-medical prescribing is perceived as a successful initiative that has contributed to the achievement of macro-level political rationalities and autonomy for non-physicians. However, at the micro-level, empirical data suggests significant variability in practice, and for some, despite training and qualification, prescribing medicines has not become a reality (Drennan et al. 2014). One explanation for this is context, the matrix of relations between 'people and people, people and things, [and] people and events' (Rose et al. 2006 p87) introduced in Chapter 3. Context, constituted through discourses and non-discursive elements such as laws, regulatory decisions and architectural arrangements through which discourse applies itself (Hardy 2011), and in which relations of power are exercised, provides an explanation for the present. Interpretive policy analysis offers one way to gain insight into the contextual specificity of our present (Schwartz-Shea and Yanow 2012), and in the next chapter I draw on this methodology once again to investigate physiotherapist non-medical prescribing in the workplace. This time my investigation is framed by Foucault's notion of governmentality, an idea that links together individuals, groups and populations, governed towards particular ends by collective rationalities and tactics that emerge from a multiplicity of organising bodies within the social network.

Chapter 7: Challenging the physiotherapy-medical professional boundary: A case study of physiotherapist non-medical prescribing

7.1 Introduction

In the closing section of the previous chapter I highlighted the variability of non-medical prescribing in practice, and suggested that contextual specificity was the axiom for this. In this chapter, I focus on the non-medical prescribing practices of physiotherapists working in an NHS musculoskeletal outpatient service in England to explore these ideas further. Although physiotherapists have held supplementary prescribing rights since 2005, little has been published about their prescribing practices. Given the legislative change in August 2013 to allow independent prescribing of medicines by physiotherapists, and the inconsistency in non-medical prescribing identified among other professional groups (Dobel-Ober et al. 2010; Hacking and Taylor 2010; Courtenay et al. 2012), an investigation was apposite.

The aims of the case study were:

1) To describe the prescribing practices of physiotherapists working in the musculoskeletal outpatient service context chosen.

2) To identify the discourses and extra-discursive elements shaping and constituting physiotherapist prescribing practices, including professional working relationships, procedural, organisational and political factors.

3) To examine the key discursive formation emerging from the analysis of physiotherapist non-medical prescribing.

What constitutes prescribing practice is debated (DoH 1999; Weiss et al. 2006). Traditionally, the success of non-medical prescribing is gauged by the frequency of prescribing and the number of non-medical prescribers issuing a prescription (Latter et al. 2010; Drennan et al. 2014; Gielen et al. 2014), although Courtenay et al. (2012) suggest that medicines management activities should also be acknowledged due to the potential for significant benefit to patients and health services. For the purpose of this study, I have taken prescribing practice to embody taking and understanding a medicine's history, giving advice or guidance to patients about medicines (including over-the-counter medicines), making recommendations about medicines to GPs or other healthcare professionals, and writing a script for a prescription-only medicine (DoH 1999; Courtenay et al. 2012).

7.2 Approach and methods

Analogous with the previous case study, I adopted a Foucauldian-informed interpretive discursive approach to explore the meaning of physiotherapist non-medical prescribing for the communities interpreting it (Yanow 2000), and the network of relations shaping and constituting prescribing practices. As highlighted at the end of Chapter 6, interpretive policy analysis provides a way to gain insight into the contextual specificity of policy implementation. The identification and analysis of policy relevant symbolic languages, objects and acts and their inter-relations, enables the circulating discourses within the field of study to be located.

7.2.1 Ethical approval

Ethical approval to conduct the study was granted by the East of Scotland Research Ethics Service committee (Appendix H) and the project was registered with the relevant research governance office. The lead physiotherapist at the study site facilitated access to potential participants and provided information about processes and people. Physiotherapists holding a qualification in supplementary prescribing for at least six months' duration at the time of recruitment were eligible to participate in the study and were sent (via the lead physiotherapist) a letter of invitation (Appendix I) and a participant information leaflet (Appendix J). Additionally, healthcare professionals (identified by the lead physiotherapist) involved in local non-medical prescribing policy and the practice of the physiotherapists, as well as healthcare professionals involved in national policy and practice, were invited to participate.

The unit of analysis was physiotherapist non-medical prescribing practice. Five physiotherapists agreed to participate in the research and consented to observation of their working practices and a semi-structured interview (Appendix K). Patients were invited to participate in the study on arrival at the service on the day of their visit, and permissions to observe and audio-record clinic interactions and consultations between the physiotherapists and patients (Appendix L), and physiotherapists and other health professionals were obtained prior to appointments (Appendix M). Additionally, a number of healthcare professionals involved in local and national physiotherapist non-medical prescribing policy and practice were invited to interview (Appendix N). Organisational and participant confidentiality was assured.

7.2.2 Evidence collection and sources

The ethnographically informed methods used to gather evidence in this study included observations of participants working practices, in addition to qualitative interviews and the collection of documents. Participant observations were undertaken during a four-week period in

the summer of 2014. Eight general musculoskeletal triage clinics (incorporating consultations with patients with a wide range of musculoskeletal conditions), two spinal triage clinics (in which patients with spinal pain and pathology were seen) and one elective orthopaedic sub-specialty surgical outpatient clinic (in which one of the physiotherapists worked alongside a consultant orthopaedic surgeon with a specialist interest in knee pain) were observed. This resulted in forty-six audio-recordings of physiotherapist-patient consultations (average duration twenty-three minutes) and associated field notes.[9] Informal conversations with the physiotherapists before or after clinic, while waiting for patients during clinic or during coffee breaks, were also captured via audio-recording and/or field notes.

Eleven semi-structured face-to-face interviews with professional staff associated with the case study site were conducted, including: the five participating physiotherapists [PT1 – 5], four orthopaedic consultants (one general non-operating [S1] and three subspecialty-operating surgeons [S2 – 4]), one pharmacist [P] and one senior manager [M]. In addition, one allied health professional [AHP] involved in national non-medical prescribing policy was interviewed. Interviews took place between June and November 2014 and lasted between 30 and 113 minutes (average duration 73 minutes). The interview topic guides (Appendices O and P) were piloted with two health professionals working in the NHS, a doctor in general practice and a physiotherapist non-medical prescriber, both of whom had an interest in, and experience of, the use of medicines in the management of people with musculoskeletal disorders. The pilot interviews were not included in the analysis but provided sensitising information that informed the study. All audio-recordings were transcribed verbatim and the transcripts supplemented with contemporaneous field notes. Finally, national and local non-medical prescribing policy documents and local Trust and service documents (some of which were publically available and a number of which were shared in confidence) were collected.

7.2.3   Data analysis and interpretation

Evidence (including documents [D, 1 – 13], transcripts from interviews [I, 1 – 12], non-participant observations [Obs, 1 – 46] and informal conversations [IC]) were imported into NVivo 10 (QRS International) for organising and coding. Throughout and following evidence gathering, preliminary ideas were generated through an iterative process of reading data and drawing on relevant literature. In a similar manner to the first case study, initial coding was undertaken line-by-line, adopting Charmaz's (2006 p48) notion of coding data as actions. This was followed by uncovering the symbolic policy artifacts within the data (Yanow 2000) and mapping the

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[9] One patient declined participation in the study. I therefore sat out of the room during the consultation.

interconnections between acts, objects and languages. I subsequently identified the circulating discourses and examined them in the light of physiotherapist prescribing practices, drawing on the key policy rationalities of increasing patient access to new medicines and medicines advice (DoH 1999, 2009a).

My analysis was influenced by Foucault's conceptualisation of *governmentality* (Foucault 1978) which can be broadly understood as the techniques and procedures for directing human behaviour towards specific ends (Rose et al. 2006). Of concern are the specific conditions under which institutional practices emerge, endure and transform (Dean 2010 p31). These can be unveiled through a focus on the technologies of government that shape human conduct and locate subjects and objects within 'a field of action' (Foucault 1988; Dean 2010; Wagenaar 2011 p127). The form of the data enabled me to not only hear how the physiotherapists were being directed in their conduct, but to see and feel how their practices were shaped by techniques of discipline and of the self. Governmentality therefore offered me a way of understanding *how* physiotherapist non-medical prescribing is '*acted into being*' (Wagenaar 2011 p126), and the effect of policy in practice.

Dreyfus and Rabinow (1983) propose that only those that share the actor's involvement but distance themselves from it can attain interpretive understanding. My own experiences as a non-medical prescriber within the NHS had illuminated some of the issues pertinent to my study. I had experienced barriers surrounding authorisation to prescribe and was aware that local Trust policy was sometimes at odds with national prescribing policy. I anticipated some commonality of practice between myself and the non-medical prescribers I was planning to observe. Thus, my preconceptions on approaching the study were founded in my understanding of the contingent nature of prescribing practice within the workplace setting.

In the following section, I present the findings from the case study. I begin by introducing the national and local policy context in which the physiotherapists were working as non-medical prescribers at the time of data collection. Subsequently, I describe the physiotherapists' prescribing practices before moving on to analyse the discourses and extra-discursive elements forming the grid of intelligibility governing physiotherapist prescribing of medicines.

7.3 Findings

7.3.1 The national and local policy background

At the time of data collection, the five physiotherapists were employed by Central NHS Foundation Trust (Central),[10] an integrated care organisation providing community and hospital-based services. Central had become an integrated organisation in 2011 following the merger of the town's primary care provider services with the secondary care hospital-based services delivered by the acute Trust. This merger had resulted from the Department of Health's *Transforming Community Services* programme (DoH 2009b) and was one of a number that took place between 2009 and 2012 (Collins 2015). The purpose of the *Transforming Community Services* programme was to drive up standards of commissioning through the separation of provider and purchaser arms, and reshape the future provision of healthcare through new patterns of organisation and delivery of community services (DoH 2009b; Ham and de Silva 2009). The policy change offered the possibility of reaffirming the position of community services within the NHS, aligning provision of care to meet the increasing challenges posed by the growing number of people living with long-term conditions, and economic gains from a reduction in overall management and back office costs, rationalising provision of services and reducing hospital admissions (Fulop et al. 2002; DoH 2008; Imison 2009; West 2010). One director and senior surgeon at the hospital recalled the acute Trust's enthusiasm for the merger:

> *we were very keen to acquire them I suppose …we thought it was vital to the long-term sustainability of this organisation and would be to the benefits of the population of [the town]. [I, S2]*

Potential opportunities cited included …*reducing lengths of stay and bed days and keeping people out of hospital and in the community [I, S2]*. However, the community service staff viewed the merger less favourably and perceived cultural divergence as a stumbling block to integration:

> *I was nervous …we would go with the hospital setting because it was very much driven by a medical model and I was very used to being in a primary care setting where it had a can-do, will-do philosophy. [I, PT1]*

Accompanying the formation of Central was the amalgamation of services, one of which was the community-based orthopaedic CATS with the hospital-based orthopaedic elective and trauma service. The CATS staff, including the five physiotherapists, two non-operating general

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[10] Pseudonym.

orthopaedic consultants and health assessment nurses, joined eleven sub-specialty operating orthopaedic consultants, their trainees and other outpatient staff from the hospital to form a *new orthopaedic service,* delivering elective outpatient care from a new-build health centre in the middle of the town [D, 1].

Historically these two services had operated relatively independently, in part for reasons related to the enactment of national policy to divert work away from acute Trusts into the community (DoH 2006c; King's Fund 2006). The town's CATS had been established to help meet the 18-week RTT, and in light of the fact that *there was stuff going through to orthopaedics that wasn't necessarily resulting in surgery [I, M]*. Its remit was to provide specialist orthopaedic assessment, diagnosis and treatment planning *for the cohort of patients previously referred to a hospital based outpatient Orthopaedic Department [D, 2]*, effectively acting as a gatekeeper to secondary care. One community orthopaedic consultant recalled the effect of the CATS gatekeeping role on referrals to the orthopaedic service at the acute Trust:

> *…for every 100 patents we saw …80% we could treat …in primary care; of the 20% who needed surgery, half were unfit or did not want surgery …[of the] 10% that would benefit, only half of that was actually delivered [at the hospital]. So for the orthopaedic department at the hospital, their referrals fell from one hundred to five …[I, S1]*

Moving health services away from acute hospitals is potentially destabilising for acute trusts (National Primary Care Research and Development Centre and Health Economics Facility 2007). For the hospital orthopaedic service, the CATS had presented *challenges [I, S2]*, as *orthopaedic services at the Trust were facing depleting referrals due to ICATs and independent treatment centres [D, 3]*. While this had, on occasions, resulted in tensions between acute and community workers, for a number of the acute consultants, configuring services in this way was an appropriate use of NHS resources, as one surgeon described:

> *…initially I would be seeing 10 new patients and operating on two of them …now I'm seeing 10 new patients and operating on eight of them …so I'm not seeing stuff that I don't really need to …instead of the surgeon being the triage, somebody else in the middle will be the triage and the surgeon will be a little bit higher up the pecking order …doing …what nobody else can do, i.e. the operations. [I, S3]*

7.3.2 A 'new' elective orthopaedic service

Merging elective orthopaedic services offered an opportunity to design integrated end-to-end care pathways for people with musculoskeletal conditions and *remove at least one of*

the …interfaces that …get in the way of smooth and efficient patient care [I, S2], which, one acute consultant suggested, would now be all the easier because *…if you're in the same organisation then there's only one point of view [I, S3]*. The new elective service, led by an orthopaedic consultant from the acute Trust, was launched in 2012. Referrals to the service were triaged into surgical, non-surgical and general patient streams to match the skills of the service's workforce, and were planned to run in parallel to make it *easy for patients to move pathways quickly when necessary [D,1]*. The acute consultants and their trainees worked in elective surgical outpatient clinics seeing patients likely to need an operation, while the physiotherapists predominantly worked in general triage clinics, seeing patients likely to need non-operative treatment. One physiotherapist undertook sub-specialty spinal clinics, referring patients to a nearby Trust for surgery if necessary since Central did not have an operating spinal surgeon.

The physiotherapists' work in the general musculoskeletal and spinal outpatient clinics was similar to their work in the CATS and included using medicines to help people in the management of their musculoskeletal conditions. However, one physiotherapist perceived that the cohort of patients attending the clinics since integration had altered: *we get them more acutely I would say, and we get more that are borderline surgery or need further investigations [I, PT3]*. For patients in whom surgery or a surgical opinion was considered appropriate, the physiotherapists listed directly or referred via letter to the acute consultants, while for patients undergoing conservative management, they offered advice about exercise and self-management strategies, referral to other services such as physiotherapy or podiatry, therapeutic injections and medicines optimisation and/or prescriptions.

7.3.3   Physiotherapists' prescribing practices

The physiotherapists prescribing practices were based around a P formulary of eleven medicines, nine for the treatment of pain associated with musculoskeletal conditions, one gastro-protective agent for use in conjunction with a non-steroidal anti-inflammatory drug, and one benzodiazepine – Temazepam [D, 4]. The P formulary had been developed during the physiotherapists' time in the CATS when opportunities to train as non-medical prescribers had been made available to support a key remit of their role, *…to make sure all sensible, conservative measures had been tried before the patient was referred onto surgery [I, PT1]*. Prescribing had been embedded within the physiotherapists' competency framework [D, 5], seen as something that should be in their …*toolbox of things to do [I, PT5]* and valued for its contribution to the care provided for people with musculoskeletal disorders: *so …just a knowledge of medicines and their interactions and their …contribution to the orthopaedic symptoms have been a big advancement in delivering these services [I, S1]*.

In the new elective service, physiotherapist prescribing practices remained crucial in diverting people away from orthopaedic surgery. One physiotherapist stated:

> … *if it's something simple like an OA knee pain, you can't really suggest major surgery …if they've not given themselves an adequate trial of pain relief. [I, PT2]*

Helping patients decide about future management for their musculoskeletal conditions involved informing patients about the relative risks of different treatments:

> *So Paracetamol is generally safe, Codeine generally safe but with some side effects. If they're relying on anti-inflammatories and they've got some cardiac risk factors or a history of gastric ulcers … perhaps they shouldn't. [I, PT2]*

and offering a range of treatment options:

> **Patient:** *So, I was thinking a knee replacement …would just sort it. …What I didn't realise was that I wouldn't get full movement and I wouldn't be able to kneel, because they're the two problems …*
>
> **Physiotherapist:** *In your case, you don't have to have an operation …there are other things. …You could …take more medication; you could try more physio; you could lose some weight; and you could wait and see.*
>
> [Obs, 14]

7.3.4 Increasing access to medicines optimisation

Medicines optimisation is recommended as routine practice during consultations with patients (Royal Pharmaceutical Society 2013) because between 30% and 50% of people do not take their medicines as directed, and one third of patients are known to be non-adherent to their medicine by day ten of a new prescription (WHO 2003; Barber et al. 2004; Cramer 2004). The physiotherapists shared this view of the need for optimisation: *…most people aren't taking it as prescribed; I think it just all sits …in a cupboard …but the GP thinks that they are on all …this [I, PT5]*. As a result, engaging patients in dialogue about their medicines was a key focus of physiotherapist-patient interactions:

> *I think what I'm mainly doing is looking at the way they're taking their medication, and making sure that they're taking it properly and if they're not …then doing very simple things to rectify that. [I, PT5]*

The *simple things* that the physiotherapists did were seen to sometimes make *the biggest difference [I, P]*; these included explaining to and advising patients about how to use their pain medicines as a means to improve their health outcomes:

> **Physiotherapist:** *Ok …so that tablet that you've got is a split of both Codeine and Paracetamol …now, I'm happy with you taking one [Co-codamol] because that means you're …getting a lesser dose of Codeine …but if you only take one you're taking below the therapeutic dose of Paracetamol.*
>
> **Patient:** *Aaahh! Right, OK.*
>
> **Physiotherapist:** *So I'm happy that you only take one, but always have [one] Paracetamol with it as well.*
>
> [Obs, 32]

and to maximize engagement in self-management and with physiotherapy treatment strategies, and avoid harm from inappropriate use:

> **Physiotherapist:** *Ok. Let's stop your Ibuprofen, it's probably not helping you and it's putting you at risk. Co-codamol – your maximum is eight …so you can't exceed eight.*
>
> [Obs, 6]

7.3.5   Increasing access to new medicines

Contiguous with medicines optimisation is increasing access to new medicines. The Allied Health Professions Prescribing and Medicines Supply Mechanisms Scoping Project Board argued that extending physiotherapist prescribing would enable the profession to provide holistic management for patients, as practitioners would be able to address patients' diagnostic, physical and medicines needs (DoH 2009a). However, for many of the patients attending the elective orthopaedic service, prescribing for their musculoskeletal problem had already been initiated in general practice, thereby curtailing the need to issue a script, as most of the time people had *already got one …[I, PT2]*. As a result, prescribing a new medicine was a relatively infrequent practice for the physiotherapists - *…oh, probably no more than one a month, really [I, PT2]* – but was nonetheless perceived as a task that fell within their jurisdiction:

> *…it's wrong to send them [patients] back to the GP to have a prescription done when they've come for an orthopaedic appointment …we should be dealing with that if pain is their problem. [I, PT3]*

When physiotherapist prescribing of a new medicine did take place, easy access to the health centre's pharmacy on the ground floor enabled a one-stop service model:

> *Her sleep …and her work is …affected by pain …so …we …agreed on Amitriptyline …10mg for about three days …increasing to 20mg if she needs to …[so she's] gone down to the pharmacy and got it. [IC, PT1]*

This was valued by the physiotherapists for its contribution to convenient and timely patient care: …*it's great they don't have to go back to the GP, because otherwise they do wait weeks to get a GP appointment [I, PT4]*. But working within the new orthopaedic service had brought a change to the physiotherapists' prescribing of new medicines. Some physiotherapists perceived that integration had affected the number of prescriptions written: …*to actually prescribe a medicine, I think that has dropped …it's been more difficult the last two years since we moved [I, PT4]*.

In the following section, I explore the grid of intelligibility governing physiotherapist prescribing of new medicines through the policy-related symbolic artifacts holding meaning for the communities at Central. My findings centre on a number of key acts [A] that reconfigured the division of labour within the new elective service and thereby changed the physiotherapists' established ways of working. Entwined with these acts are specific policy-related objects [O] and languages [L], suffused with meaning for the communities interpreting them.

7.3.5.1 Getting authorisation to prescribe [A]

Individualised patient CMPs form the capstone of supplementary prescribing (DoH 1999; 2005a) and need to be agreed by the patient, the supplementary prescriber and an independent prescriber prior to prescribing taking place (DoH 2005a), a process that the physiotherapists had found relatively easy when they worked in the CATS. Following integration, however, gaining authorisation to prescribe became more difficult, as one physiotherapist explained:

> *…it's becoming an increasing problem, because at one point we worked with two orthopaedic consultants who worked full time; we were all in the same building on the same floor …and they were accessible …you could leave your room, knock on another room and discuss the case and ask for the CMP to be signed …instantaneous really. [I, PT2]*

While the number of doctors potentially now available to the physiotherapists had increased as a result of integration, strong organisational and cultural divisions between the acute and

community workers pervaded the new service and resulted in a bit of an 'us and them' type situation that constrained action:

> *…obviously …we were PCT and [they were] Trust, and now we've integrated they were never brought on board with that [prescribing]. [I, PT4]*

Physiotherapist observations of the acute consultants' working practices had impressed on them that prescribing was not a task that they commonly undertook: …*the orthopaedic consultants …they don't really mention medication [I, PT5]*. One consultant explained that this was because people attending the service for an orthopaedic opinion would …*have gone through all …that [I, S4]*. Thus, for the acute consultants, prescribing analgesic medicines for patients in the elective service in the absence of a surgical intervention was the jurisdiction of the patients' general practitioner: …*by offloading a lot of the practice to GPs …we're not really involved in that [I, S4]*. Analysing these data suggested that these ways of describing work practices around prescribing could be considered as a *language of disconnect* [L]. This disconnect between the acute consultants and the physiotherapists about prescribing practices permeated the service and inhibited engagement. This behaviour also aligned with cognitions about which professional should be managing patients with non-surgical musculoskeletal conditions, notably that …*the GPs the best place to manage that patient longer term [I, S2]*.

Physiotherapist awareness of this perspective led to a reticence to engage the acute consultants in conversation about prescribing developments: *I would be worried …because I've heard them say …we don't need …any of our nurses to prescribe [I, PT1]*. This concern was not without some foundation: …*I am not sure that it would greatly disadvantage patients if they [the physiotherapists] didn't [prescribe] [I, S2]*. In addition, perceptions about the acute consultant's knowledge of prescribing for people with spinal pain was a barrier to engagement for one physiotherapist, as asking for authorisation to prescribe would have been *fudging the system* [as] …*they don't know the conditions well … [IC, PT1 Fieldnotes]*. For another physiotherapist, the obstacles to authorisation of a CMP by one of the acute consultants were far more tangible:

> *...the thing is, they [the acute consultants] are quite busy, [the] door is closed ...they don't encourage people to knock on the door …[so] you've just got to wait ...in a corridor ...outside a closed door …it's just not an appropriate system. [I, PT2]*

The phenomenon of 'waiting outside the door' has been noted elsewhere in the literature. It is commonly associated with supplementary prescribing (Hales et al. 2010), although Kroezen et al. (2014a) observed frequent 'hanging around' by independent nurse prescribers wishing to discuss issues with physicians prior to prescribing, despite their autonomous legal status. Regular

informal interactions with physicians about prescribing are highly valued by non-medical prescribers (Stenner et al. 2010; Kroezen et al. 2014a) and the existence of a supportive doctor-non-medical prescriber relationship, based on trust, has been identified as a key variable in the success of the initiative (Avery et al. 2007; Stenner and Courtenay 2008). My knowledge of this research led me to examine my data for evidence of these interactions. However, relations of this nature with the acute consultants were largely absent at Central:

> *I've never thought of going to him as …a mentor …he has nothing to do with my*
>
> *prescribing. [I, PT4]*

and authorisation for physiotherapist prescribing remained by and large with one community consultant, as he was seen as …*the only person who will really sign it off [I, PT5]*. But integration and the move to the new health centre had restricted proximity to this doctor, as one physiotherapist described:

> *[The community consultant] has dropped his hours significantly …he does all his*
>
> *[speciality] clinics in a different building …and he's our main …go-to guy for all our*
>
> *clinical problems …so I've got six clinics a week [and] the only time I'm in clinic jointly*
>
> *with him is on a Monday morning. [I, PT2]*

Access to doctors to authorise CMPs has been identified as a major obstacle to supplementary prescribing (Weiss et al. 2006; Courtenay and Carey 2008), in particular when supplementary and medical independent prescribers are not co-located (DoH 2009a). While transgressions in the use of CMPs have been reported in the literature, with doctors signing off retrospectively (Weiss et al. 2006), this was not something that the physiotherapists at Central countenanced – …*I'm not willing to issue a prescription unless I've got …consent [I, PT5]* – even though one physiotherapist recognised the futility of this act:

> *…I stick a form in a pigeon hole and it gets signed and comes back to me …for some*
>
> *reason that makes me feel better… even though we haven't actually discussed it. [I, PT5]*

As a result, to counter reduced access, a new system for authorising prescriptions was developed. Now, the physiotherapists telephoned the community consultant to discuss the case and gain authorisation. Although this worked well for some, others found the process disruptive and time consuming:

> *…you have to go out of the room …you're trying to get hold of him …if he's got a patient*
>
> *he can't always speak to you and the clock's ticking all the time. [I, PT4]*

This led to non-prescribing and the re-direction of prescribing work to the GP: *[It's] easier to say ...I'll mention that to your GP in my letter…[I, PT5]*. Similarly, non-prescribing was the norm when the community consultant was away from Central, as was noted during one observation:

> *The physiotherapist tells me she will not be able to prescribe today as the community orthopaedic consultant is on holiday. She puts the prescribing pad back in her drawer and locks it before heading to clinic. [IC, PT1 Field notes]*

The loss of medical hours within the non-surgical arm of the service is traceable to a symbolic object, *a notification from Monitor* [O], the independent regulator of Foundation Trusts. Shortly after integration Central failed to meet two key performance targets: the 18-week RTT (admitted) and the A&E 4-hour wait. This had prompted the Primary Care Trust to raise its concerns with the regulator [D, 6] who subsequently informed the Trust that it was in *significant breach* of the terms of its Authorisation and required the Trust to report regularly on progress [D, 7]. But managing the operational performance problems of the new organisation caused other difficulties, as one senior surgeon stated:

> *...we threw money at it, at those operational things, which then caused us to tip over financially. I don't think we had as clear a financial grip, and it was as a consequence of merging two finance departments, two information departments, restructuring the divisions [...]. A financial black hole appeared really. We spent money we thought we had, but didn't have. [I, S2]*

The fiscal position of the Trust became increasingly difficult and, as a consequence, Central implemented a cost savings plan, from which *no department* [was] *immune [D, 9]*. For the orthopaedic department, this resulted in workforce reconfiguration and, despite improvements in processes, procurement and efficiency, a restructuring to rid the elective service of *…excess out-patient capacity.* This led to losses within the non-surgical arm of the service that included community consultant hours [D, 9].

7.3.5.2 Moving into fracture clinic [A]

The excess capacity in the non-surgical arm of the new service came to light as a result of *a capacity and demand evaluation [D, 10]*. To mitigate, several of the physiotherapists *moved into fracture clinic* [A] to help manage the Trust's historically large low-level trauma workload, that *absolutely swamped* …[I, S3] the service. Fracture clinic work is the bread and butter of orthopaedics and was perceived to be …*well within the remit of [the physiotherapists] [I, S3]*. One acute consultant explained:

> *Most of the stuff we see in fracture clinic is relatively minor stuff …needs a bit of time in*
> *a splint or a plaster …and it gets better …so it doesn't matter who sees the patient,*
> *almost. [I, S3]*

Subsequently, embedding a physiotherapist training post within the fracture clinic assuaged
pressure on the medical workforce: *…they [the fracture clinics] are a lot smaller …I would*
imagine …a consultant …used to see 35 to 40 patients personally …and now they see 20 …[I, S2],
and alleviated some of the incertitude associated with medical trainees:

> *…with junior doctors changing every six …or twelve months, having them [the*
> *physiotherapists] in clinic just gave that continuity of care if I was away or something. [I,*
> *S4]*

Having a stable physiotherapist presence in fracture clinic benefitted both professions. For the
senior surgical trainees it contributed to career development opportunities:

> *So some of our registrars, the senior ones in particular, we tried to pull them out of*
> *fracture clinics, doing routine, lower-level stuff, to doing …more operating and …making*
> *their CV a bit more up to spec in time for their consultant appointment. …So if we can*
> *offer that to them …people want to come. [I, S3]*

and for the physiotherapists, a new area of work in which to advance practice, including non-
medical prescribing:

> *…we're kind of on the registrar rota …so assessing whatever comes through …new*
> *fractures or follow ups …deciding on the management plan …ordering investigations and*
> *referring on for surgery …[and prescribing] maybe once a fortnight [for] the ones that*
> *aren't really coping with the analgesia they're on. [I, PT3]*

Within fracture clinic, being able to prescribe medicines was …*a handy thing [I, S3]*, valued by the
surgeons for its contribution for the treatment of acute conditions: *For me its post op pain and*
post trauma pain …you can't say 'Go and see your GP', it would be terrible to do that [sic] [I, S2].
As a consequence, having prescribing skills in fracture clinic was seen as necessary for the role:
The [physiotherapists] …need to be able to prescribe analgesics …because you are dealing with
acute painful conditions …[I, S2]. However, openings to develop prescribing practices in the
management of trauma were not available to all. A plan for a rotational training post stalled:

> *Twelve months came and went, and then it got to two years and still nobody has rotated*
> *in …maybe the surgeons …got comfy with the clinicians …because …why train anybody*
> *up when we've got two that are working quite nicely …*[I, PT4]

Despite curbed opportunities to work within the fracture clinic, the tacit knowledge embodied in the routine practices of the hospital transcended the cultural boundary between the acute and community work spaces and facilitated resolution of another challenge to physiotherapist prescribing of medicines, namely the lack of *the right prescribing pad* [O]. A prescription pad is an essential tool within the legal and organisational framework of prescribing, and the importance of using the correct prescription pad relates to cost. First, by using hospital outpatient prescriptions a dispensing fee is avoided, and second, the use of hospital prescriptions at Central allowed real-time surveillance of prescribing of medicines, as the service pharmacist explained:

> *so …with the hospital outpatient prescriptions, if it's a non-formulary item [we] would ring the specialist pharmacist attached to that area to find out is this allowed …if it's not then …we'd …go back to the prescriber and say …why are you using this? [I, P]*

However, in the period following integration generating prescriptions was frustrated, as one physiotherapist recounted:

> *We moved building, physically moved buildings, and employer …and we were never issued with any other forms. Then we were issued with some pink forms, but they were still PCT forms …and we debated could we use those as we don't work for the PCT …we weren't sure what to do. So for a full 12-month period I did not issue a single prescription, and to my knowledge none of my mates did either. [I, PT2]*

Delays in newly qualified prescribers receiving pads have been reported (Hall et al. 2006; George et al. 2006; Courtenay et al. 2007) and are commonly resolved at institutional level. In this case, however, it was the physiotherapist working in fracture clinic who acted as the conduit for organisation-specific knowledge to pass across the boundary between the acute and the community setting:

When Anne[11] was working in fracture clinic she said 'Oh, I just write these out …the hospital prescriptions, A4 pads, duplicate copy, rip it off' …[so] I wrote a prescription …and the patient went to our pharmacy and no one's ever come back. [I, PT2]

7.3.5.3 Doing the elective surgical work [A]

In addition to working in the hospital fracture clinic, some of the physiotherapists also moved to work alongside the acute consultants in their elective surgical outpatient clinics [A]. The rationale for this act was …*because the 18-week targets weren't being met [I, PT4]*, and it was underpinned

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[11] Pseudonym.

by the acute consultants' belief that …*if they [the physiotherapists] embedded in our …clinics we could see more patients …and speed up the time … [1, S4]*. A *language of 18-weeks* [L], impelled by Monitor's requirement that the Trust report regularly on its progress towards delivery of the target, circulated within the new elective service and led to orthopaedic staff involvement in weekly service manager meetings …*where they look at things like 18 weeks very closely [I, PT1].*

Monitoring the 18-week RTT had been familiar practice for the physiotherapists when they worked in the CATS:

> *week to week …you'd be presented with a list of your patients, and they'd all be colour coded …if your patients were in green that meant that you were hitting targets …if they were amber then they were close. [I, PT5]*

and resulted in desirable behaviour change among workers, as one manager observed: …*once they saw the status at a glance …the clinicians …started to take ownership … "I'll flex, I'll do another" [I, M]*, a practice that aligned well with the rapid access ethos of the community service:

> *…what we were doing [was] trying to work …patients up quickly …so that they could get to the surgeons and …had plenty of time to hit their 18-weeks. [I, PT1]*

The physiotherapists' strong connection with the 18-week target was expressed by one physiotherapist as being …*in our core [IC, PT1]*. It guided service transformation and had led to doing …*all sorts of things to get everything lean*, including embedding medicines advice within service outcome sheets to *stop the 18-week clock [D, 11]*, and using medicines to facilitate the rapid throughput of patients needing MRI scanning: …*so to give Temazepam, two tablets the night before and then an hour before, really streamlined that system [I, PT1].*

However, in the new elective service, although monitoring of the 18-week RTT was ongoing, it had in some ways become more remote for the physiotherapists: …*we don't really get the data …that we used to, …* in part, due to a greater emphasis on the latter end of the pathway because of …*issues …getting into surge*ry *[I, PT1]*. Despite this, the target continued to govern physiotherapist practices from a distance.

One approach to minimise delay in the pathway was to match the right patient with the right practitioner at the right time, an activity influenced by *Triage Rules* [O], a symbolic object developed by the acute consultants. The *Triage Rules* guided patients to *an appointment with a surgeon and not a generalist* in the presence of certain criteria [D, 12], but they were ambiguous in their effect, due to inherent difficulties in triaging from a referral letter:

Physiotherapist: *His diagnosis was that he had a meniscal tear …whoever has seen him and scanned him has clearly made that decision …I wouldn't have scanned him …never mind sent him through …*

Intv: *Who did the scan?*

Physiotherapist: *Erm …GP, and then because he has been sent through as a meniscal tear with a positive scan he has been triaged directly to surgery, so …[pause] well yeah*

[IC, PT4]

In addition, primary care providers and GPs could access the acute consultants directly through …*a kind of NHS service at the …private hospital down the road…[I, S1]*, which led to a feeling among the physiotherapists that the acute consultants were *seeing cases that they should never see [I, PT1]*.

Despite the ubiquity of patients in the 'wrong' clinic, the physiotherapists perceived the work in the elective surgical clinics differently to that in the general triage clinics. One acute consultant described the nature of the tasks: *The decision making is …about is this patient a surgical candidate …seeing people post op …dealing with complications …higher level stuff that we're used to dealing with as consultants and our senior team [sic] [I, S3]*. In this setting, prescribing a new medicine was a practice that happened *not very often at all [I, PT3]*, shaped by a number of organisational and individual factors. One physiotherapist found the pace of the elective surgical clinics constrained any idea of prescribing: …*it's all so fast and furious …the nurses are pushing 'em through the door at you and they're …mainly surgical* […] *the thought of trying to undertake that in that clinic would be a nightmare [sic] [I, PT4]*. For another physiotherapist, the different configuration of working spaces and the distribution of workers in the surgical outpatient clinics led to the adoption of more traditional prescribing conformations, including getting the doctor to sign a script:

> …*there could be two or three doctors in the same room as me …might as well get a doctor to sign the prescription …[I, PT2]*

and non-prescribing, that aligned with the acute consultants' way of working:

> …*a young lad I listed for a scope of his knee … said I've run out of Co-codamol. I said … you'll have to see your GP, 'cos I know that's what [the acute consultant] would have said … [I, PT2]*

Isomorphism is common in organisations and leads to a homogeneity of approach (DiMaggio and Powell 1983). For example, Mizrachi et al. (2005) observed various isomorphic practices

undertaken by practitioners of complementary medicine when interfacing with practitioners from a more biomedical background in a hospital in Israel. To gain legitimacy and acceptance from the dominant biomedical practitioner group, practitioners of alternative medicine took on biomedical behaviours even though these contrasted with their own holistic beliefs about patient care (Mizrachi et al. 2005). In this case study, physiotherapist isomorphic behaviour was governed by normative orthopaedic surgical practices and prompted in its expression by uncertainty over prescribing practices:

> *What am I supposed to do? Am I required to write prescriptions for …patients, or should I send every one of them back to their GP? Should I do what the consultants do? Should I not really enter into prescribing at all? [I, PT2]*

The move of the physiotherapists into the elective surgical clinics *probably reduced everyone's capacity [to do work in the general triage clinics] by …15% … [I, PT2]* and impacted on another act ingrained in the framework of prescribing medicines – the act of following up patients.

7.3.5.4   Following up patients [A]

Reviewing patients to assess the efficacy and safety of a prescribed new medicine is intrinsic to medicine's optimisation and was recommended practice during the physiotherapists' non-medical prescribing training: *We were asked to prescribe and review …by the university … [IC, PT1 Fieldnotes]*. While this was a practice evident in the work of the physiotherapist undertaking the subspecialist spinal clinics:

> *…on top of her 4g of Paracetamol …I've added …Pregabalin 75mg, one at night. Ideally …it would be bd ...but she's very very slight ...[and] she's had a response before to 75mg …so I'll see her again in two weeks. [IC, PT1]*

following up patients in whom prescribing had been initiated caused difficulties for another physiotherapist working in the general triage clinics: *…my follow-up slots are very scant, I only have two a week …[I, PT4]*. This led to clinics being overbooked *…because I've been prescribing for patients that you want to review [I, PT4]*. However, this was not however a universal problem for the physiotherapists, as one physiotherapist found that non-prescribing worked well alongside a limited number of follow up appointments:

> *it's not a problem for me only having one follow-up a week [IC, PT3] …most of my patients I only see once because …if there's not any orthopaedic intervention I usually ring them …so if I'm never going to see them again I write to the GP and ask them to do their meds review [sic]. [I, PT3]*

In their study of district nurse independent prescribers Downer and Shepherd (2010) identified that prescribing a new medicine was perceived by some nurses as adding to their workload due to the need to follow up patients. Similarly, one physiotherapist said they wanted *some prescribing time built into the system [I, PT4]* so that they could utilise the skills learnt, but regretted that target pressures meant that the service manager was *…not happy to give …more follow up appointments [IC, PT4 Fieldnotes].* Because of difficulties reviewing patients, prescribing work was sometimes re-directed to the service pharmacist, who explained:

> *…a lot of the neuropathic agents patients are referred to me …I think they [the physiotherapists] perhaps feel that it's easier for me to see that patient … because …I can see them and …follow them up [sic]. [I, P].*

Thus non-prescribing for patients by the physiotherapists again aligned with the jurisdictional beliefs of the acute consultants, as one surgeon stated: *I don't go round prescribing Gabapentin, or Amitriptyline* [drugs commonly used in the treatment of neuropathic pain] *…*[the physiotherapists would] *be mad if they did [I, S4].*

7.3.5.5   Starting a spinal pathway [A]

The final act on which this case study converges was the instigation of a spinal pathway within the orthopaedic service at Central. Akin to the move of the physiotherapists into the fracture and elective surgical outpatient clinics, starting a spinal pathway [D, 13] also effected a reconfiguration of the division of labour within the service, although on this occasion it was initiated not by the acute consultants, but by the physiotherapist with a sub-specialism in spinal pain. The purpose of the pathway was to direct urgent patients attending general practice, the emergency department and/or who were admitted to Central for spinal pain of a non-serious cause, to the non-surgical arm of the service. The motivations behind the pathway were that *…a fifth of …the urgent call-outs from the orthopaedic team to A&E were spines [IC, PT1],* that *…nobody at the hospital does spines [I, PT1],* and that this was work that the physiotherapist thought *could come to us* at the health centre *[IC, PT1].* The community consultant outlined the problem: *…A&E had nobody to send them to …quite often …they end up in the middle of the night, they get seen by a very junior doctor who …admits them and they don't really need to be admitted, so they were blocking beds [I, S1].*

The spinal pathway was very successful in reducing hospital admissions for back pain and added to the portfolio of services offered by the new orthopaedic department. But this redirection of work again accentuated pressures in the non-surgical arm of the service – *…our capacity is quite stretched [so] if I can't get them in …I …overbook …so today I'm overbooked …tomorrow I'm*

overbooked [I, PT1] – and brought a change to the physiotherapist's prescribing practices: *…my complexity of cases has …become more concentrated. …I would get more …simple cases [in the CATS] where it would be very easy to write a prescription … Now, lots of my patients are complex for some reason [I, PT1]*. This shift in the nature of the work caused a greater dependence on the service pharmacist for support, particularly when controlled drugs were present:

Physiotherapist: *…because you've got to the stage …where you're using morphine [Butrans patches] I would like the help of our pharmacist …would you be alright to see … our pharmacist?*

[Obs, 11]

Morphine is a Class A controlled drug, a substance open to abuse, and dangerous in its effects and therefore classified under the 1971 Misuse of Drugs Act and the Misuse of Drugs Regulations 2001 (Monaghan 2014; CSP 2015). As a controlled drug, it is available under a supplementary prescribing mechanism, but was not catalogued on the physiotherapists' CMP as they felt it to be beyond their scope of practice: *If it goes up to Morphine, I absolutely pass it to [the pharmacist] [I, PT1]*. One physiotherapist stated that *you'd have to know what you were doing [I, PT2]* to reduce a patient's dose of morphine, although the pharmacist felt it was the physiotherapist's lack of familiarity with the patches that sometimes led to onward referral:

> *…I think …they are concerned that patients are on really high doses of opiates …when the clinical picture …perhaps says they shouldn't be …but sometimes it's just they're not familiar with the patches and they're actually quite a low patch …in strength, or it might be that they're on it for other pain reasons. [I, P]*

In addition to being available via a supplementary prescribing mechanism, Morphine was indexed on the *list of seven controlled drugs* [O] presented to the Commission of Human Medicines for approval at the same time that a recommendation to take independent prescribing by physiotherapists forward was being sought [D, 13]. But the list of seven controlled drug excluded two medicines used most frequently by the physiotherapists. This was *…a bit of a backwards turn … [I, PT4]*, as one physiotherapist explained:

> *So the major ones that we prescribe …Co-codamol, Codeine phosphate …we won't be able to …[so] it's going to have to be a supplementary prescribing role rather than independent. [I, PT4]*

The omission of Codeine, a Class B controlled drug commonly used in the management of pain, was explained by an allied health professional involved in the proposals for independent prescribing by physiotherapists:

…it's fair to say that we exercised a cautious approach …for fear that to ask for too much might jeopardise the whole process … [I, AHP]

Even though independent prescribing was seen by the physiotherapists as a way to *write more prescriptions [I, PT2]*, the disadvantages of 'list based prescribing rights' (Millett 2015) were further illuminated in June 2014, when Tramadol, an analgesic for moderate to severe pain included in the physiotherapists' CMP, was re-classified from a prescription only medicine to a schedule 3 controlled drug, due to safety fears (The Misuse of Drugs Act 1971 (Ketamine etc.) Amendment Order 2014). This further narrowed the drugs available to the physiotherapists via independent prescribing, although for one physiotherapist this was a relief:

…I've never …prescribed it [Tramadol] …I'm …worried …the fact that it's an opioid …addiction and things …[so] I am quite glad it's a controlled drug so I don't need to feel bad about it anymore. [I, PT5]

Recognising the challenges posed by controlled drugs to independent prescribing by physiotherapists, one physiotherapist suggested: *…[we] will need more support …more mentorship really …[particularly] when we get to independent status [I, PT4]*. On-going education and support has been identified as fundamental to non-medical prescribing activity (Otway 2002) and a symbolic *language of prescribing support* [L] circulated within the service. The non-medical prescribing lead at the Trust kept non-medical prescribers *up to date [I, PT5]* and provided an annual non-medical prescribing study day. Aside from this, however, organisational support for the physiotherapists prescribing practices was limited and led to a feeling that a more robust service framework to underpin non-medical prescribing was necessary. Mentorship for the physiotherapists' prescribing practices had originally been given by the community orthopaedic consultants, but in the new elective service there was a perception that this role should transfer to the acute surgeons:*…the [acute] consultants feel that now we're integrated they [the physiotherapists] should go to each consultant for the specific problem …[I, S1]*. The orthopaedic surgeon acting as clinical lead for the service had *wanted to take over the [physiotherapists'] competencies [I, PT1]* with the move of some of the physiotherapists to work in the fracture and elective clinics, and although professional development sessions were still timetabled, there was a sense that the training now available was less useful:

When we were part of the PCT … everything was focused towards our type of area…now...I go to an audit meeting at the hospital and …sit and listen to a talk about paediatric hip fractures that isn't …relevant to me in my job. [I, PT5]

This change in emphasis in training appeared to align with surgeons' ideas about the future role of the physiotherapists within the service, as one acute consultant explained:

> *In my view, they [the physiotherapists] should be in our fracture clinics, elective clinics. Potentially they could have a role on the wards …a role as surgical assistants …so they could really become a major part of …a hip …or …knee unit. [I, S4]*

However, not only was the focus of the education now different, but its frequency was also at risk as a result of on-going service pressures, highlighting the vulnerability of continuing professional development to organisational and economic factors:

> *…they are… cutting …our CPD [Continuing Professional Development] …and …want us to see extra patients in that time […] so we will have a governance meeting for an hour once a month and a joint audit meeting, and then every now and again …they have scheduled in a CPD for us … [IC, PT5]*

Although formal educational sessions are important, it is the informal contact with physicians about prescribing medicines that is valued most by non-medical prescribers (Stenner and Courtenay 2008; Kroezen et al. 2014a). While there was an intention that support for prescribing would be available from the acute consultants – *..we're there, you know. I wouldn't be expecting them to do it in isolation [I, S3]* – it was anticipated that the type of support needed would be predominantly about surgery rather than prescribing:

> *It's difficult to think of a scenario where there would be a difficulty with prescribing per se; it would be more about decision making for surgery …and that's the discussion that they need to have with you rather than should we be prescribing this drug or not. [I, S3]*

Support for the physiotherapists' prescribing came predominantly from the specialist pharmacist: she was the *person you go to if you're not sure [I, PT3]*. She provided feedback about the patients they had referred, *…helping your learning all the time [I, PT3]*. For the physiotherapist doing the spinal work, time with the pharmacist provided opportunities for sharing and developing prescribing knowledge – *…we'll have discussion about shall we increase the Amitriptyline? Shall we add Pregabalin in? [I, PT1]* – and joint sessions had led to some *amazing results [I, PT1]*, although this required either the pharmacist or physiotherapist to *…flex out of our admin …as we don't have a clinic slot like that [I, PT1]*. Pharmacists have been identified as key individuals in supporting other non-medical prescribers (Watterson et al. 2009), but integration also brought changes to the pharmacist's role within the organisation, leading to new perceptions about who should be supporting the physiotherapists with their prescribing practices:

…I don't feel that that's necessarily my role any more …while we were in …the PCT, I was
happy to advise them because I was the only one there for them really …but…now we're
within the wider Trust …there are other people who should be doing that. [I, P]

and led to queries being fielded to the non-medical prescribing lead at the hospital: … *now if they*
ask me certain questions I just refer them back to [the non-medical prescribing lead at the Trust]
[I, P]. One physiotherapist, reflecting on the current situation in Central, summed things up:

I'm not sure…that it [physiotherapist non-medical prescribing] will be going anywhere
within this service, the way it is run now …we need …more follow-up capacity and
prescribing slots, we need …more support mechanisms and governance …and …until
controlled drugs can be signed off by independents then we're going to need support still
in a supplementary role [sic]. [I, PT4]

7.4   Discussion

The findings of this case study bring to the fore a number of key symbolic acts, interwoven with
specific languages and objects that transformed the division of labour between the
physiotherapists and the orthopaedic consultants at Central in the months following service
integration. A change to the act of gaining authorisation to prescribe, a move of some of the
physiotherapists into the fracture clinic and consultant-led elective surgical outpatient clinics, and
the instigation of a new spinal pathway, all changed the physiotherapists established ways of
working.

Organisational mergers are known to cause significant disruption to healthcare services, with
cultural divergence substantially affecting co-working and practice (Fulop 2002; Ferlie et al. 2005;
Fulop et al. 2005). Culture is 'the way things are done around here', and incorporates subjective
and objective dimensions and organisational artifacts that reflect shared beliefs, values and
expectations (Buono et al. 1985). The joining together of the community-based CATS and the
hospital-based orthopaedic service to form a new orthopaedic service, brought to light
contradistinctions in meaning for service professionals, about the nature of the work to be done
with people with musculoskeletal conditions, including prescribing medicines, and the 'correct'
professionals to do it. For the operating orthopaedic surgeons, physiotherapist prescribing
practices were valued for their role in managing the acute work in the fracture clinics, while for
patients with non-surgical musculoskeletal conditions attending the service, prescribing medicines
was perceived to be the jurisdiction of the GP. Conversely, the physiotherapists valued prescribing
medicines for patients attending the nonsurgical arm of the service and perceived this role to fall
within their jurisdiction. Observations of the physiotherapists' work with patients highlighted the

embodiment of medicines optimisation in physiotherapist-patient consultations, constituted through a discourse of 'limiting the surgical work'. This discourse was legitimised by the physiotherapists' previous role in the community CATS and sustained by patients' suboptimal use of prescribed medicines. Juxtaposed was infrequent prescribing of new medicines, confirmed via observations in the workplace and during interviews. Coproducing this 'non'-prescribing were the prescribing habits of other healthcare professionals (for example patients were often on medicines prescribed in general practice at the point of referral), and a miscellany of contiguous discourses and non-discursive elements that formed a grid of intelligibility governing physiotherapist prescribing practices.

7.5   Chapter summary

Previous evaluations of non-medical prescribing have highlighted variability in implementation and practice. Cited barriers to practice include time limits, lack of mentorship and a lack of access to the right prescribing tools. Yet the way in which these factors emerge, intertwine and constitute practice has been sparsely studied. In this case study, I have traced and mapped the flow of social power that structured the field of action for physiotherapist non-medical prescribing within a wider pharmaceutical regime, and unveiled a complex system of relations or as Foucault states 'a highly intricate mosaic' (Foucault 1980d p62). This grid of intelligibility constituted by circulating discourses and extra-discursive elements, and underpinned by techniques of government to conduct the physiotherapists in their prescribing practices forms the basis of Foucault's notion of governmentality. Through this grid, orthopaedic surgery was given primacy and physiotherapist prescribing of medicines was marginalised.

In the final chapter of this thesis I reflect on the grid of intelligibility and the discursive formation emerging through both case studies, in which was situated professional boundary-work.

Chapter 8: Discussion: Power, governmentality and medical hegemony in the division of labour

8.1 Introduction

At the outset of this thesis I set out my primary research aim – to explore *how* the physiotherapy-medical professional boundary is being challenged by NHS workforce modernisation policy, and the effect of this challenge on the division of healthcare professional labour. From this aim, a number of subsidiary objectives followed:

1) At the meso-level of healthcare, to explore a challenge to the physiotherapy-medical professional boundary brought about as a result of national level workforce modernisation policy.

2) At the micro-level of healthcare, to explore a challenge to the physiotherapy-medical professional boundary brought about as a result of locally-enacted workforce modernisation policy.

3) To analyse the historically specific discursive formations emerging from these boundary challenges.

These objectives have been addressed in the preceding chapters of this thesis. In Chapter 5, I investigated a challenge to the physiotherapy-medical professional boundary that took place at the national level of healthcare organisations and professional societies. The boundary disturbance was precipitated by the publication of a national guideline for the management of chronic non-specific low back pain. The data for this study, drawn from NICE policy documents and texts produced by professional bodies and their members, led me to identify a dominant discursive formation encircling CG88, within and through which power was exercised, the guideline resisted and medicine's hegemony in the market place maintained. In Chapter 7, I explored physiotherapist non-medical prescribing in the workplace and the effect of this challenge on the physiotherapy-medical professional boundary. The study was carried out in one musculoskeletal outpatient service in a single NHS Trust in England, and the data were gathered from observations of physiotherapist work practices, interviews with healthcare professional staff, and local and national service and policy documents. My analysis of the data unveiled a grid of intelligibility governing the physiotherapists' prescribing practices; circulating discourses (sustained by techniques of government) and extra-discursive elements, within and through which orthopaedic surgery was given primacy and physiotherapist prescribing of medicines was marginalised in the management of people with musculoskeletal conditions. Underpinning the

analysis in each of these chapters are junctures from the past – specific historical moments and processes informing the rationalities and discursive formations of the present (Tamboukou 1999). In Chapter 2, I considered physiotherapy's professional project across four epochs between the end of the nineteenth century and the start of the twenty-first century, and highlighted a number of processes through which the profession sought to position itself in the market and achieve social status. In Chapter 6 I traced the permutations of the practice of prescribing medicines in England as a component of a pharmaceutical regime, from the sixteenth century up to the granting of independent prescribing to physiotherapists in 2013, illuminating the recurrent contestation for this jurisdiction.

In this final chapter, I reflect on the findings of the empirical studies presented in this thesis and the contribution they make to knowledge about how NHS workforce modernisation policy is challenging the physiotherapy-medical professional boundary. I offer some thoughts about my use of Yanow's steps of interpretive policy analysis as a portal to a Foucauldian-informed discourse analysis, before moving on to consider some of the limitations of this research and the approach that I took to developing trustworthy interpretive accounts. To conclude, I propose a number of areas in which I foresee future scholarly activity.

8.2   Clinical Guideline 88: a boundary challenge at the meso-level

The response of professional organisations and their members to the publication of a UK national guideline for the early management of chronic non-specific low back pain was the focus of my first case study. The guideline recommendations against spinal imaging (except in cases of suspicion of serious spinal pathology or if proceeding to a surgical opinion) and spinal injections, and the perceived exclusion of specialist doctors in pain medicine from the patient pathway, was controversial for some professionals. Notable among those potentially disadvantaged by the guideline were doctors in interventional pain medicine within the British Pain Society and the Royal College of Anaesthetists, who felt threatened by the possible demise of core professional work tasks. A heated debate took place within the BMJ and other web fora, and the associated socio-political events that followed represent a counteroffensive by specialist doctors in pain medicine disaffected by the formulation and outcome of the guideline.

Implementation of clinical guidelines can be problematic for professions or segments (Rashidian et al. 2008; Spyridonidis and Calnan 2011), reconfiguring work and workers and transforming the traditional historical division of professional labour. Clinical guidelines seek to standardise healthcare across settings and systems (Timmermans and Berg 2003), although their enactment

leads to the elevation of particular 'values, things or people at the expense of others' (Timmermans and Epstein 2010 p83). For professions and their segments engaged in professionalising projects, standardisation can be highly contentious. For example, Berg (1997 p1085) identifies the development and implementation of the medical protocol (a tool to standardise healthcare work) as potentially marginalising some professions (for example, nurses and general practitioners) and their tasks, due to difficulty codifying the 'softer' nature of their work. Clinical pathways are also devices of standardisation, and in their policy ethnography about the introduction of a midwife-led clinical pathway for normal labour in Wales, UK, Hunter and Segrott (2014) captured the alienation and exclusion felt by obstetricians as midwives used the pathway to demarcate which labouring women doctors could have access to.

Loss of professional work tasks, either through appropriation by other professions or as a result of changes in supply and demand, have been associated with the dissolution of a profession or segment (Abbott 1988; Rutkow 1993), as it is these very work tasks that form the foundations of professional jurisdiction (Abbott 1988). As an example, Rutkow (1993) recounts the rise and fall of Railway Surgeons in the United States – a large professional segment that emerged in the late 1880s in response to rising numbers of workers injured on the developing railroad network. Although influential nationally in the latter part of the nineteenth century, the segment faded due to the shift from surgical-based tasks to occupational health-based tasks and the decline of corporate medicine, and had all but disappeared by 1917 (Rutkow 1993). A more contemporary example is the case of US primary care physicians, a segment of the medical profession that McKinlay and Marceau (2008) speculate will have vanished by about 2025. They suggest that the growth in new technologies aimed at self-management and monitoring for people with long-term conditions, increasing numbers of competent and capable non-physicians in the market place and the rapid growth in the production and dissemination of clinical guidelines leading to the codification of knowledge and the possibility of workforce substitution, will result in the disappearance of this segment. While these scenarios do not reflect the creative and rejuvenating strategies commonly employed by professions and segments threatened with a loss of work tasks (Pawluch 1983; Halpern 1990; Salhani and Coulter 2009), the implication of jurisdictional loss for what Colebatch refers to as the 'shadow of the future' (Colebatch 2014 p351) is nonetheless a significant professional concern.

Professional concern about potential jurisdictional loss was evident in my first case study. The data led me to identify a number of historically contingent discourses circulating within the province of CG88 that revealed not only *what* the guideline meant to policy-relevant interpretive communities but *how* it meant something to them. Foucault's conceptualisation of discourse as

both an instrument and effect of power (Foucault 1979 [1998 p101]) provided the theoretical underpinnings for the identification of both the 'systems of thought' and the 'systems of action' within my discursive analysis (Rose and Miller 1992 p177). The capilliarised network of power circulating within the field of CG88 constituted 'new objects of knowledge', for example Article 50.1 and the blog, new subjectivities in the form of 'risky' non-medical practitioners and 'holistic' specialist doctors in pain medicine, and 'new bodies of information' about the 'correct' processes of guideline development and legitimate presidential leadership of the British Pain Society (Foucault 1980a p51). The discursive construction of subjects and objects within the socio-political terrain of CG88 (at once the products, components and reproducers of discourse (Howarth 2002; Fadyl et al. 2012) joined together to give rise to a new yet historically contingent discursive formation. This discursive formation legitimised a particular truth about the predominance of specialist doctors in pain medicine in the management of patients with chronic non-specific low back pain and medical hegemony in the subdivision of labour between physiotherapy and medicine. This 'truth' about medicine's pre-eminence was made possible by other historically-specific discourses, discourses leading to the emergence of the Society of Trained Masseuses under medical patronage at the end of the nineteenth century, the affirmation of medical dominance in healthcare with the introduction of the NHS in 1948 (Armstrong 1976), and the development of the extended scope physiotherapy practitioner segment in consultant-led secondary care orthopaedic clinics (Byles and Ling 1989). Although these historical moments and processes are not representative of tradition, influence and development (Foucault 1972), the 'repetition, transformation and reactivation' of statements (Foucault 1972 [2002 p31]) reflects the continuous exercise of social power.

The performative and constitutive effect of power has been the focus of a number of studies in healthcare (Nettleton 1989; Nettleton 1991; Barker 1998; Ceci 2004; Shaw and Greenhalgh 2008). For instance, Barker (1998) showed how, in the US at the start of the twentieth century, the object of pregnancy was pulled from its pre-medical discursive space into a physician-dominated discursive space through the distribution of *Prenatal Care*, a document produced and circulated to a wide readership for a period of *seventeen years* by the United States Children's Bureau. The pages of *Prenatal Care* constructed pregnancy as 'medically problematic' as opposed to a natural but demanding experience (Barker 1998 p1067), thereby firmly installing the specialist physician as a key actor within the nine-month period from conception to delivery. In relation to the constitutive effect of discourse, Nettleton (1991) unveils the construction of different types of mothers (the natural, ignorant, responsible and caring mother) through a moral discourse of oral hygiene in the twentieth century. These mothers assumed the role of agents of 'dental government' within the home, disciplining and normalising their offspring in the correct practices

(Nettleton 1991 p109). This discursive construction of subjects and the historical conditions and context that underpin them is brought to light by Ceci (2004) in her analysis of the professional discourse surrounding the deaths of twelve children undergoing cardiac surgery in a paediatric cardiac surgical unit at a centre in Winnipeg. Informed by data from documents and a report into the inquests of the children's deaths, Ceci (2004) shows how nurses were constituted as unknowing and unknowledgeable subjects about the surgical practices on the unit when they repeatedly voiced concerns about a particular surgeon and his work habits. This construction of nurses as lacking credibility was made possible by the subordination of nurses to doctors in the socio-historical division of healthcare labour (Witz 1992), leading (tragically) to their inability to influence the course of events.

8.3   Physiotherapist non-medical prescribing: a boundary challenge at the micro-level

The subject of my second case study was physiotherapist non-medical prescribing, prompted by legislative change in 2013 to enable appropriately trained and qualified physiotherapists to independently prescribe medicines. Little is known about physiotherapist prescribing of medicines, although previous investigations into non-medical prescribing by other professional groups have identified geographical and specialty variability in practice (Hall et al. 2006; Watterson et al. 2009; Courtenay et al. 2012; Cole and Gillett 2015), with a significant number of non-medical prescribers not using their prescriptive authority (Dobel-Ober 2010; Hacking and Taylor 2010; Courtenay et al. 2102). My own experience of working as a non-medical prescriber within the NHS suggested similar slippage between the meaning of physiotherapist non-medical prescribing as intended by policy makers and the meanings constructed in practice (Yanow 2000), and I was interested to explore this further. My approach this time was informed by Foucault's notion of governmentality, focused on the mentalities guiding government (both the collective rationalities that emerge from bodies of knowledge, and the a-rational elements commonly founded in the emotions) (Dean 2010), and governing technologies to show *how* the government of physiotherapist prescribing of medicines was acted into being at a particular moment in time in a musculoskeletal outpatient service in an NHS Trust in England.

Fundamental to governmentality is an appreciation of the diverse collection of organisations, groups and individuals through which the government of a population is effected, each with rationalities underpinned by sets of practices and technologies (Rose et al. 2006). This 'ensemble' (Foucault 1978 [1994 p219]) and the construction of circumstantial forms of government has been investigated by scholars in a number of health-related fields (Rose 1986; Martin et al. 2013;

Ferlie and McGivern 2014; Waring et al. 2016). For example, in a genealogy of psychiatry in the UK Rose (1986) captured the government of mental health across a number of historical moments from the period just after the First World War to the middle of the twentieth century, uncovering a labyrinth of actors and institutions through which the care of people with mental health problems was actualised. In their examination of school-based anti-obesity interventions Powell and Gard (2015) show how the corporate giant Coca-Cola is enrolling children, their parents and teachers in a wide-ranging network of self-governance through its colonisation of the childhood obesity political space, while Pickard (2010) has examined the interconnections between the state, policy makers, professionals of geriatric medicine and general physicians in the professionalising of UK geriatric medicine.

The ensemble at Central, identified and constructed from observations of practice, analysis of qualitative interviews and national and local documents, gave rise to a grid of intelligibility, a framework and method for organising aspects of the social world in a particular way (Dreyfus and Rabinow 1983). Brenner (1994) argues that Foucault's grid of intelligibility is a functional system, orientated towards specific targets and underpinned by tactics within a specific context. These targets have as their focus the government of populations and individuals and seek to render docile and useful human bodies through techniques of government.

8.3.1 The grid of intelligibility

Constituting the grid of intelligibility at Central were dominant circulating discourses, sustained by the mentalities of a whole host of institutions, organisations and individuals traversing the space between the state and the workplace. These discourses interacted with non-discursive elements for example architectural and administrative arrangements at the health centre to objectivise the physiotherapists and constitute new subjectivities (Foucault 1980c; Hardy 2011). A discourse of fiscal economy, founded on the Trust's deviation from normative authorisation procedures overlaid a discourse of human productivity and efficiency, and effected a move of the physiotherapists from their triage role to work alongside the acute orthopaedic consultants in their elective surgical clinics. Panoptic surveillance of the 18-week RTT, supported by regular target monitoring within the orthopaedic service and intensified through interaction with Monitor, the independent regulator of Foundation Trusts, disciplined workers in their practices. This tactic was layered upon deep-rooted physiotherapist beliefs and behaviours about wait times and targets learnt from working in the PCT, and governed the physiotherapists in their practices, albeit from a distance (Rose and Miller 1992).

Direct disciplining of subjects has been identified in governmentality studies of healthcare (Sheaff et al. 2004; Waring 2007; Martin et al. 2013). However, it is the induction of self-government through an 'indirect form of power' (Ferlie and McGivern 2014 p76) that offers most promise for the government of populations – something that Foucault described as a 'superb formula: power exercised continuously and for what turns out to be a minimal cost' (1980b p155). The transformative effect of government at a distance on individuals (Rose and Miller 1992) has been observed in acute UK hospital settings (Martin et al. 2013). As a result of staff awareness of surveillance-based managerial and information technology techniques to promote quality and patient safety, healthcare professionals modified their behaviours to comply with expectations (Martin et al. 2013). Although these behaviours can on occasions align with other more autonomous rationalities (Sheaff et al. 2004; Waring 2007), the techniques of discipline at Central led to productive and normalised physiotherapists, something akin to the 'new professionalism' – an individual professional duty to enhance productivity – described by Moffatt et al. (2014).

Once in the surgical space at Central, another technique of discipline was able to take effect - normalisation. Normalising judgement is a key disciplinary technique, and in the new outpatient space the physiotherapists took on the norms of the surgical way of working, included in which was 'non' prescribing of medicines. Time pressures and reduced follow-up capacity, limited dialogue between the acute consultants and the physiotherapists about prescribing practices, uncertainty about the 'correct' behaviour concerning prescribing medicines, and expectations of a surgical outcome despite known ambiguity in the referral system, all led to the task of prescribing medicines being passed to other practitioners, notably the GP, thus confirming their traditional signature technique (Norris 2001).

Superimposed on the dominant economic and productivity discourses circulating at Central was a tributary discourse of safe physiotherapist prescribing, constituted from knowledges about risk associated with the supply and use of prescription only opioids (for example Tramadol and Morphine) for the treatment of chronic musculoskeletal pain (Dhalla et al. 2011; Francis 2013; National Advisory Group on the Safety of Patients in England 2013; Weisberg et al. 2014; Shapiro 2015). This knowledge of use of prescription only opioids is supported by a 'normalisation of bodies', a technology in line with normative beliefs about health and productivity (Duff 2015 p82). While this technology operates at a macro level in society, it was joined at Central by a technology of the self, founded on physiotherapist's beliefs that opioid prescribing practices for pain were too risky and beyond their remit. As a result, the physiotherapists governed themselves and enacted a self-imposed distancing from these medicines leading to the constitution of new (and possibly limited) physiotherapist subjectivities.

Douglas (2002) argues that the concept of risk is constructed within social, historical and cultural influences and, when shared, effects normative practice. It can be perceived as a 'calculative reality' supported by a myriad of tactics to regulate human behaviour and bring about particular effects, albeit unexpected at times (Dean 2010 p207). Notwithstanding evidence of increased mortality associated with opioid misuse (Advisory Council on the Misuse of Drugs 2016), opportunities for improved musculoskeletal pain management through healthcare professional exposure to, and experience of, opioid prescribing do exist (Gooberman-Hill et al. 2011), and Powell and Davies (2012) have shown that professionals fears about personal competence in the administration of controlled drugs for pain can be overcome with sustained staff training and support. Regardless of the transfer of prescribing work involving patients using or requiring opioid medications to the service pharmacist at Central, 'opiophobia' among the physiotherapists could affect opportunities for medicines optimisation or lead to under-medication of patients (Zacny et al. 2003), thereby potentially marginalising prescribing practices for patients with musculoskeletal pain. Other scholars, interested in the role of individual agency within the 'large anonymous symbolic structures' that govern the social world (Wagenaar 2011 p109; Hanna 2013), have identified similar marginalising effects of technologies of the self. For example, in a study of breastfeeding workers in New Zealand, Payne and Nicholls (2010) showed how women transformed themselves to be both good mothers and workers by undertaking practices to minimise and hide their presence as breastfeeding mothers in the workplace.

Circulating in the grid of intelligibility that emerged through this second case study was a 'micro-physics' of power (Foucault 1977a [1991 p139]) that enabled me to show how physiotherapist prescribing practices were governed, shaped and fostered at Central. A rationality of orthopaedic surgery primacy for the management of people with musculoskeletal conditions emerged through the grid, and effected a marginalisation of physiotherapist prescribing of medicines. However, the effects of power are multicausal (Hardy 2011), and in the new 'orthopaedic' space at Central, flush with competing discourses, the acute consultants were able to translate the interests of others to advance their own professional project and subordinate the physiotherapists in the subdivision of labour.

8.4 Professional boundary-work and a discursive formation of medical professionalism

Underscored within the dominant discursive formation emerging from the case studies set out in Chapters 5 and 7 is medicine's pre-eminence in the jurisdiction of healthcare for benign musculoskeletal conditions. Despite policy to promote skill-mix change and task shifting among the NHS workforce, and liberate the professions from their historically-specific working practices, the findings from this research suggest that 'medical professionalism' remains the primary template organising the division of healthcare labour at the physiotherapy-medical interface (Battilana 2011 p820). Medical professionalism is a model in which physicians dominate in the field of healthcare, and acute hospitals take precedence over primary care organisations (Battilana 2011). In other words, specialist physicians in secondary or tertiary care lie at the top of the NHS professional and organisational hierarchy. However, upholding this position requires work, both professionally and institutionally, to expand and defend occupational boundaries and preserve privilege in line with the conventions of a professional project.

On opening this thesis I illustrated some of the 'hundred and one ways of self-presentation and behaviour' that the professions employ to enact occupational closure (Macdonald 1995 p52). Professional knowledge claims are a common manifestation (Burri 2008; Kroezen et al. 2013; Martin et al. 2013; Traynor et al. 2015; Bucher et al. 2016), and were palpable in both case studies, constituting statements that contributed to the discursive formation of medical professionalism. This form of boundary-work is particularly significant in jurisdictional contests because of the 'constitutive interdependence' of power and knowledge (Gordon 1980 p239). While Bucher et al. (2016) has identified discursive framings of issues used by professionals in jurisdictional contests, including justifying, self-casting and altercasting, Sanders and Harrison (2008) have distinguished four principal areas within which healthcare professionals make claims to legitimise their position: specialist expertise, organisational efficiency, patient-centredness and competence. In the discursive formation surrounding CG88 specialist doctors in pain medicine asserted knowledge claims about their expertise in the 'correct' interpretation of evidence and the administration of therapeutic spinal injections, while at Central the acute orthopaedic consultants legitimised their position through claims about their 'higher level' work in the surgical orthopaedic outpatient clinics. Juxtaposed with this claim was a description of the 'relatively minor stuff' in the fracture clinics, mirroring Allen's (2000) observation of doctors' rhetorical downgrading of tasks when work was moved from doctors to nurses and the altercasting focus identified by Bucher et al. (2016). Other knowledge claims focused on the affinity between specialist doctors in pain medicine and a patient-centred approach towards the care of people

with chronic non-specific low back pain, and were situated within the paradigms of patient complexity (Sanders and Harrison 2008) and biographical medicine (Armstrong 1979), with the latter more commonly espoused (although not always enacted) by generalists (Charles-Jones et al. 2003). Positioning these claims alongside other social policy concerns, for example patient choice, creates an image of association between specialist doctors in pain medicine and the management of people with non-specific low back pain, thereby helping to secure a dominant public representation about which professional group 'should' manage this condition (Abbott 1988 p60). Colebatch (2014) explains:

> Participants who can expand the appeal of their claim through more inclusive interpretation are more likely to be successful, those with a more narrowly-focused interpretation less likely.
>
> **(Colebatch 2014 p352)**

In addition to knowledge claims, other expressions of professional boundary-work were embedded in the discursive formation of medical professionalism: strategies of demarcation through which segments and professions distinguish themselves from others (Gieryn 1983; Witz 1992; Allen 2000; Norris 2001; Bucher et al. 2016), and practices of exclusion, to subordinate one professional group to another (Abbott 1988; Burri 2008; Salhani and Coulter 2009; Huby et al. 2014). Concerns over the implementation of CG88 led doctors to demarcate non-medical professionals as 'lacking' in assessment skills in the management of people with low back pain, thereby helping to invoke concern about risk when people with chronic non-specific low back pain were not under the care of a medical practitioner. Risk is a key discursive device mobilised by professionals to maintain institutional arrangements (Currie et al. 2012a). It can be called upon to effect work delegation rather than worker substitution, and in the professional and public arena it is legitimised through its association with a dominant discourse about patient safety (Francis 2013; National Advisory Group on the Safety of Patients in England 2013).

Other demarcatory strategies such as monitoring and regulating the work of others were also present (Witz 1992; Allen 2000). Appropriation of the physiotherapist's competencies by the acute orthopaedic surgeons, an educational focus on the surgical work, normalising judgements about prescribing medicines and reduced opportunities for continuing professional development, all coalesced to demarcate the 'correct' knowledge base and jurisdictional boundaries of the physiotherapists, leading to a weakening of the link between the physiotherapists and the practice of prescribing medicines. The forceful effect of such strategies has been recognised (Witz 1992; Currie et al. 2012a). For example, Witz (1992) showed how midwives were subjugated to

doctors in the late 1800s through a deskilling demarcatory strategy promulgated by the Obstetrical Society of London. The obstetricians sought to limit the role of the midwife during labour through the implementation of a comprehensive scheme of education (the content of which was decided by doctors), examination and registration, thereby controlling and defining the midwife's knowledge base and field of competence. The effect of this demarcatory deskilling was to confine the midwife to 'attending women in natural labour' (Witz 1992 p133), thus ensuring medicine's control of the labour process while at the same time alleviating medical men of some of the more tiresome and less well-remunerated aspects of their work.

Coexistent with demarcatory strategies are tactics of exclusion, which Abbott (1988) suggests are pivotal in the subordination of others. In the socio-political events following the publication of CG88, the instigation of the Extraordinary General Meeting at a time when some of the British Pain Society membership was on vacation, in combination with the twenty-eight day mandate laid down in Article 50.1, produced an exclusionary force that limited participation by some of the Society's members. Similarly, limiting opportunities to work in the fracture clinics to only some of the physiotherapists served to privilege the professional project of the acute orthopaedic consultants. A competent and stable physiotherapy workforce in the fracture clinics freed up time to develop the surgical trainees, thus ensuring longevity of the orthopaedic surgical segment. Although the fracture clinic work can be seen to represent a new jurisdiction for the physiotherapists, with the potential to advance physiotherapy's professional boundary, I argue that the constraining of a collective project of mobility contributed to physiotherapist subordination in the traditional hierarchy of labour.

Identifying the method and effect of the boundary-work embedded in the historically-contingent discourses circulating in these case studies brings to the surface the repetitive and refractory nature of medical professionalism. One contemporaneous explanation for this is a theory of foundational values proposed by Montgomery et al. (2015); based on society's need for fulfilment of the core common values of survival, security and flourishing. Fulfilment of these needs, Montgomery et al. (2015) suggest, demands differentiation of specialist physicians from other healthcare professionals, thereby contributing to the perpetuation of medical professionalism. While this thesis certainly warrants further attention, I suggest that in its present form it does not sufficiently account for the changing relationship between physicians and the public (Irvine 2001), the effect of public enquiries such as Shipman, Francis and the Bristol Royal Infirmary enquiry on public trust in the medical profession (Kennedy 2001; The Shipman Enquiry 2002; Francis 2013), and the shift towards care rather than cure as chronic health problems become the primary healthcare burden (WHO 2002). Nor is it cognisant of the enactment of occupational closure by

other groups of healthcare workers outside the professional arena, for example healthcare support workers and volunteers (Traynor et al. 2015; Van Bochove et al. 2016). The research presented in this thesis certainly suggests currency in the concept of occupational closure at the physiotherapy-medical professional boundary, a view that Saks (2016) concurs with. As Ashcraft et al. (2012 p472) point out, 'integrating Others …is a self-defeating exercise', as excluded others form part of a professions frame of reference and professional identity, and their inclusion 'undermines occupational worth' (ibid. p468).

In the next section I outline what I believe to be the key contributions of this research and two of its primary limitations.

8.5   Contributions and limitations

The research presented in this thesis contributes to knowledge in three areas. First, I propose that it widens the field of the sociology of the professions through a focus on the professional boundary between physiotherapy and medicine, an interface that to date has received relatively little attention. Physiotherapists are the largest group of the allied health professions in the UK (Dorning and Bardsley 2014), and their work in a range of settings frequently traverses professional domains. They are considered a key group in current plans to transform the NHS (Oliver 2015), yet empirical research exploring *the effect* of jurisdictional change between physiotherapists and other healthcare professionals to inform this is limited. I propose that the meso- and micro-level case studies presented in this thesis showing *how* the physiotherapy-medical boundary is being challenged and transformed in the jurisdiction of healthcare for musculoskeletal conditions, makes a small but much needed contribution towards advancing understanding in this field.

In a complementary contribution to the literature, this research can also inform studies that integrate organisations, socio-political forces and the professions (Muzio and Kirkpatrick 2011; Suddaby and Viale 2011; Currie et al. 2012b, Lockett et al. 2014). Suddaby and Viale (2011 p424) note that professional projects carry with them projects of institutionalisation, a co-dependence that has been acknowledged in more recent ideas about the professions (Saks 2016). One systematic review of barriers and facilitators to task shifting from doctors to nurses by Niezen and Mathijssen (2014) highlights a range of factors that contribute to institutionalised professional practice. The authors coalesce their findings around four key analytical themes: knowledge and capabilities, professional boundaries, organisational environment and the institutional environment, and stress the inter-relations between them. I suggest that the focus on

Foucauldian power as sets of relations between people and people, people and things [and] people and events, as adopted in this research, provides a means to trace and understand these inter-relations and their effects. Through this approach the role of 'highly agentic actors' in explanations about the outcome of jurisdictional contests is de-focalised (Suddaby and Viale 2011 p425). As Foucault (1976) states:

> no one is there to have invented them, and few who can be said to have formulated
> them.

(Foucault 1979 [1998 p95])

The second contribution that I believe this research makes is in the field of non-medical prescribing. My contextualised single case study investigating UK physiotherapist prescribing in the workplace is the first, to my knowledge, since non-medical prescribing was extended to this professional group.[12] To date much of the published research investigating the practice of non-medical prescribing has converged on safety and appropriateness (Latter et al. 2012; Naughton et al. 2013; Smith et al. 2014), stakeholder views of the initiative (Cooper et al. 2008; Rana et al. 2009; Drennan et al. 2009; Kroezen et al. 2014b) and clinician experiences of practice, including barriers and facilitators (Watterson et al. 2009; Ross and Kettles 2012; Bowskill et al. 2013). Case studies exploring the context in which non-medical prescribing practice is constituted are less readily available, although the study of nurse specialist prescribers in a range of work settings in the Netherlands carried out by Kroezen et al. (2014a) is a notable exception. This study highlights a number of interrelations between nurses and doctors and nurses and their institutions that influenced nurse prescribing practice. The added benefit of the governmentality approach that I chose to adopt in this study facilitates an understanding of *how* and *why* these factors influence actual practice, thereby offering new insights into the variability of non-medical prescribing practice previously highlighted (Dobel-Ober 2010; Courtenay et al. 2012; Drennan et al. 2014; Kroezen et al. 2014a; Cole and Gillett 2015). It is for this reason that I suggest that my study makes a novel contribution to the literature about non-medical prescribing.

The third arena in which I believe this thesis contributes is in the realm of methods. I postulate that drawing on Yanow's initial steps of interpretive policy analysis as a foundation for a Foucauldian-informed discourse analysis augments the body of studies that seek to exteriorise the methodological elements employed when drawing on Foucault's work. Foucault's prodigious outputs, his shifting ideas and diverse subject matter, in combination with a lack of an official

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[12] A national evaluation of the effect and efficacy of independent prescribing by physiotherapists and podiatrists is currently taking place. Information available from: http://www.surrey.ac.uk/fhms/research/healthcarepractice/evaluation_of_physiotherapy.htm [Accessed 22 December 2016]

method to conduct an analysis, can be especially challenging for researchers (Nettleton 1992; Tamboukou 1999; O'Farrell 2005; Garrity 2010; Graham 2011). While the idea of a 'Foucauldian method' is antithetical to Foucault's philosophy (Nicholls 2009a), a number of scholars working in the field of healthcare have laid bare their approach to empirical research based on a close alignment with Foucault's texts (Nicholls 2009a; Garrity 2010; Fadyl et al. 2012). However, as Wagenaar (2011 p243) points out, methodology texts may be of limited benefit to novice researchers who lack the body of experience to interpret them correctly, and I certainly found the formulation of a pragmatic method based on these studies problematic. My position appeared to echo Graham's observation that Foucauldian theory can be particularly inaccessible to those from 'practice-orientated fields' (Graham 2011 p664). On the other hand, Yanow's steps to an interpretive policy analysis offered a way in, and provided me with a more definitive approach to data analysis that enabled me to bridge the gap between the new ideas that I was exploring in Foucault's texts and my case study data.

As a methodological portal, the first two steps in an interpretive policy analysis share some characteristics with Foucault's archaeology (Glynos et al. 2009), a key objective of which is to identify statements as the units of discourse and describe the sets of relations between the elements of discursive formations (Foucault 1972 [2002]). But as Garrity (2010) points out, defining and identifying statements can be problematic as what counts as a statement depends upon the particular field of relations in which it lies and the 'use that is made of it'(Foucault 1972 [2002]; Dreyfus and Rabinow 1983 p55; Fadyl et al. 2012).

I propose that Yanow's artifactual symbols as the conveyors of human meaning are comparable with Foucault's description of the statement as a function (1972 [2002 p98]), and that through the identification of symbolic objects, acts and languages that represent particular values, beliefs and feelings for communities, the field of relations through which statements have their effect can be mapped (Graham 2011; Fadyl et al. 2012). Using this approach to identify the discourses and extra-discursive elements emerging through my case studies put me a position to identify points of conflict, and 'unmask' the microphysics of power circulating within and between the various elements of a discursive formation (Foucault 1983; Howarth 2002 p118).

However, reconciling the notion of the statement with Yanow's symbolic artifacts raised a methodological tension that I had to accommodate. The identification and location of artifactual symbols is an interpretive act, requiring interaction between the analyst and the text within a specific context and a background of shared practices (Yanow 2000). The aim is to understand the meaning making of individuals and groups as they make sense of policy in order to expose different value positions (Colebatch 2014). Conversely, the underpinnings of archaeology rest on

the 'pure' description of discursive formations and a rejection of the interpretation of statements (Howarth 2002):

As you know, I have no great liking for interpretation…

(Foucault 1972 [2002 p222])

Hook (2001) suggests that interpretive endeavours in a Foucauldian-informed analysis can only identify the *effects* of discourse and not the mechanism of its formulation and circulation, and therefore are not needed. Others highlight the impossibility of statement identification without interpretation on the part of the analyst (Dreyfus and Rabinow 1983; Howarth 2002). The answer to this impasse lies in genealogy (Dreyfus and Rabinow 1983; Howarth 2002), as by focussing on power the analyst becomes firmly integrated within an interpretive endeavour (Howarth 2002). I propose that drawing on Yanow's initial steps of interpretive policy analysis as a portal to a Foucauldian-informed discourse analysis could offer opportunities to increase the application of Foucault's work to a wider audience in the field of healthcare.

Having set out these contributions, I now turn to two principal limitations of this work.

8.5.1 Generalisability from case studies

The first limitation relates to the generalisability of my research findings. The single case study method is an approach that has been criticised for its lack of generalisability and limited value in the development of scientific knowledge (Flyvberg 2006). To mitigate for this, some scholars researching policy implementation in healthcare adopt longitudinal or cross-case analysis, to increase confidence in their findings and enhance transferability between systems and settings (see for example Pettigrew et al. 1992 and Currie et al. 2012a). Others contend that as contextual generalisability is neither possible nor desirable (Marinetto 2012), the value of the single case study lies in the in-depth and novel insights generated about a particular phenomenon in its natural setting (Flyvberg 2006). Proponents of this approach argue that the case study offers a coherent medium for exploring the socio-political world, and that *theoretical* generalisability about the development and implementation of healthcare policy is possible (Eisenhardt 1989, Nettleton 1992 p129; Exworthy and Peckham 2012). Certainly, the opportunity to investigate multiple cases of guideline implementation and physiotherapist non-medical prescribing in different organisational settings would have enabled me to compare findings between sites and identify patterns across cases (Yin 1981; Eisenhardt 1989). However, this breadth of coverage would likely have been at the cost of the depth of my engagement and analysis. The opportunistic nature of events associated with the publication of CG88 and the small number of

physiotherapists prescribing in the English NHS at the time of undertaking the study, alongside finite resources, precluded the addition of further sites. By examining policy discourses using the CG88 case and then focussing on everyday prescribing practice, I have been able to shift perspective between the meso- and micro-levels and provide a more comprehensive analysis than is typically afforded in case study work. I have also provided sufficient detail about the cases and methods to allow others to judge the transferability of my interpretations. I therefore argue that my research findings do offer opportunities for the initiation of theory development about the division of labour at the physiotherapy-medical boundary.

The other area pertaining to case study generalisability concerns the location of the research. While other healthcare systems are facing similar socioeconomic pressures and rising demand for healthcare, occupational closure as the axiom for professional life may not be ubiquitous (Saks 2016). In addition, many of the problems and constraints facing the English NHS are unique (Klein 2013) and the UK's current and past configuration of the professions is idiosyncratic. My findings may therefore not be applicable to other countries, although there is evidence to suggest that medical professionalism is a feature in some other healthcare systems (Australian Medical Association 2012, 2016; Kroezen et al. 2013; 2014a; Conn et al. 2016).

8.5.2   Interpretive accounts and reflexively managing bias

The second limitation of this work relates to the breadth and nature of the data upon which I drew to construct my interpretive accounts. I highlighted at the outset of this thesis that interpretative accounts can only ever be partial representations of reality, informed by the preconceptions of the researcher and the breadth and nature of the data gathered and analysed. The choice of particular texts, the involvement of some actors and not others in the generation of data, and the exploration of certain topics during interview all lead to selective meaning making. Of note particularly in this thesis is the omission of interview data from management personnel in the orthopaedic service at Central in the second case study, and time constraints during an interview with one of the acute orthopaedic surgeons that limited this account.

In addition, the use of interviews in the generation of data in Foucauldian-informed studies has been the subject of some discussion (Fadyl and Nicholls 2013). The argument advanced is that the researcher, herself a discursive product with a particular subjectivity, participates in the production of discourse during the interview and thereby proliferates a discourse that fits the preliminary research construct (Fady and Nicholls 2013) – i.e. the account produced merely reifies the researchers prejudice for a particular position (Flyvberg 2006; Schwartz-Shea and Yanow 2012). While I recognise researcher subjectivity and the co-construction of interview texts, I argue

that this perspective fails to account for individual agency during the interview process and the researcher's capacity for reflexively managing her biases (Schwartz-Shea and Yanow 2012). In an effort to manage my biases throughout this research and develop trustworthy accounts, I undertook a number of reflexive strategies (Schwartz-Shea and Yanow 2012). I kept an electronic project journal for the duration of the case study research within which I recorded my observations and reflections. These subsequently informed connections between the data and my emerging analysis. I looked for multiple meanings of symbolic artifacts across different sources and worked to triangulate the data to increase confidence in my developing ideas (Eisenhardt 1989). In addition, I was particularly circumspect when drawing on my interview data and purposively considered the circumstances in which the data were generated, looking at what came before and after particular texts and the situations that provoked them (Foucault 1972 [2002 p31]. Finally, I discussed my findings with others and challenged my dominant logic and researcher bias by searching the data to support other explanations and possibilities (Schwartz-Shea and Yanow 2012).

8.6   Directions for future research

The contributions and limitations of this research laid out above pave the way for future enquiry into professional boundaries. Physiotherapy's professional boundaries warrant further contextualised exploration both in the UK and in other healthcare settings given the dearth of literature in this field and the rapid evolution and operationalisation of new professional roles, both within physiotherapy, for example as first contact practitioners in general practice (CSP 2016), and in other professions, such as physician associates with whom physiotherapists are likely to interact (Buchan et al. 2016). Understanding barriers and facilitators to skill-mix change and task shifting involving physiotherapists through the adoption of multiple case studies offers the potential for new insights and learning opportunities for future developments in professional workforce planning and change in the UK and other countries.

Beyond this, I would like to undertake further research to explore the context associated with successful initiatives to implement skill-mix change and task shifting. Undoubtedly, the maintenance of impermeable professional and segmental boundaries can adversely affect patient care (Ceci 2004; Powell and Davies 2012; Liberati et al. 2016), reduce the spread of innovation (Ferlie et al. 2005; Waring 2007; Martin et al. 2009) and lead to staff loss from particular work roles (Currie et al. 2012a). But discursive formations do change (Hook 2001), and while some statements appear to be relatively stable configurations, they can be transformed through changes in relations with other statements (Foucault 1972 [2002 p38]). Research identifying the sets of relations, knowledge claims and institutional practices that effect professional co-working

within shared jurisdictions is emerging (Currie et. 2012a; Huby et al. 2014; Conn et al. 2016). Consulting, mobilising and adapting strategies implemented by professionals have been found to mitigate professional boundaries, while enforcing, avoiding, limiting and expecting behaviours magnifies them (Conn et al. 2016). Identifying the context that enables professionals to employ such mitigating strategies in healthcare work may lead to training opportunities and the possibility of discursive transformation.

8.7   Conclusion

At the start of this thesis I set out to explore how the professional boundary between physiotherapy and medicine is being challenged by NHS workforce modernisation policy, and the effect of this challenge on the subdivision of labour between the two professions. This has been accomplished through two case studies, one at the meso-level of healthcare and one at the micro-level. These case studies centre on policy in the field of musculoskeletal conditions – the publication and implementation of a clinical practice guideline for low back pain, and the everyday practice of physiotherapist non-medical prescribing. Drawing on an interpretive discursive approach to policy analysis and insights from the writings of Michel Foucault, I have shown the mechanism and effect of these challenges, informed by traces from the past that reflect a 'long-term continuity of form of what can only be called power' (Dreyfus and Rabinow 1983 p4).

The argument presented in this thesis is that that this power and its interdependence with knowledge, intertwined with institutions, architectural forms, regulatory decisions and administrative measures, constitutes an organising framework at the physiotherapy-medical boundary. This framework can be understood as a grid of intelligibility that makes certain ways of thinking and behaving possible. Emerging through this grid is a familiar template of medical professionalism, in which specialist physicians are pre-eminent in the field of musculoskeletal conditions, and physiotherapists are subordinated in the sub-division of labour. I have shown in this thesis how this is sustained by significant professional and institutional work, the foundations of which lie in the concept of occupational closure. This boundary-work limits the impact of workforce modernisation policy at both the meso- and micro-level of healthcare, and reduces the potential for healthcare efficiencies through skill-mix change and task shifting between the professions of physiotherapy and medicine.

Skill-mix change and task shifting among the healthcare workforce continues to be a key mechanism for provision of effective public healthcare within funding constraints. However, I argue that achieving jurisdictional change requires a deep understanding of context and the

configuration of power relations that constitute subjectivities for the healthcare professions. Ultimately, discursive transformation needs to occur to enable new ways of thinking and behaving. Unless we understand how social power circulates and is exercised however, jurisdictional change will prove difficult.

Appendices

Appendix A   Letter from the British Pain Society

THE BRITISH PAIN SOCIETY

The British Chapter of the
International Association
for the Study of Pain

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Churchill House
35 Red Lion Square
London WC1R 4SG

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F +44 (0)20 7831 0859

E info@britishpainsociety.org
W www.britishpainsociety.org

An alliance of professionals
advancing the understanding
and management of pain for
the benefit of patients

Nicky Wilson
PhD Student
School of Health Sciences
University of Southampton
SO17 1BJ

1st April 2010

Dear Ms Wilson,

Thank you for your letter regarding the British Pain Society response to NICE with regards to the NICE guidance for the management of non-specific low back pain (CG88).

Your requests were considered, however I am afraid that the Society does not wish to participate in your research. Since there was free correspondence on blogs regarding this matter we feel that you will be able to access the information you require from this source.

We would however, like to take this opportunity to update on developments with NICE since the guidelines were launched in May 2009. Contact has been made with NICE and a very positive meeting was held in November, As a result, a further meeting between representatives of NICE and the British Pain Society took place in February 2010. Under the chairmanship of Prof. Sir Michael Bond and Prof. Peter Littlejohns, it took the form of presentations by both NICE and BPS representatives, followed by research and implementation focused group discussions. The guideline process, the evidence base and problems with its implementation, together with a research strategy were discussed.

The key outcomes of the meeting were; a decision to produce a joint report for the two organisations with recommendations suggesting solutions for problems that have arisen from the misinterpretation of the guidelines by some PCTs and others, a review of certain elements of the evidence base for the guidelines and a longer term research agenda to involve NICE and the BPS. This work remains ongoing.

Kind regards,

Prof. Sir Michael Bond
Interim President

Appendix B   Ethical approval (study 1)

UNIVERSITY OF
Southampton
School of Health Sciences

E04/Oct 2008/ v1.0

Nicky Wilson
School of Health Sciences

17 December 2009

Dear Nicky

Ethics Submission No: SoHS-ETHICS-09-030
Title: Issues affecting role extension

I am pleased to confirm **full approval** for your study has now been given. The approval has been granted by the School of Health Sciences Ethics Committee.

You are required to complete a University Insurance and Research Governance Application Form (IRGA) in order to receive insurance clearance before you begin data collection. The blank form can be found at http://www.soton.ac.uk/corporateservices/rgo/regprojs/whatdocs.html

You need to submit the following documentation in a plastic wallet to Dr Martina Prude in the Research Governance Office (RGO, University of Southampton, Highfield Campus, Bldg. 37, Southampton SO17 1BJ):

- Completed IRGA Research Governance form
- Copy of your research protocol/School Ethics Form (final and approved version)
- Copy of participant information sheet
- Copy of SoHS Risk Assessment form, **signed**
- Copy of your information sheet and consent form
- Copy of this SoHS Ethical approval letter

Building 67
School of Health Sciences, University of Southampton, Highfield Campus, Southampton SO17 1BJ United Kingdom
Tel: +44 (0)23 8059 7979 Fax: +44 (0)23 8059 7900 www.southampton.ac.uk/healthsciences

Your project will be registered at the RGO, and then automatically transferred to the Finance Department for insurance cover. **You can not begin recruiting until you have received a letter stating that you have received insurance clearance.**

Please note that you have ethics approval only for the project described in your submission. If you want to change any aspect of your project (e.g. recruitment or data collection) you must request permission from the Ethics Committee and RGO (students should discuss changes with their supervisor before submitting the request to the Ethics Committee).

Yours sincerely

Malbrith

PP   Professor Sue Latter
Chair, SoHS Ethics Committee

t: +44 (0)23 80 597959
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Appendix C   Amendment to ethical approval (study 1)

UNIVERSITY OF
Southampton

E08/Aug 2010/ v1.1

Nicky Wilson
Faculty of Health Sciences
University of Southampton
Highfield
Southampton
SO18 1HG

8ᵗʰ September 2010

Dear Nicky

Ethics Submission No: Issues affecting role extension
Title: SoHS-Ethics-09-030

Thank you for your letter dated 11ᵗʰ August 2010 requesting amendment to your previously fully approved study.

The Faculty of Health Sciences (FoHS) Ethics Committee has approved your amendment regarding:

- A time extension on the project until October 2011
- The outlined amendments to the PIS and letter of invitation.

Please contact the Research Governance Office to ensure that they are aware of the changes.

Yours sincerely

Dr Maggie Donovan-Hall
Vice Chair, FoHS Ethics Committee

t: +44 (0)23 80 598880
e:mh699@soton.ac.uk
f: +44 (0)23 80 597900

Building 67
Faculty of Health Sciences, University of Southampton, Highfield Campus, Southampton SO17 1BJ United Kingdom
Tel: +44 (0)23 8059 7979 Fax: +44 (0)23 8059 7900 www.southampton.ac.uk/healthsciences

Appendix D   Participant invitation letter (study 1)

UNIVERSITY OF
Southampton

PDF VERSION – letter for distribution by email / mail

To healthcare professionals and / or individuals from other professional organisations

14th September 2010

Dear

I would like to invite you to participate in a PhD research study being undertaken at the Faculty of Health Sciences, University of Southampton. The research seeks to explore issues affecting role extension of allied health professionals.

Please find attached an information sheet. If you require further details please contact me, Nicky Wilson via the Faculty of Health Sciences on 023 80595277.

Yours sincerely,

PhD student
Faculty of Health Sciences
University of Southampton

Appendix E   Participant information sheet (study 1)

UNIVERSITY OF
Southampton

Participant Information Sheet

Study Title:
Exploring issues affecting role extension of allied health professionals

Researcher: Nicky Wilson – PhD student

Ethics number: SoHS-ETHICS-09-030

Introduction:
I am undertaking research for a PhD looking at issues affecting role extension of allied health professionals into areas traditionally undertaken by medical practitioners. As part of this, I am interested in the role of evidence-based practice, pathways and clinical guidelines. To further my knowledge I am interested in how health professionals and the learned or professional societies which represent them responded to guidance for the management of lower back pain, notably the publication of the National Institute for Clinical Excellence (NICE) guidance (CG88).

Please read this information carefully before deciding to take part in this research and do contact me if you would like further information regarding the study. If you are happy to participate in this research you will be asked to sign a consent form.

What is the research about?
The NICE guideline published in May 2009 (Low back pain: early management of persistent non-specific low back pain CG88) generated debate amongst professional organisations and has been discussed in clinical journals, web fora and blogs about management of back pain. My study will analyse texts (e.g. reports and web materials) surrounding the publication of the NICE guidance to help me understand debates about extended roles in the management of back pain. I am also conducting interviews with a small number of health professionals to provide some more detail and background to these debates.

The research is sponsored by the University of Southampton and the study will be supervised by Catherine Pope, Professor of Medical Sociology at the University of Southampton.

Why have I been chosen?
You have been identified through information that is in the public domain or via snowball sampling (that is, someone I have already spoken to suggested I contact you).

What will happen to me if I take part?
You will be invited to take part in a semi-structured interview arranged at a time and location convenient to you (a telephone interview may be organised if necessary). It is anticipated that the interview will last approximately 40 - 50 minutes and it will explore your perspective on guidelines and the debates surrounding the publication of the NICE guidance in May 2009. Interviews will be audio-recorded with your consent and subsequently transcribed. The interviews will need to be conducted outside of NHS professional time as there are no service costs allocated to this study.

[11ᵗʰ August 2010] [Version 3]   1

Are there any benefits in my taking part?
There is no direct benefit to you but we hope that the information gained will contribute to an understanding of the extension of role of allied health professionals.

Are there any risks involved?
There are no direct risks to you. You will have the opportunity to view the interview topic guide prior to the interview taking place.

Will my participation be confidential?
Every attempt will be made to protect the identity of participants. All interview data will be made anonymous and your identity will only be known to the researcher and her PhD supervisors. Any text made available to the researcher will be made anonymous unless it has already been published. The researcher will disguise participants by not reporting identifying features and by grouping together quotes. Should it be necessary to identify an individual, then the participant will be shown commentary / quotes and approval to use them will be obtained. All coded data will be kept on a password protected computer within the University of Southampton to which only the researcher will have access. Data will be securely stored within the University for a 10 year period, in accordance with University policy.

What happens if I change my mind?
Should you change your mind with respect to participation in this study, then you would be free to withdraw at any time without giving reason and without prejudice.

What if there is a problem or I have a complaint?
If you have a concern or a complaint about this study you should contact Susan Rogers, Head of Research & Enterprise Services, at the Faculty of Health Sciences (Address: University of Southampton, Building 67, Highfield, Southampton SO17 1BJ; Tel +44 (0)23 80597942; Email: S.J.S.Rogers@soton.ac.uk).
If you remain unhappy and wish to complain formally Susan Rogers can provide you with details of the University of Southampton Complaints Procedure.

Where can I get more information?
If you would like any further information about the study please contact Nicky Wilson, Faculty of Health Sciences, University of Southampton. Telephone – +44 (0)23 80595277. Email njw4@soton.ac.uk

What do I do now?
If you would like to participate in this research please email me at njw4@soton.ac.uk or telephone on +44 (0)23 80595277 leaving the time and date of your call along with your contact details.
Thank you for taking the time to read this information sheet.

Appendix F   Consent form (study 1)

UNIVERSITY OF
Southampton

CONSENT FORM (Version 1)

Study title:
Exploring issues affecting role extension of allied health professionals

Researcher name: Nicky Wilson
Ethics reference: SoHS-ETHICS-09-030

Please initial the box(es) if you agree with the statement(s):

I have read and understood the information sheet (11.08.2010/version 3) and have had the opportunity to ask questions about the study

I agree to being interviewed and understand that any information I provide will remain anonymous (unless previously published), being used solely for the purpose of this study

I agree to the interview being audio-recorded and for my data to be used for the purpose of this study

I understand my participation is voluntary and I may withdraw at any time without providing a reason and without prejudice

I understand that all information collected from me as part of this project will be retained by the University of Southampton for 10 years in line with University policy

Name of participant (print name)...

Signature of participant..

Name of Researcher (print name)...

Signature of Researcher...

Date...

[25th October 2009] [Version 1]

Appendix G   Interview schedule (study 1)

Semi-structured interview schedule
Exploring issues affecting role extension of allied health professionals
(Ethics No: SoHS-ETHICS-09-030)

Current role

1. Can we start by you telling me about your current role within healthcare?
   (Prompts: Setting (NHS / PP), length of time in this role, type of work)

2. Are you a member of any of the professional societies which have an interest in the management of musculoskeletal disease?
   (Prompt: Length of membership, positions of responsibility (past and current)

Extended roles

3. What are your views of allied health professionals undertaking roles within orthopaedic or rheumatology clinics that were traditionally undertaken by medical clinicians?
   (Prompts: Personal experience, mentorship, limits, future, promotion of multidisciplinary working)

Clinical guidelines

4. The NICE guidance for the early management of persistent non-specific low back pain (CG88) was published in May 2009. They have been controversial and generated much debate.

4a) Could you tell me your views on clinical guidelines in general
    (Prompts: Have you experience of other NICE clinical guidelines that have impacted on your area of work / expertise? Impression of them, value, implementation, change of practice (change in nos or types of patients seen? Loss of services? Effect on private practice?)

4b) What are your views of the NICE (CG88) guidance?
    (Prompts: value, implementation, affect on individual practice / professional group practice)
      Much was written in the BMJ about the process of consultation concerning the development of the guidance and the make up of the GDG
      Any personal or professional organisational experience of contact or consultation with the GDG?
      Your views on the consultation process and development of the guideline

4c) What do you feel has been the effect of the publication of the CG88 guidance within the media
    (Prompt: Assessment of back pain, treatment of back pain, influence, professional organisations

4d) What do you feel has been the effect of the guidance within professional organisations / societies
    (Chiropractic / osteopathy, spinal surgery associations, BPS, EGM)

Appendix G

The future management of back pain

5. How do you see back pain being assessed and managed in the future? By what means could this be achieved.

Appendix H   Ethical approval (study 2)

EoSRES

NHS
SCOTLAND
Research Ethics Service

East of Scotland Research Ethics Service (EoSRES) REC 2
Tayside Medical Sciences Centre (TASC)
Residency Block C, Level 3
Ninewells Hospital & Medical School
George Pirie Way
Dundee DD1 9SY

Mrs Nicky Wilson
Faculty of Health Sciences, (building 45)
University of Southampton
Southampton
SO17 1BJ

Date:	23 April 2014
Your Ref:	
Our Ref:	**LR/DL/14/ES/0056**
Enquiries to:	Mrs Lorraine Reilly
Extension:	Ninewells extension: 83878
Direct Line:	01382 383878
Email:	eosres.tayside@nhs.net

Dear Mrs Wilson

Study title:	**An investigation into the implementation of physiotherapist prescribing of medicines in the assessment and managament of patients with musculoskeletal disorders.**
REC reference:	14/ES/0056
IRAS project ID:	131983

The Proportionate Review Sub-committee of the East of Scotland Research Ethics Service REC 2 reviewed the above application on 22 April 2014.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Assistant Co-ordinator Mrs Diane Leonard, eosres.tayside@nhs.net.

Ethical opinion

No ethical issues noted.

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

14/ES/0056	Please quote this number on all correspondence

Yours sincerely

D. Leonard.

for Dr Anthony Davis
Vice-Chair

E-mail: eosres.tayside@nhs.net

Appendix I Participant invitation letter (study 2)

UNIVERSITY OF
Southampton

PDF Version – letter for distribution by email by local collaborator or researcher

1st May 2014

Dear

I would like to invite you to participate in a PhD research study being undertaken at the Faculty of Health Sciences at the University of Southampton. The research is looking into how the prescribing of medicines by physiotherapists is being implemented within the National Health Service.

Please find enclosed a participant information sheet that explains in more detail what the study involves. I would be grateful if you could take the time to read the information and, if you are interested in taking part, please send me an email with your contact details and a good time to reach you. Alternatively, telephone me on the number below and leave your name and a contact number. I would appreciate it if you would do this within 3 weeks of the date above.

If you require further details about the study please contact me, Nicky Wilson, via the Faculty of Health Sciences on njw4@soton.ac.uk or by phone on 07739 749170.

Yours sincerely,

Nicky Wilson
PhD student
Faculty of Health Sciences
University of Southampton

Appendix J Participation information sheet -

physiotherapists (study 2)

UNIVERSITY OF Southampton

Physiotherapist prescribing of medicines in the NHS [v1]
Participant information sheet - physiotherapists

Study Title
An investigation into the implementation of physiotherapist prescribing of medicines in the assessment and management of patients with musculoskeletal disorders.

Researcher: Nicky Wilson   **Ethics reference number**: 14/ES/0056

Introduction:
I am undertaking research for a PhD and am interested in issues affecting role extension by physiotherapists into areas traditionally undertaken by medical doctors. As part of this, I am keen to understand how the prescribing of medicines by physiotherapists working in the National Health Service is being implemented.

Please read this information sheet carefully before deciding to take part in this research. If you are happy to participate you will be asked to sign a consent form.

What is the research about?
In July 2012 physiotherapists were granted rights by the government to independently prescribe medicines and new legislation came into force in August 2013 to enable this. Currently physiotherapists can act as supplementary prescribers, however, relatively few are registered, with some believing that there are too many obstacles to practice.

One area of work in which the prescribing of medicines by physiotherapists might increase and may be of particular value is in the management of patients with musculoskeletal conditions. Musculoskeletal disorders form a considerable societal burden and physiotherapist prescribing is seen as one means of making healthcare for these disorders more efficient, effective and convenient for patients.

To date, there has been very limited research into the prescribing of medicines by physiotherapists and this study aims to understand how it is currently being implemented. In particular, the study aims to explore issues that both help and hinder prescribing by physiotherapists for patients with musculoskeletal conditions.

This research is sponsored by the University of Southampton and supervised by Professor Catherine Pope, Professor of Medical Sociology at the University of Southampton.

Why have I been chosen?
You have been chosen because you are a physiotherapist working in the management of patients with musculoskeletal disorders within the National Health Service, are registered with the Health and Care Professions Council and hold a non-medical prescribing qualification.

What will happen to me if I take part?
Two things will happen if you agree to take part in this study:
Firstly, I would like to observe a number of your clinical interactions with patients and other professional staff relating to prescribing practices during your usual clinical practice (consent will be obtained from patients and other healthcare professionals). I would like to audio-tape the interactions with your permission and I may make some field notes during observations, but I will not participate in the interactions. In order to gather sufficient data, it is anticipated that I will observe between 1 and 3 musculoskeletal clinics, during which patients attend.

Participant (physiotherapist) information sheet: 14th December 2013 [Version 1]

UNIVERSITY OF
Southampton

Secondly, you will be interviewed and your experiences of prescribing within the National Health Service explored. It is anticipated that the interview will last approximately 40 – 50 minutes and will be conducted at a time and place convenient to you. Interviews may need to be conducted outside of NHS professional time as there are no service costs allocated to this study. The interview will be audio-taped and transcribed. The data will then be anonymised and stored on a password protected computer. I would also like to record or make notes about any informal conversations associated with your prescribing practices. Only myself (the researcher) and my supervisory team will have access to the data, which will be handled confidentially at all times.

Are there any benefits in my taking part?
It is unlikely that there will be any direct benefit to you, but, your participation in this project may help advance our understanding about prescribing by physiotherapists within the National Health Service.

Are there any risks associated with my taking part?
There are no foreseen risks associated with participating in this study. You will have the opportunity to view the interview topic guide prior to the interview taking place.

Will my participation be confidential?
Every attempt will be made to protect the identity of participants. All interview data and field notes will be anonymised and coded and only seen by the researcher and potentially her PhD supervisors. Any text made available to the researcher will be made anonymous unless it has already been published. The researcher will disguise participants by not reporting identifying features and by grouping together quotes. All coded data will be kept on a password protected computer within the University of Southampton to which only the researcher will have access. Data will be securely stored within the University for a 10 year period in accordance with University policy. In the unlikely event of the researcher observing any clinical practice in which the patient may be harmed in any way, the researcher is duty bound to report this to the physiotherapy services manager.

What happens if I change my mind?
It is up to you whether or not to take part in this study. Should you agree to participate in the study but then change your mind, you would be free to withdraw at any time, without giving a reason and without prejudice.

What happens if something goes wrong?
In the unlikely case of concern or complaint, please contact Dr Martina Prude, Head of Research Governance at the University of Southampton (02380 595058, mad4@soton.ac.uk) who will be able to help you.

Where can I get more information?
If you would like to know more about the study or would like to discuss specific aspects of this research prior to making a decision about whether or not to take part, please contact Nicky Wilson on: 07739 749170 or at njw4@soton.ac.uk

What do I do now?
If you would like to participate in this research, please email me at njw4@soton.ac.uk or telephone on 07739 749170, leaving the time and date of your call, along with your contact details.

Thank you for taking the time to read this information sheet.

Appendix K   Consent form - physiotherapists (study 2)

UNIVERSITY OF Southampton

CONSENT FORM (Physiotherapist)

Study title:
An investigation into the implementation of physiotherapist prescribing of medicines in the assessment and management of patients with musculoskeletal disorders.

Researcher name: Nicky Wilson   **Ethics reference number**: 14/ES/0056

Please initial the box(es) if you agree with the statement(s):

I confirm that I have read and understand the information sheet dated .... (version ...) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I agree to the researcher observing my working practices, including interactions with patients and other professionals.

I agree for these observations and interactions to be recorded, via field notes and/or audio-recordings, and for the data to be used for the purpose of this study.

I agree to being interviewed.

I agree to the interview being audio-recorded and agree to this data being used for the purpose of this study.

I understand that this data may be used in reports about this research, but that no names or information that could identify me will be used.

I understand that my participation in this study is voluntary and that I may withdraw at any time, without giving any reason, without prejudice and without my legal rights being affected.

I understand that all data collected from me as part of this project will be stored on a password protected computer and retained by the University of Southampton for 10 years in line with University policy.

I agree to take part in this research study.

Name of participant (print name)... Date ....

Signature of participant...

Name of researcher (print name)...

Signature of researcher... Date ....

Consent form (physiotherapist) [Version 1] 14th December 2013   One copy to be held by the participant, one by the researcher.

Appendix L   Consent form - patient (study 2)

UNIVERSITY OF Southampton

CONSENT FORM (Patient)

Study title:
An investigation into the implementation of physiotherapist prescribing of medicines in the assessment and management of patients with musculoskeletal disorders.

Researcher name: Nicky Wilson   **Ethics reference number**: 14/ES/0056

Please initial the box(es) if you agree with the statement(s):

I confirm that I have read and understand the information sheet dated .... (version ....) relating to the researcher observing the consultation between myself and the physiotherapist as part of the above study. I have had the opportunity to ask questions about the study and have had these answered satisfactorily.

I agree to the researcher observing the consultation between myself and the physiotherapist and for the data to be used for the purpose of this study.

I agree to the researcher making notes during the consultation between myself and the physiotherapist and for the data to be used for the purpose of this study.

I agree to have the consultation between myself and the physiotherapist audio-recorded and for the data to be used for the purpose of this study.

I understand that data from the consultation between myself and the physiotherapist may be used in reports about this research, but that no names or information that could identify me, will be used.

I understand that my participation in this study is voluntary and that I may withdraw my consent for this at any time, without giving any reason, without my care or legal rights being affected.

I understand that all data collected from me as part of this project will be retained by the University of Southampton for 10 years in line with University policy.

I agree to take part in this research study.

Data Protection
I understand that the audio-recorded consultation will be made anonymous, stored on a password protected computer and will only be used for the purpose of this study. A copy of this consent form will be stored in my patient record file and within the research site file.

Name of participant (print name)...

Signature of participant...Date.............................

Name of physiotherapist taking consent (print name)..

Signature of physiotherapist .... Date....................................

Consent form (patient) [Version 2] 23ʳᵈ March 2014
One copy to be held by the patient, one copy for the patient notes and one for the research site file

Appendix M   Consent form - local professionals (study 2)

UNIVERSITY OF
Southampton

CONSENT FORM (Local healthcare professionals)

Study title:
An investigation into the implementation of physiotherapist prescribing of medicines in the assessment and management of patients with musculoskeletal disorders.

Researcher name: Nicky Wilson   **Ethics reference number:** 14/ES/0056

Please initial the box(es) if you agree with the statement(s):

I confirm that I have read and understand the information sheet dated ....
(version ...) for the above study. I have had the opportunity to consider the
information, ask questions and have had these answered satisfactorily.

☐

I agree to the researcher observing my interactions with non-medical prescribing
physiotherapists working with patients with musculoskeletal disorders.

☐

I agree to the interaction being recorded via field notes and / or audio-recording and
understand that any information I provide will remain anonymous (unless previously
published), being used solely for the purpose of this study.

☐

I understand that my name will not be identifiable in any written reports or papers
arising from this research.

☐

I understand that my participation in this study is voluntary and that I may withdraw at
any time, without giving any reason, without prejudice and without my legal rights
being affected.

☐

I understand that all data collected from me as part of this project will be stored on a
password protected computer and retained by the University of Southampton for 10
years in line with University policy.

☐

I agree to take part in this research study.

☐

Name of participant (print name)..

Signature of participant.. Date ....

Name of researcher (print name)..

Signature of researcher... Date ....

Consent form (local professional) [Version 2] 23rd March 2014   One copy to be held by the participant, one by the researcher.

Appendix N   Participant information sheet - professionals (study 2)

UNIVERSITY OF Southampton

Physiotherapist prescribing of medicines in the NHS [v1]
Participant information sheet - professionals

Study Title
An investigation into the implementation of physiotherapist prescribing of medicines in the assessment and management of patients with musculoskeletal disorders.

Researcher: Nicky Wilson   **Ethics reference number:** 14/ES/0056

Introduction:
I am undertaking research for a PhD and am interested in role extension by physiotherapists into areas traditionally undertaken by medical doctors. As part of this, I am keen to understand how the prescribing of medicines by physiotherapists working in the National Health Service is being implemented.

Please read this information sheet carefully before deciding to take part in this research. If you are happy to participate you will be asked to sign a consent form.

What is the research about?
In July 2012 physiotherapists were granted rights by the government to independently prescribe medicines and new legislation came into force in August 2013 to enable this. Currently physiotherapists can act as supplementary prescribers; however, relatively few are registered, with some believing that there are too many obstacles to practice.

One area of work in which the prescribing of medicines by physiotherapists might increase as a result of legislative change and may be of particular value is in the management of patients with musculoskeletal conditions. Musculoskeletal disorders form a considerable societal burden and physiotherapist prescribing is seen as one means of making healthcare for these disorders more efficient, effective and convenient for patients.

To date there has been very limited research into the prescribing of medicines by physiotherapists and this study aims to understand how it is currently being implemented within the National Health Service. In particular, the study aims to explore issues that both help and hinder prescribing by physiotherapists for patients with musculoskeletal conditions.

This research is sponsored by the University of Southampton and supervised by Professor Catherine Pope, Professor of Medical Sociology at the University of Southampton.

Why have I been chosen?
You have been chosen as you have been identified as someone who is currently or has previously been involved in the development of national, or local, prescribing policy and practice for physiotherapists.

What will happen to me if I take part?
You will be invited to take part in a semi-structured interview arranged at a time and location convenient to you (a telephone interview may be organised if necessary). It is anticipated that the interview will last approximately 40 – 50 minutes and will explore your perspective on physiotherapist prescribing. Interviews will be audio-recorded with your consent and subsequently transcribed. If you are an NHS employee, the interviews may need to be conducted outside of NHS professional time as there are no service costs allocated to this study.

UNIVERSITY OF Southampton

Are there any benefits in my taking part?
There is no direct benefit to you from taking part, but your participation in this project may help advance our understanding about prescribing by physiotherapists within the National Health Service.

Are there any risks involved?
There are no foreseen risks associated with participating in this study. You will have the opportunity to view the interview topic guide prior to the interview taking place.

Will my participation be confidential?
Every attempt will be made to protect the identity of participants. All interview data will be anonymised and coded and only seen by the transcriber, researcher and her PhD supervisors. Any text made available to the researcher will be made anonymous unless it has already been published. The researcher will disguise participants by not reporting identifying features and by grouping together quotes. All coded data will be kept on a password protected computer within the University of Southampton to which only the researcher will have access. Data will be securely stored within the University for a 10 year period in accordance with University policy.

What happens if I change my mind?
It is up to you whether or not to take part in this study. Should you agree to participate in the study but then change your mind, you would be free to withdraw at any time, without giving a reason and without prejudice.

What happens if something goes wrong?
In the unlikely case of concern or complaint, please contact Dr Martina Prude, Head of Research Governance at the University of Southampton (02380 595058, mad4@soton.ac.uk) who will be able to help you.

Where can I get more information?
If you would like to know more about the study or would like to discuss specific aspects of this research prior to making a decision about whether or not to take part, please contact Nicky Wilson on: 07739 749170 or at njw4@soton.ac.uk

What do I do now?
If you would like to participate in this research, please email me at njw4@soton.ac.uk or telephone on 07739 749170, leaving the time and date of your call, along with your contact details.

Thank you for taking the time to read this information sheet.

Appendix O   Interview schedule - physiotherapists (study 2)

Semi-structured interview schedule (physiotherapists)

An investigation into the implementation of physiotherapist prescribing of medicines in the assessment and management of patients with musculoskeletal disorders
(Ethics reference number: 14/ES/0056)

Current role

1.   Can we start by you telling me about your current role(s) within healthcare?

Prompts: setting (secondary care, interface service, education, other), length of time in this role, type of work - local patient group seen, relationships with other professionals within the setting.

2.   Are you a member of any of the professional societies / local professional organisations which have an interest in the management of musculoskeletal disease including the prescribing of medicines?

Prompts: length of membership, positions of responsibility (past and current), prescribing groups – regional & national.

Non-medical prescribing (supplementary)

3.   Can you tell me about your experiences of non-medical prescribing?

    a.   What prompted you to undertake the training to qualify as a non-medical prescriber and when did you qualify?

    b.   In what ways have you used your qualification as a non-medical prescriber?

Prompts: advising about medication use (optimal use of already prescribed medicines, side effects, advising on starting / stopping medications), prescribing of medicines - specific conditions, specific groups of patients, specific drugs or groups of drugs), frequency of prescribing encounters.

4.   What has been your experience of using your non-medical prescribing knowledge and practice? Can you give specific examples (positive and negative?).

Prompts: value, implementation, effect on individual practice, effect on patients, effect on other healthcare professionals from both physiotherapy and other disciplines.

5.   Have you encountered any barriers or facilitators to your practice as a non-medical prescriber?

Prompts: people (patients or family members, other healthcare professionals, managerial staff) national & local practice systems (electronic prescribing, electronic decision support, prescription pads, clinical management plans, issuing prescriptions), governance (national / local policy & procedure, contact / support from a medical prescriber, non-medical prescribing groups, pharmacist).

Interview schedule physiotherapist [Version 2] 23rd March 2014

Non-medical prescribing (independent)

6. Can you tell me about your views on the change in legislation which now enables physiotherapists to act as independent prescribers?

   a. What has influenced those views?

   Prompts: Personal experience, type of work / setting, mentorship, governance, limits, future, promotion of multidisciplinary working, integration of healthcare providers.

   b. Are you planning on converting from supplementary to independent prescribing?

   Prompts: rationale, employer view & support, service commissioning, views and support from other healthcare professionals, national policy, status.

   c. If so, what effects do you anticipate from independent status?

   Prompts: personal - change in prescribing habits, professional working relationships, evaluation of practice, elevated risk; patient care - ease of prescribing episode, liaison with other healthcare professionals, patient experience, increased governance for perceived increased risk.

   d. If not, do you envisage any change to your current prescribing practice in the near future?

   e. What are your views on independent prescribing by physiotherapists given increasing multi-morbidity and poly pharmacy?

   Prompts: long term MSK conditions, benefits, risks, enactment - sources of support & training, multi-professional team working.

   f. What advice would you give to someone starting out to gain IP status?

   Prompts: knowledge base, working environment, relations with other professionals, work-place support.

The future of non-medical prescribing

7. What are your views on the potential long term effects of physiotherapists acting as independent prescribers?

Prompts: status, primary providers of MSK care, consequences for patient health outcomes, safety, insurance, inter-professional working, co-ordinated care.

Appendix P   Interview schedule - professionals (study 2)

Semi-structured interview schedule (other professionals)

An investigation into the implementation of physiotherapist prescribing of medicines in the assessment and management of patients with musculoskeletal disorders

(Ethics reference number: 14/ES/0056)

Current role

1. Can we start by you telling me about your current role within healthcare?

Prompts: setting (NHS, education, DoH, other), length of time in this role, type of work, relationships to other professionals within the setting.

2. Can you tell me about your role in relation to non-medical prescribing policy and practice at a national or local level (past and current)?

Prompts: nature of involvement (how, why, where, what), positions of responsibility (past and current), relationships with other professionals (who - healthcare and other groups, e.g. government).

Non-medical prescribing policy & practice

3. What are your views on the expansion of the non-medical prescribing policy programme to now include more groups of healthcare professionals prescribing a range of medicines?

Prompts: professional groups & their readiness for prescribing, personal experiences – specific examples, mentorship & education, governance, limits – medicines & conditions, patient care, promotion of multidisciplinary working.

4. What factors have influenced national / local non-medical prescribing policy development? Can you give examples?

Prompts: budgets, service pressures / targets, clinical need, professional groups / individuals / other, systems affecting practice e.g. documentation, systems of governance - who, where, what, why.

5. Have you encountered any barriers or facilitators to the practices of non-medical prescribers?

Prompt: people (patients, other healthcare professionals, managerial staff), national & local practice systems (electronic prescribing, prescription pads, clinical management plans, issuing prescriptions), governance (national / local policy & procedure, contact / support from a medical prescriber, non-medical prescribing groups, pharmacist), resources / finance, other policies / practices.

6. Do you see limits to non-medical prescribing practices within the NHS

Prompts: complexity of patient care, multi-morbidity, polypharmacy, specific drugs (e.g. biologics), cost, professional / organisational reputation loss

7.   What are your views on the governance systems for non-medical prescribing (local & national)?

Prompts: overarching medicines' management for patients (who, how, where), role of medical and non-medical professionals in governing prescribing, systems of recording / documenting / reporting.

The future of non-medical prescribing

8.   What are your views on the potential long-term effects of physiotherapists acting as independent prescribers?

Prompts: limitations, professional status, primary providers of MSK care / service re-distribution, consequences for patient health outcomes, safety, insurance, inter-professional working, co-ordinated care.

9.   How do you see both medical and non-medical prescribing working within the National Health Service?

Prompts: setting, type of services, integration of systems, clinical teams.

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Accompanying Material

Enclosure 1: Paper published in Social Science & Medicine

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Governing healthcare: Finding meaning in a clinical practice guideline for the management of non-specific low back pain

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A R T I C L E   I N F O

A B S T R A C T

Clinical practice guidelines produced by NICE — the National Institute for Health and Care Excellence — are seen as key mechanisms to regulate and standardise UK healthcare practice, but their development is known to be problematic, and their adoption and uptake variable. Examining *what* a guideline or health policy means to different audiences, and *how* it means something to those communities, provides new insight about interpretive discourses. In this paper we present a micro-analysis of the response of healthcare professionals to publication of a single NICE guideline in 2009 which proposed a re-organisation of professional services for chronic non-specific low back pain. Adopting an interpretive approach, we seek to understand both the meaning of the guideline and the socio-political events associated with it. Drawing on archived policy documents related to the development and publication of the guideline, texts published in professional journals and on web-sites, and semi-structured interview data from professionals associated with the debate, we identify a key discourse that positions the management of chronic non-specific low back pain within physician jurisdiction. We examine the emergence of this discourse through policy-related symbolic artifacts taking the form of specific languages, objects and acts. This discourse effectively resisted and displaced the service reorganisation proposed by the guideline and, in so doing, ensured medical hegemony within practice and professional organisations concerned with the management of non-specific low back pain.

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Introduction

In the United Kingdom (UK), healthcare governance is enacted via a multiplicity of means, including national health policy and guidance, clinical protocols and through the actions of professional groups and non-government institutions (Armstrong, 2002; Nettleton, Burrows, & Watt, 2008). A key governance role is provided by the National Institute for Health and Care Excellence (NICE). Set up in 1999, NICE provides national healthcare guidance aimed at improving care and, ultimately, reducing healthcare inequalities and costs (Rawlins, 1999), however, the implementation and uptake of NICE guidance has been shown to be highly variable (Sheldon et al., 2004).

Clinical guidelines constitute one type of NICE guidance, offering evidence-based recommendations for the care and treatment of specific conditions. Processes of guidelines seek to configure work and workers, standardise healthcare and thus render it comparable across settings and systems (Timmermans & Berg, 2003; Timmermans & Epstein, 2010). There is substantial literature which shows that guideline generation (McDonald & Harrison, 2004; Moreira, 2005) and implementation (Mickan, Burls, & Glasziou, 2011; Spyridonidis & Calnan, 2011) are highly problematic and deeply politicised (this is especially well described by Timmermans & Berg, 2003).

In this paper we focus on a debate surrounding a single NICE guideline (CG88), published in 2009, which made recommendations for the care of individuals with persistent non-specific low back pain. We present a case study, looking in detail at the responses of healthcare professionals and the socio-political events that accompanied this guidance. Our interest in this particular guideline stems in part from the professional experiences of the lead author, a physiotherapist involved with managing patients presenting with back pain.

Background

In November 2005, the UK Department of Health asked NICE to produce a clinical guideline for the early management of patients with chronic (defined as lasting more than 6 weeks) low back pain (NICE, 2006). Low back pain is a major cause of work absenteeism and considerable healthcare spending (Bevan et al., 2009; Hong,

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Reed, Novick, & Happich, 2013). Approximately one third of individuals affected by an episode of low back pain will not have recovered after one year (Henschke et al., 2008) and, for the majority, a specific cause of their back pain is never identified and is therefore classified as non-specific low back pain (Airaksinen et al., 2006; Deyo & Weinstein, 2001). In addition, there exist a myriad of treatments for back pain, though research evidence suggests that most of those currently available have only modest effects (Balagué, Mannion, Pellisé, & Cedraschi, 2012). Diagnostic uncertainty, combined with this treatment diversity and outcome variability, has led to a lack of clarity about which healthcare practitioners should manage low back pain, such that general practitioners, physiotherapists, osteopaths, chiropractors, spinal surgeons and pain specialists all have some role in the treatment of this condition (Prior, 2003).

The guideline developed over a two year period, culminating in publication as CG88 in May 2009. It affirmed the non-specific nature of most low back pain and recommended that spinal imaging (X-ray and Magnetic Resonance Imaging {MRI}) should not be performed unless on grounds of suspected serious medical pathology (cancer, infection, fracture, inflammatory disorders) or where a surgical opinion was to be sought (Savigny et al., 2009). Though MRI enables the identification of spinal anomalies which are not visible externally (May, Doyle, & Chew-Graham, 1999), spinal anomalies have been demonstrated in a large number of individuals without symptoms (Jarvik, Hollingworth, Heagerty, Haynor, & Deyo, 2001), thereby reducing the diagnostic value of this procedure (Rhodes, McPhillips-Tangum, Markham, & Klenk, 1999). The significance of a spinal anomaly and its correlation with pain can be explored, for example, by injecting the spine with therapeutic substances, but secure diagnosis resulting from these procedures has not been demonstrated (Manchikanti et al., 2009). Given the lack of evidence to support the use of these injections, this practise too was not recommended.[1] Elsewhere the guideline recommended increased provision of exercise, manual therapy and acupuncture as first line interventions - treatments typically offered by physiotherapists, chiropractors, osteopaths and acupuncturists — some of whom historically work outside the NHS in the private healthcare sector. For those resistant to initial treatments and presenting with high disability and/or psychological distress, a combined physical and psychological treatment programme (termed CPP) was to be offered, whilst for the small group unresponsive to all conservative treatments, and willing to consider surgery, an opinion on spinal fusion was recommended (Savigny et al., 2009).

Reactions to the guideline were mixed; some healthcare organisations welcomed it (British Acupuncture Council, 2009; British Osteopathic Association, 2009; Chartered Society of Physiotherapy, 2009; General Chiropractic Council, 2009), while others openly contested the recommendations (Hester, 2009; Royal College of Anaesthetists, 2011). The guideline appeared to challenge common practices and professional boundaries and threatened to redistribute work amongst healthcare professionals. A heated discussion about the guideline took place in professional journals and other fora, such as blogs. This debate questioned the guideline recommendations and the processes of guideline development.

Key UK professional organisations, including the British Pain Society and the Faculty of Pain Medicine of the Royal College of Anaesthetists, called for the guideline to be withdrawn (Hester, 2009; Royal College of Anaesthetists, 2011). Following this, in July

2009, the British Pain Society held an extraordinary general meeting during which the President of the Society signalled his resignation following a vote of no confidence. The President (a consultant physiotherapist) had worked on the development of the guideline having been appointed clinical advisor to the guideline development group in 2007. In Spring 2009, he was elected President of the British Pain Society, the first non-medical healthcare professional to hold this role. The events within the Society fuelled further correspondence, and much of the debate surrounding the unseating of the President centred on the question of whether his role in the development of, and support for, the guideline was in direct conflict with his role within the Society.

Our approach

Clinical guidelines are procedural standards (Timmermans & Berg, 2003) which, through their development and implementation, transform the social world. In line with other types of standards, they have potential to 'change positions of actors', alter 'relations of accountability' and emphasise or de-emphasise 'pre-existing hierarchies' (Timmermans & Berg, 2003, p. 22). Moreover, standards can both shape and constitute our understanding of things (Pickersgill, 2012), and their effects warrant 'careful empirical analysis' (Timmermans & Epstein, 2010, p. 69). Our study sought to investigate these transformations and, in particular, to examine how these were accomplished via the discourses and actions of health professionals.

We were interested to explore the guideline debate in relation to ideas about professional boundaries and boundary-work. In part, we were inspired by classic sociological analyses of professional segmentation (Bucher & Strauss, 1961) and demarcation (Gieryn, 1983), but also more recent contributions including Mizrachi and Shuval's study (2005) of the symbolic boundaries between alternative and biomedical practitioners in hospital and ambulatory settings, Burri's work about how imaging technologies are used to configure professional authority in radiology (2008), and Pickard's analysis (2009) of power struggles involving general practitioners with special interests. To our knowledge, the role that clinical guidelines play in boundary-work and relations between the physiotherapy and medical professions has not previously been examined, and we therefore hoped to augment the literature by providing empirical analysis of debate surrounding guidelines and possible shifts in lines of demarcation between healthcare professions.

We employed a Foucauldian-informed discursive interpretive approach to make sense of the socio-political events associated with the CG88 guideline. Interpretive approaches to policy analysis allow us to focus on meaning — for example, the meaning of policy for those formulating and implementing it (Yanow, 2000) — and consider how meaning shapes actions, practices and institutions (Bevir & Rhodes, 2004, p. 130) and how meaning itself is shaped by context (Schwartz-Shea & Yanow, 2012). This interpretivism contrasts with more 'naïve rationalist' models of policy-making, which Russell, Greenhalgh, Byrne, and McDonnell (2008, p. 40) describe as 'decision science', seeing policy as a linear and logical process.

Wagenaar (2011) and Schwartz-Shea and Yanow (2012) note that meaning is neither directly accessible nor appreciable at the surface of human existence. Yanow's work (Yanow, 2000, 2006), however, provides examples of how meaning can be identified through a focus on policy-related artifacts. She argues that symbolic artifacts, in the form of *languages*, *objects* and *acts*, are the concrete symbols of human meaning — infused with the beliefs, values and feelings of those generating, enacting and interpreting policy and policy-related events. Thus, they express the meanings embedded within a particular policy process (Wagenaar, 2011;

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[1] The guideline recommended research into the effectiveness and cost effectiveness of facet joint injections and radiofrequency lesioning for people with persistent non-specific low back pain.

Yanow, 2000). One of the difficulties with Foucault's discursive approach is that he is notoriously silent about how exactly the analyst should practically proceed, however Yanow provides a helpful framework to guide an interpretive policy analysis. Applied to this case study, Yanow's framework focussed us on signifiers of meaning that could illuminate *what* this particular guideline meant to individuals, groups and communities interpreting it and *how* it meant something to them.

Study design and method

Having identified that there was an area of tension around the guideline, we widely reviewed sources in which the debate occurred. We were keen to capture variation and so we purposively looked for views and contributions from medical and non-medical professions and for policy documents relating to the guidance. We included collective and individual contributions to the debate and explored official documents (*e.g.* NICE reports), professional journals and less formal texts such as blogs. In this paper, we focus on three documentary sources and interview data collected for this study. Our documentary data sources include: firstly, the complete set of 43 rapid response letters published in the British Medical Journal between 28th May 2009 and 10th August 2009 in response to publication of the guideline [L 1–43]. Whilst this journal has a generalist audience and contributors, these particular letters were mainly authored by doctors and this gave us insight into individual views from the medical profession. Secondly, we referred to documents produced by NICE relating to CG88 [D 1–9], (conveniently archived at http://www.nice.org.uk/CG88) to provide a policy perspective. Thirdly, we drew on a collection of documents associated with a professional society, the British Pain Society [D 10–24], a professional organisation representing a collective (but not necessarily consensual) view of both medical and non-medical professions. We focussed on these to illustrate the different professional discourses played out in core texts and accounts. We have, in line with constraints of the ethical approval of this study, chosen to only present publically available texts here and not to identify individuals by name.

To augment the analysis of these texts we also undertook 11 semi-structured interviews with health professionals involved in the debate [I 1–11]. Our sampling was purposive and inter-textual, as we sought key individuals from the healthcare professions named in the debate or occupying formal positions in organisations involved in the debate. Each interview lasted approximately one hour, was audio-recorded and subsequently transcribed verbatim and anonymised. A brief topic guide, developed from the scoping and literature reviewing phase of the study and iteratively informed by the documentary sources and early interviews, was used to prompt questioning. The questions sought opinion on such things as development and implementation of the NICE low back pain guideline, the effect of the guideline on individual practice and professional groups and the impact on professional organisations of the British Pain Society extraordinary general meeting. Interviews were conducted by the lead author, who made initial contact with interviewees as a doctoral student but who was known to some respondents in a professional context. We recognise that her identity may have both helped and hindered rapport and the kinds of accounts given, for example, some respondents may have felt more comfortable discussing these issues with a researcher of the same profession. That said, we do not believe that the views expressed were overly biased by this, for example, some respondents had articulated their view in public fora and documentary sources and did not give markedly different accounts in interview. Data were entered into QSR NVIVO 9 (QSR International Pty Ltd) to enable archiving, recording of codes and data

management. Ethical and research governance approval for this study was granted by the University of Southampton and all interviews were recorded with individual participant consent.

We recognise that the data presented here are not exhaustive but we have attempted to represent the principal threads in the debate and the range of perspectives outlined. We note of course that in using only the publically available documents we meet the requirements of our ethical approval but exclude some of the more extreme voices in the debate.

Using the steps suggested by Yanow (2000) (Table 1), initial coding focused on identifying the symbolic artifacts (languages, acts and objects), for the various interpretive communities surrounding NICE CG88. We read and reviewed the data, discussed and coded through an iterative process, thus enabling us to identify discourses and discursive practices.

Findings

Symbolic languages

We identified examples of symbolic languages reflecting the beliefs of the communities interpreting the guideline and, through the iterative process described above, we were able to group and focus these around four key themes: legitimisation of practice, diagnostic expertise, the individual patient and the evidence-base. These are described in turn below.

Legitimisation of practice

Embedded in the responses to the publication of CG88 was language confirming that different professional groups saw the guideline as a tool that would shape and legitimise certain forms of practice and alter the distribution of resources. For those professions already providing treatments recommended within the guideline it was viewed as supportive of their position:

'...for physiotherapy, if you look at what was recommended, [physiotherapy] was written all over [the guideline] ... looking at it from a marketing perspective ... for example, the Chiropractors ... lobbied every PCT [Primary Care Trust] ... in England.' [I, 6]

Crucially, the recommendations were perceived by some as curtailing the role of the specialist pain doctor, as indicated by this interviewee:

'... most pain specialists spend most of their time treating people with low back pain — that's what we do. And a guideline comes out that says, You're not needed. Full stop...... It can be managed without any reference to you whatsoever; you don't need injections; you don't need TENS [Transcutaneous Electrical Nerve Stimulation]; GPs can give all the drugs; the manipulation therapists and the physios can do all the manipulation and acupuncture; oh, and we have a little bit of rehab..... And it was like, Hey? Hang on, this is what I do!' [I, 11]

Table 1
Overview of Yanow's approach.

1. Identify the policy-related symbolic artifacts (languages, objects, acts) that carry significant meaning for the communities interpreting them.
2. Identify the different interpreting communities for each policy-related symbolic artifact.
3. Identify the discourses emerging through the policy-related symbolic artifacts.
4. Identify the points of struggle reflecting the different meanings interpreted by the different communities.

Adapted from Yanow, 2000, p. 22.

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with pain clinic funding identified as a potential casualty:

Funding to Pain Clinics will be stopped, to provide acupuncture and chiropractic and also the more useful, but less well-funded options, of exercise and CPP (Combined Physiotherapy and Psychology) - no need for doctors and nurses. [L, 34]

The '*no need for doctors and nurses*' symbolic language at the end of this extract highlights the potential disruption to professional position and power signalled by the guideline.

Diagnostic expertise

The guideline recommendations against imaging and interventional pain medicine techniques attacked core diagnostic procedures used by pain physicians, though this threat was rebutted by marshalling claims to diagnostic expertise, as seen through the following extracts:

In order to make a diagnosis patients need an MRI scan and specific nerve blocking or structure stimulating techniques … [L, 12]

The legal implications of missing serious pathology of the pelvis, urinary tract, bowel or bone presenting as "non-specific LBP" will become a time bomb waiting to explode. [L, 36]

… adherence to these guidelines will result in prolonged treatments by non-medical professionals without proper assessment of the patient. [L, 25]

Diagnosis can be considered as both a category and process (Blaxter, 1978), used to structure the healthcare field. It demarcates providers (which speciality "owns" the patient) and technologies, and allocates rights to resources (Jutel & Nettleton, 2011). Jutel (2009, p. 284) argues that medicine's authority is embodied in diagnosis at 'both institutional and individual levels'. This NICE guideline threatened to make obsolete the diagnostic tools of the interventionalist pain specialist and so coarctate the bridge between illness and disease (Jutel, 2009; Schubert, 2011) thus potentially de-legitimising the role of the interventional pain physician and, more widely, doctors of pain medicine. The language used in the letters, as shown, makes this threat very clear.

The individual patient

The British Pain Society in responding to the publication of the guideline, wrote:

Application of these guidelines to all those with persistent low back pain will result in a major change in clinical practice, which in the opinion of the Council of the BPS [British Pain Society], will not represent good or appropriate patient care. [L, 10]

The 'patient' began to be conceptualised and presented in the debate as both individualised (requiring specific, tailored treatment) and agentic (able to make choices about their own care). The heterogeneity of symptom presentation and uncertainty about diagnosis allowed clinicians to argue about the contingent nature of lower back pain:

'… *we've tried to lump them [patients] altogether and not found that possible, so what we have to do is find a route, [a] way through [so] we can manage this individual, manage them physically, psychologically and socially, through to some sort of … agreed end-point where they are better, or they are managing*

it better, or they're coping a bit better with what they have got.' [I, 8]

The language of the individualised patient was rationalised as a means to resist the re-organisation of care:

… the treatment has to be tailored to patient's needs and prescriptive guidelines promoting "one size fits all" is not acceptable. [L, 12]

The terms of this part of the debate resonate with Armstrong's analysis of clinical autonomy and resistance to 'formalised systems of control' by General Practitioners in the management of depression (Armstrong, 2002, p. 1776). Individual autonomy was achieved by 'promoting the idiosyncrasies of individual patients' (Armstrong, 2002, p. 1776), which in the debate over CG88 were overlaid with ideas about patient choice:

'There's a population out there who manage and cope, and it [an injection] is their preferred way of managing their back pain, and doctors accede to that; we do lots of things for patients because that's what they want.' [I, 9]

Indeed the tension between patient rights to choice and the curtailing of choice was embedded in the very language of the guideline where 'patient choice' was explicitly promoted:

Offer one of the following treatment options, taking into account patient preference: an exercise programme, a course of manual therapy or a course of acupuncture

(Savigny et al., 2009, p. 2) [D, 8]

'Choice' has been a feature of 'NHS-speak' since the late 1990s, alongside the introduction of a consumer-led market for healthcare (Peckham et al., 2011). However it 'remains a limited concept' (Peckham et al., 2011, p. 200), and in practice, many NHS systems restrict choice, for example by waiting lists and resource management systems (Klein & Maybin, 2012). Nonetheless the notion of choice has been formally extended to encompass not only choice of provider, but also choice of treatment (DoH, 2010) so that the exclusion of some treatment pathways in the guideline remapped the provider landscape, thus potentially restricting choice. In the language of one interviewee, choices were clearly linked to care provider:

'But these injections work as long as it's pain doctors who give 'em and not Orthopaedic surgeons …' [I, 11]

Thus the language of 'choice' was used to support the claims of pain doctors to rebut the recommendations in the guideline.

The evidence-base

Language manifesting concern over the nature of the evidence-base underpinning the guideline was evident in both letters and interviews. A core tenet of evidence-based medicine is that randomised controlled trials (RCTs) and systematic reviews are the highest quality of evidence. This understanding of 'evidence' was core to the debate about how the guideline was developed, as the following illustrate:

'I do think the Guideline Development Group, in an effort to not produce something totally whacky that everybody was just going to roll over and laugh at … set their level of evidence very high, i.e. only randomised controlled trials.' [I, 9]

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'… a lot of the evidence that we've already got doesn't meet that criteria, and we're writing guidelines on things that really have been set up not to represent real life.' [sic] [I, 2]

'So they had some evidence-based stuff, and then sixteen on personal recommendation. Now, once you start doing that, you've broken the rules, and you either have it all as evidence-based — in which case you'll have to come up with a very weak guideline — or you have it all on personal opinion, in which case you've got to be really careful how you pick your committee.' [I, 11]

Naylor (1995) draws our attention to the many 'grey zones' (p. 840) of clinical practice, where current data is insufficient to guide practice, and the resultant minimalism or experience and inference based inventions that follow (Naylor, 1995). The language in this last quote reveals the perceived association between the experiences and inferences of the guideline development group and the guideline recommendations—an association that McDonald and Harrison (2004) have evidenced as influential in the construction of local clinical guidelines for statin use and managing heart failure.

Symbolic objects

Discussed below are three key symbolic objects visible within the data through which guideline meaning was manifested and sustained: the blog, the guideline development group membership list and the Articles of Association of the British Pain Society.

The blog

As the debate unfolded in the professional societies and medical journals it also spilt over into other fora, notably the Web, where several blogs discussed the issue. One internet web-site - www.nicelbp.blogspot - was set up following the publication of the draft guideline. Initially publically accessible, this blog housed comments about the guidelines and the role of the British Pain Society's President:

'… there were comments around the individual, and there were comments around NICE is barmy.' [I, 9]

The blog played an agentic role within the debate, mobilising those who were against the guideline and those who wished to censure the President for his involvement in the guideline development, as exemplified in this extract:

I have put up a poll @ http://niceguideline.questionpro.com for anyone who is interested in registering their dissatisfaction with [the President's] behaviour and involvement with the NICE guidelines. In my view he has done our specialty and the Society an enormous disservice, he does not deserve to be our president. If you agree or even if you don't please vote so that the depth of feeling can be gauged.

(Extract taken from www.nicelbp.blogspot) [D, 11]

One interviewee recalled that the debate on the blog was like:

'… listening in on the … rioters in … Hackney' [I, 9]

(referring to the public disorders in London which occurred in the summer of 2011). Other professional organisations copied extracts from this blog, reproducing them in other media and widening the net of professionals caught up in the activity:

Our experience in handling very difficult cases counts as nothing now that we form part of a merry band of PC 'health care professionals'; We are led by a physiotherapist! A [Professional] who

cannot even interpret straight forward evidence when it is presented to him on a plate. Who's going to be the next BPS President? A Hospital Porter?

(Extract taken from www.nicelbp.blogspot Available from: www.csp.org.uk) [D, 16]

Over time, access to the blog was restricted, eventually becoming subscription only. Following the British Pain Society's extraordinary general meeting the blog took on a new role as a focal point for the campaigning for a new president for the society.

Guideline development group membership list

The debate about the guideline raised questions concerning the process of guideline development and these centred on the role of different stakeholders. Key here was the claim that the British Pain Society had not been adequately represented:

'If we had been able to comment on the scope, we should have been able to … make a comment to NICE to say we think it's vital that you have these people on the development group. We missed that opportunity.' [I, 7]

The reasons for the failure of this apparently key organisation to register as a stakeholder in the preliminary development of the guideline become clear when looking at the guideline development group membership list. The President (although not elected to that role at the time) had been appointed as the clinical advisor to the group prior to the initial stakeholder meeting. This was perceived by some as advantageous:

'… because [the President] was the clinical lead for that particular guideline … there was a perception … in the Pain Society that he was representing the British Pain Society, which he wasn't.' [I, 8]

The membership of the guideline development group (confirmed in the record of attendees at guideline development meetings) [D, 7] was drawn from nominations made by stakeholder groups. In addition to the chair and the clinical advisor, the professions represented within this group included a general practitioner, a physiotherapist, a chiropractor, an osteopath, a clinical psychologist, an occupational health physician, an orthopaedic surgeon, a nurse, and an expert in non-surgical interventional procedures (i.e. a radiologist, rheumatologist or anaesthetist). There were also two patient representatives.

Documents surrounding the guideline development group consultation which took place between February and March 2007, highlight anxieties from groups that were not represented, and enthusiasm from those who had secured a place:

…it would appear that practitioners of complementary and alternative therapy will have strong representation on the GDG when these therapies are not normally provided in the NHS. Is there a danger of these enthusiasts making unrealistic claims for treatments for which positive evidence from RCTs is scant or nonexistent? This would be a pity especially if people who have a firm grasp of evidence-based medicine (e.g. from pain medicine and rheumatology) are not represented. (Royal College of Anaesthetists) [D, 3]

We welcome the creation of this Guideline and look forward to supporting NICE in its development through our involvement with

both the GDG and the Stakeholder consultation process. (Chartered Society of Physiotherapy) [D, 3]

Following the publication of the guideline, the membership list of the guideline development group became a focal object in the debate. Some interpreted the constitution of the group as prejudicial:

> … every modality represented by the panel members but, as no interventionalist has been accepted onto the panel, no injection treatment [L, 14]

whilst others did not:

> '… who it is that's on the group … [is] *a lot less relevant than what the evidence is saying.*' [I, 6]

Some of those dissatisfied with the guideline felt that the President of the British Pain Society, as the clinical advisor, needed to be an advocate for the Society, and this became key in the events (acts) which followed. Before we attend to these symbolic acts, we will examine another symbolic object that was enrolled in the discourse, namely the Articles of Association of the British Pain Society.

Articles of association

The formal Articles of Association of the British Pain Society, adopted in January 2004 contained a key clause – article 50.1 – which permitted the convening of an extraordinary general meeting at the request of *not less than twenty-four Ordinary Members* [D, 14] which had to be called within 28 days of receipt of the request. The opportunities afforded by this object had not however been appreciated by all members:

> 'I don't think … anybody quite realised how easy it was to call an EGM. I think we suddenly said, What! Can they really do that?' [I, 7]

It is worth noting that in common with many formal documents, this object was not a fixed, permanent entity. This article was however a pivotal object in the debate and acts that followed. Its significance might not have been realised, though once it was, the object was altered: following its use in the summer of 2009, article 50.1 was amended by special resolution, so that *10 percent of Ordinary Members* [D, 15] would subsequently be required to convene an extraordinary general meeting.

Symbolic acts

In this final section we examine and interpret two symbolic acts which emerged from the data. These acts communicate the meaning of the guideline and its recommendations for communities interpreting it.

Calling for withdrawal of the guidance

As part of the guideline development process, NICE opened a consultation, encouraging stakeholders to submit comments between 1st October and 26th November 2008. One interviewee said that this had produced a '*huge amount*' [I, 9] of responses from the Pain Society's interventional pain special interest group. Not everyone was dissatisfied, however:

> *Overall, we welcome this guideline and agree with the underlying principles of encouraging activity, exercise and self-management in a context of appropriately prescribed analgesia* [D, 6]

> '… *many individuals … felt that the guideline was in fact balanced and reasonable.*' [I, 9]

There was a belief that stakeholder submissions would be reflected in the final guideline to be published in May 2009:

> '*So, we were quite confident … that they wouldn't dream of bringing that out. … So we were really quite shocked and staggered when it didn't change.*' [I, 11]

However, when the guideline was published it became clear that this hope was not to be fulfilled. At this point there was a key act in the unfolding drama – a call for guideline withdrawal made by the British Pain Society Council:

> '… *we couldn't do nothing; we had to say that we felt these Guidelines were wrong.*' [sic] [I, 7]

Not all members of the Society were in favour of this call however:

> '… *immediately afterwards* [the call for withdrawal] *the membership said, well we didn't ask the committee to make this decision but effectively … it … has historically always been ceded over to them because of the lack of engagement.*' [I, 1]

> '… *there was concern that if that group … wasn't placated in some way, by the Society taking a fairly rigorous stance … there was a danger that the Society would fracture.*' [I, 7]

On the 12th June 2009, the British Medical Journal published an official statement from the British Pain Society which called for the withdrawal of the NICE guideline. The Faculty of Pain Medicine within the Royal College of Anaesthetists also acted, recommending withdrawal, and the language of their call specifically referenced the lack of a pain medicine specialist or anaesthetist within the guideline development group:

> *Neither the person nominated by the RCoA nor any other anesthetist or pain medicine specialist was selected by NICE.* (Royal College of Anesthetists) [D, 24]

Extraordinary general meeting

Five weeks after the publication of the guideline a letter signed by 25 pain society members was received at the London offices of the British Pain Society. The letter called for an extraordinary general meeting to debate the guideline and vote on a motion to remove the President from office due to:

> … *his involvement with and the continued endorsement of, the NICE Guidelines on Low Back Pain* … (British Pain Society, 2009) [D, 22]

This was the first time that an extraordinary general meeting had been called within the history of the society and its predecessor organisations. The meeting took place on 21st July 2009 with forty-five members of the British Pain Society present, not counting the chair and the secretariat [D, 20]. Some members of the Society had written to the chair stating their objection to the vote and expressing their support for an alternative resolution to the crisis [D, 17; D, 18]. During the meeting, a representative from NICE gave a short presentation, about the role of the clinical advisor and the formation of the guideline development group, offering a further meeting between NICE and the Society to move forward with the guideline. There followed a discussion around a proposal to take the vote in secret with one interviewee recalling that:

'… all hell broke loose at that point, and people were threatening to resign, and … getting very, very angry.' [I, 2]

The vote ultimately went ahead and was carried by seven votes, the total votes cast representing a quarter of the Society's membership. After the meeting, the President duly resigned his position having been in post for only three months. An interim president was appointed, an emeritus professor of psychological medicine, who subsequently facilitated discussions between representatives of the Society and NICE. One outcome of these discussions was confirmation that the guideline would be reviewed in 2012 and that a pain specialist would be included in the future guideline development group. A new President of the Society (a consultant in anaesthesia and pain medicine) was elected, and this restored the position of a medical practitioner at the head of the Society. Restoring a medical practitioner at the helm of the Society reassured some:

'… doctors understand doctors. Other professions, I believe, don't have the same insight, not for any reason than they're not doctors. … traditionally, you know, doctors have led teams of medics and of pain professionals. Why the doctor? Because the managers listen to them more, um, and they're intelligent, motivated people.' [I, 9]

Discussion

We have shown how policy-related symbolic languages, objects and acts expressed the meanings of the guideline for those interpreting it. This analysis provides a foundation for an interpretive discourse which defines the nature of the work to be done with individuals affected by non-specific low back pain, describes how it should be done and delineates (crucially) who should do it (May & Fleming, 1997). The symbolic languages initially centred on legitimisation of practice, diagnostic expertise and the individual patient, and then marshalled arguments about 'the evidence base'. These functioned collectively to identify and situate each patient affected by persistent back pain in the hands of a designated healthcare professional; one with authority to request and interpret imaging, one with skills in specialised diagnostic interventional pain management techniques, enabled through access to technologies (such as imaging and injections). The language of patient individualism and choice was employed to preserve specialised knowledge and autonomous practice. Other practitioners were marginalised through this discourse by being segregated from these approaches and technologies through skill or location, exacerbated by the number of competing professions treating back pain, the variation in occupations and the overlap in treatment provided (Norris, 2001).

Similarly, the symbolic objects (the blog, the guideline development group membership list and article 50.1) coalesced to identify, voice and mobilise particular subjects, whilst shadowing, silencing and constraining others. The list of those permitted to contribute to the formulation of the guidelines represented particular organisations and professionals; these are not just names but signals of expertise and association. From this object tributary discourses flowed, about guideline development group member bias, forms of knowledge, and claims about the privileging of doctors in interventional pain medicine. The blog too had specific demarcations that gave voice to those disenchanted with the guidance and served to connect to networks defined by professional and social difference (Duke, 2011). These two objects provided a platform for opposition to the Society's President and a further object - article 50.1 - was invoked to enable action.

The symbolic acts (the call to withdraw the guideline and the holding of the extraordinary general meeting) opened up discursive spaces, in which some could speak and be heard, whilst others could not. The call for withdrawal of the guideline by the British Pain Society, a society which could lay claim to represent a range of professionals involved in providing care for patients with back pain, gave legitimacy to the claims of doctors in interventional pain medicine disenfranchised by the guidance. The extraordinary general meeting identified and ordered subjects and events, and the vote and resignation of the President (*re*)legitimised the position of doctors. These acts ensured that a particular professional order was restored.

Through our analysis we have demonstrated that these languages, objects and acts intertwined to make meaning around the NICE guideline. A key discourse emerged that enabled boundary-work by doctors in interventional pain medicine - activity designed to protect and expand jurisdiction, assert professional authority, claim resources and protect autonomy (Gieryn, 1983). This kind of professional boundary-work is not new (Burri, 2008; Mizrachi & Shuval, 2005; Pickard, 2009), but our examination of this case study has shown how meaning and actions connect. On their own, each text and event might appear to be limited and isolated, and the power being asserted may be unclear: as Foucault suggests, it appears that 'no one is there to have invented them, and few who can be said to have formulated them' (Foucault, 1998, p. 95), yet together they provide a familiar discourse of medical dominance (Freidson, 1970). The symbolic artifacts of this case study reveal tactics of exclusion and control, along with the creation of new knowledges, spaces and subjectivities arising through the discourse.

Conclusion

Previous research has shown that guidelines are contested and contingent. Much of our attention has focussed on guideline implementation and 'failure'. This paper has deliberately taken a step back to tackle the issue at an earlier stage, to try to understand a few moments in the development and debate around a single guideline and to show how meaning is made and how a discourse of power is created and sustained. Our case study has demonstrated how discourse, displayed through language, objects and acts, enabled professional boundary-work and supported claims to power. The discourse had significant effect, countering the re-positioning of healthcare workers proposed through the guideline, thus continuing to challenge efforts to govern practice and standardise healthcare.

Acknowledgements

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Enclosure 1

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Enclosure 2: Poster presentation – PGR Conference, Faculty of Health Sciences 2014

Enclosure 3: Abstract presented at BSA Medical Sociology 48th Annual Conference

A Case Study of Physiotherapist Non-Medical Prescribing: Service Re-Organisation, a Primacy of Orthopaedic Surgery and the Marginalization of Prescribing Medicines

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Rights to prescribe medicines now extend to a range of healthcare professionals including some physiotherapists, who can act as supplementary and independent prescribers. Non-medical prescribing is a key pillar of NHS modernisation policy, designed to deliver quicker access to treatment and result in improved health outcomes for patients.

In this paper we investigate the non-medical prescribing practices of physiotherapists working in an outpatient service in England. The enactment of non-medical prescribing in this context occurred against a backdrop of significant national and local service re-organisation (including shifts between primary and secondary care provision associated with wider NHS reforms) and financial austerity.

Our analysis is framed by an interest in professions as social bodies that engage in jurisdictional boundary-work and is informed by Foucault's conceptualisation of governmentality. The data presented is drawn from non-participant

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observation of physiotherapist working practices during eleven half-day outpatient clinics, informal conversations before, during and after clinics, analysis of documents associated with the case study and twelve semi-structured interviews with participating physiotherapists and other healthcare professionals involved in the policy and practice of non-medical prescribing.

Using Yanow's (2000) steps for interpretive policy analysis, we explore the microphysics of power shaping and constituting these physiotherapists and their non-medical prescribing practices. We identify a dominant discursive framework within which elective orthopaedic surgery is given primacy over non-surgical management of people with musculoskeletal conditions and the prescribing of medicines by physiotherapists is marginalized, despite the national policy rhetoric.