The Rise of Non-Medical Prescribing and Medical Dominance

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ABSTRACT

This article contributes to the continuing debate on the professional dominance of medicine given the rising number of professions allied to medicine that now have the legal authority to prescribe and could potentially threaten this dominance. The key questions addressed are whether non-medical prescribers represent a threat to the dominance of medicine and if they do not, what has mediated doctors' response to these newer prescribers such that they are able to retain dominance? Drawing on Abbott's work on jurisdictional claims, this paper explores how the rise of non-medical prescribing has led to competing jurisdictional claims over prescribing between doctors and non-medical prescribers. This paper particularly focuses on pharmacist prescribing and how competing jurisdictional claims could be settled. It discusses why the profession of medicine is still dominant and the importance of professional ideologies to influencing the outcome of competing jurisdictional claims. The professional ideology of medicine has shifted from valuing prescribing to valuing the indeterminacy involved in complex clinical decision making, illustrating medicine's ability to adapt, retain dominance and maintain cultural authority over clinical knowledge. In contrast, pharmacist prescribers' professional ideology involves having specialist medicines expertise and being safe prescribers. Pharmacists draw upon this ideology to argue their unique competence as a prescriber: given their pharmacological knowledge and attention to detail which facilitates their role as clinical checker or 'safety net' on prescribing. However, medicine's cultural authority in clinical decision-making enables, when there are competing jurisdictional claims over prescribing, for doctors to retain intellectual jurisdiction: control over the cognitive knowledge base involved in prescribing and clinical decision making. Could this be eroded to a weaker form of control involving advisory jurisdiction? Should political developments further favour the

widespread acceptance of prescribing as a core part of the pharmacist's role, an erosion to advisory jurisdiction may yet be possible.

Keywords:

Medical decision-making; medicine; medical dominance; pharmacy; prescribing; professional autonomy

INTRODUCTION

Prescribing is a key area of occupational work for the medical profession and, increasingly, for those professions allied to medicine who have gained the authority to prescribe. Prescribing is an area where professionals are able to display their clinical autonomy; their control over the object of their work, the prescription, through autonomous decision-making and, by implication, the prescribing process and how medicines are used. Control over prescribing is important for professionals because, at a macro level, it demonstrates a control over resources (e.g. the spending of money on medicines) and, at a micro level, control over the consultation through the use of the prescription as a way of coping with workload pressures and to demonstrate their professional expertise.[1] For those occupations wishing to call themselves a profession, prescribing has been a key part of the rationale for their claim to professional status. Freidson characterised medicine as a profession because its members have autonomy or control over the object of their work, in part realised through, up until recently, its monopoly over the prescribing process.[2]

Historically definitions of a profession have included this notion of autonomy, which is based on expert judgement, founded on access to a unique body of knowledge.[3] Indeed, Freidson noted that doctors' control over this body of knowledge, made possible by a lengthy period of training with subsequent certification by professional institutions and legally underwritten by the state, was what underpinned medical dominance.[4,5] The clinical decision making displayed through the act of prescribing gave professional power and status to medicine within wider society. However, societal, political and regulatory changes have led to increasing numbers of professionals, including pharmacists, nurses and other professionals the authority to prescribe. Non-medical prescribing, prescribing by

pharmacists and nurses, in particular, represents a potential threat to medical dominance as, in the UK, pharmacist and nurse prescribers are able to prescribe at an autonomous level comparable to a doctor.

The key questions that arise from this situation are: do non-medical prescribers represent a threat to the dominance of medicine? If they do not, what has mediated doctors' response to these newer prescribers such that they are able to retain dominance? Further, how does this inform the development of theory in the sociology of the professions?

In the paper, pharmacist prescribing is used to explore the threat to medical dominance because pharmacists are a profession that could, theoretically, pose a competing claim to medicine's dominance over prescribing due to pharmacy's long historical association with medicines and medicine supply. Much of the research drawn upon in this paper involves pharmacist prescribers working in the primary care setting (general practice). Theoretically, this paper uses Abbott's (1988) work on jurisdictional claims, and how competing jurisdictional claims might be settled, to explore how pharmacist prescribing has led to both pharmacy and medicine having a jurisdictional claim to prescribing.[6] This paper will seek to develop Abbott's theoretical premise by exploring the rise of pharmacist prescribing in the UK, the threat posed by non-medical prescribing to medical dominance and the importance of professional ideologies in mediating the outcome of competing jurisdictional claims over prescribing between pharmacy and medicine. Finally, this paper will make a case for the role of professional ideologies in developing Abbott's thesis around jurisdictional claims and in how these ideologies influence potential settlements arising from competing jurisdictional claims.

BACKGROUND TO PHARMACIST PRESCRIBING

Pharmacist prescribing in the UK has been possible, in some form, since 2003. These changes were informed by the *Crown Report,* published in March 1999, which recommended that 'the legal authority to prescribe should be extended beyond currently authorised prescribers'.[7] In 2003, legislative changes were introduced which permitted prescribing by other health-care professionals such as nurses and pharmacists. This initial UK legislation allowed pharmacists and nurses to prescribe under supplementary prescribing (SP) arrangements where pharmacist and nurse prescribers could act, with the patient's agreement, to implement a patient-specific clinical management plan (CMP) in partnership with a doctor or dentist. Drivers behind supplementary prescribing were to improve patients' access to medicines, make better use of the clinical skills of eligible professionals and, in time, to decrease general practitioners' workload so they could concentrate on more complicated cases.[8]

In 2006, further legislative changes were introduced to allow pharmacists and nurses to become independent prescribers, defined as 'a practitioner responsible for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing'.[9] This hallmark change meant nurse and pharmacist prescribers were on a par, at least in terms of legislative authority to prescribe, with doctors. Nurses and pharmacists are the most frequently cited professional able to prescribe as independent 'non-medical' prescribers' although, in the UK, this has expanded to include additional prescribers such as physiotherapists, podiatrists, optometrists, chiropodists and therapeutic radiographers.[10] All Allied Health Care Professional non-medical prescribers need to work within their professional competence with some having limitations on what they are able to prescribe (e.g. opticians can only prescribe drugs for ocular conditions).

Nancarrow and Borthwick, in their exploration of changing workforce boundaries, argue that independent prescribing by nurses and pharmacists can be seen as a form of vertical substitution: in this case when the professional task of prescribing is delegated or adopted across a disciplinary boundary, from medicine to, for example, pharmacy. This adoption of a new task usually expands the scope of practice of the receiving profession without necessarily leading to an increase in status or rewards.[11] Indeed, globally, models of prescribing vary with regard to prescriptive authority (whether or not the nurse or pharmacist has independent authority or works in collaboration with a doctor), whether the non-medical prescriber works from a limited list of drugs or limited formulary (or is able to prescribe any drug), and whether they can only prescribe within the context of a specific protocol, such as those patients with particular clinical conditions or for specific patient groups (or can prescribe for anyone).[12] The UK's independent prescribing model is arguably one of the most liberal prescribing models, enabling non-medical prescribers, after completion of an accredited training programme, the independent authority to prescribe (e.g. without collaboration with a doctor) and the ability to prescribe any drug from the British National Formulary (with the exception of diamorphine, dipipanone and cocaine for the treatment of addiction) for any clinical condition within their clinical competence.[10,13]

The diverse models of non-medical prescribing practiced internationally have been reviewed by Stewart.[14] One model can be exemplified by the U.S. where, in some States pharmacists can assume professional responsibility for particular clinical conditions within a given protocol. The second model can be exemplified by Canada where, depending on province, pharmacists can prescribe any drug within their professional competence. Stewart also describes a third model such as is available in New Zealand where pharmacists are able to prescribe as part of a collaborative agreement with a doctor.[14] This third model is similar

to the supplementary prescribing model developed in the UK before the development of full independent prescribing.

THE PROFESSION OF PHARMACY

In the UK, the traditional view of a pharmacist is that of a community pharmacist or 'chemist' on the high street, employed by a large chain of pharmacies. However, pharmacists can also work in other sectors such as primary care (within a GP practice) or secondary care.[15] In addition to being employed by a company owning a chain of pharmacies, community pharmacists can also own an independent pharmacy or a small number of pharmacies themselves. Health is a devolved responsibility across the UK and therefore non-medical prescribing has evolved at different rates across England, Scotland, Wales and Northern Ireland.[16] For example, in Scotland, *Prescription for Excellence* in 2013 described their vision for all pharmacists to become independent prescribers, collaboratively working with medical prescribers,[17] with a recent survey suggesting there is a significant pharmacist independent prescribing workforce currently prescribing.[18] While in Wales, *Our Plan for Primary Care in Wales up do March 2018*, was more focussed on the shortage of GPs and how non-medical prescribing could support this.[19] In England in 2015, as part of NHS England's Clinical Pharmacists in General Practice scheme, money was provided to increase the number of pharmacists working in general practice. These pharmacists aimed to improve outcomes from medicines, consulting with, and treating, patients directly.[20] General practice-based pharmacists can be directly employed by the practice, for example, to undertake patient reviews of medications, manage long term conditions or manage the practice's repeat prescriptions. They can also be wholly or partly employed by the local clinical commissioning group (CCG) to conduct practice audits and implement the CCG's strategic plans with regard to medicines. In secondary care,

pharmacists work in roles on wards (reviewing medication charts, attending ward rounds) to more strategic roles developing the organisation's policies on which, and how, medicines are to be used. Evidence suggests that pharmacists prescribing in secondary care do so safely, across a range of therapeutic areas.[21] The range of settings which pharmacists can work in enables a diverse range of roles for pharmacist prescribers.

Pharmacist prescribing can be seen within the broader professional landscape of pharmacy as part of a professionalising strategy which has sought to increase the professional status of pharmacy through engagement in more clinical or patient-facing activities.[22] In 1968, American sociologists Norman Denzin & Curtis Mettlin published their seminal work on the profession of pharmacy, describing pharmacy as an occupation that had undergone incomplete professionalization.[23] That is, while pharmacy had some elements meriting categorisation as a profession (specialised training, a code of ethics, a specialised skill), other aspects of pharmacy (commercialisation, lack of altruism and an inability to control the activities around the object of their work: the drug) meant it could only be considered a marginal or incomplete profession.

Later researchers claimed that Denzin & Mettlin narrowly conceived of the object of pharmacy's work, the drug, as solely a material object when, for Dingwall & Wilson the drug was a social object, serving as the basis for social interaction around which information is offered and exchanged.[24] However, over the past 40 years, the categorisation of pharmacy as an incomplete profession has largely remained, with pharmacy increasingly engaging in more clinical activities such as patient counselling, ward prescription monitoring and medicines information as a way of addressing this "incomplete" professionalisation. This shift towards more clinical activities has in part been a way to counter the loss of a compounding role in making up medicines, but also to enhance the professional status of

pharmacists through an association with more 'doctor-like' work. Pharmacists themselves have described the increased visibility associated with being involved in clinical decision-making[25] and, for some, the increased professional status they feel clinical activities offer them.[1] However, Freidson noted that paramedical professions gain legitimacy by their association with medicine but lack the autonomy to be considered a profession.[4] With the development of pharmacist prescribing in more recent years, pharmacist prescribers may have achieved the holy grail of professionalisation: increasing their professional autonomy and professional status.

MEDICAL DOMINANCE THREATENED?

While in the UK pharmacist independent prescribing had been successfully accomplished in the legal sphere, workplace practices have continued to reinforce the superior role of the doctor. In the workplace there are a range of everyday (often tacit) workplace strategies that reinforce the dominance of medicine. Cooper et al's study of supplementary prescribers, identified several strategies which support the dominance of medicine.[26] These include the practice of doctors legitimising/overseeing the supplementary prescribing process and supplementary prescribers, doctors' control of access to prescribing training, the perception (by patients and by supplementary prescribers) of doctors as being hierarchically superior, supplementary prescribers' tendency to seek advice from doctors and doctors' denigration of 'routine' prescribing. Such routine prescribing, appropriate for delegation to a pharmacist prescriber, can include continuing existing prescriptions or when supplementary prescribers make minor dose adjustments. At a regulatory level, previous training requirements for the education of pharmacist independent prescribers also required the individual who supervises the pharmacist prescriber in training to be a medical

practitioner although this requirement has recently been changed to include any experienced prescribing practitioner.[27,28]

Across the range of workplace strategies which support the dominance of medicine, deference to medical practitioners by pharmacists is often implicit. Deference has been a long-standing theme to interactions between pharmacists and doctors where pharmacists, for example, use (arguably excessive) tactful communication strategies so as to not upset or appear to question the doctor's expertise.[28] These strategies have the effect of reinforcing the superior role of the doctor at an interactional level in the workplace.[25, 29-31] Yet this is not the only possible way of working. With the growth in team working and collaboration across professional groups, it is possible for other professionals such as pharmacists with the appropriate skills to lead the team and achieve the team's patient management aims.

Workplace strategies that reinforce the superior role of the doctor have been accompanied by a conceptual shift in the importance of prescribing to professional status. In the final report of the evaluation of supplementary prescribing by nurses and pharmacists, diagnosing by doctors was considered to be a 'more skilled, uncertain and difficult task' with prescribing seen as a lesser task than *de novo* diagnosis.[32] Prescribing was considered by doctors to have diminished as a skilled practice, particularly with the widespread use of protocols. Indeed, as described by Cooper et al., doctors saw their role, with its superior knowledge, training and experience, to be reserved for diagnosis and *plus ultra* prescribing.[26] Such routine prescribing was denigrated and deemed not to be as difficult (and by implication, important) as *de novo* prescribing and diagnostic decision making.[33] Yet prescribing decision-making and diagnostic decision making (as well as other clinical decisions around referral or non-pharmacological interventions) are all, at a cognitive level, part of a broader clinical decision-making process.[33] The difference, and difficulty in

decision-making, lies not in the outcome of the decision (a prescription, a diagnosis, a referral) but rather in the level of medical uncertainty or complexity in the decision-making process to arrive at a particular outcome.

This has led to more recent authors questioning whether the extension of prescribing rights to non-doctors has threatened medical dominance.[1,5,26,34] All have concluded that while changes to the legal authority to prescribe (e.g. to enable prescribing by non-doctors), societal changes (e.g. increasing public access to knowledge) and other policies (e.g. the salaried employment of doctors) have been put in place that could undermine the dominance of medicine, they do not, 'in the end, have much control or influence.'[34] Medicine has retained its dominance.

PROFESSIONAL IDEOLOGIES

In an interview study with 23 supplementary pharmacist prescribers, researchers explored the importance of prescribing to professional power.[1] This study took place in 2005 not long after the first group of pharmacist supplementary prescribers began to prescribe. Key to facilitating pharmacist prescribers' new role was an emphasis on them defining, and limiting, their competence to specific clinical areas of practice. Declared clinical areas of competence, self-limitation on practice and the benefits of team working were seen as part of an ideology of patient safety which the pharmacist prescribers readily endorsed. Similarly, in their qualitative study involving interviews with 11 pharmacists and 11 doctors, McCann, et al., identified the importance of the multi-disciplinary team to safe prescribing and a belief, by pharmacists, of the ability of pharmacists to conduct more thorough medicines reviews due to their expertise in medicines.[35]

An ideology is defined as 'a set of beliefs or principles, especially one on which a political system, party or organisation is based'.[36] A professional ideology is the set of beliefs or principles that guide the behaviours and actions of a professional group such as pharmacists or doctors. Professional ideologies are important because while they may endorse potentially laudable beliefs or principles, interpreting or following through on these ideologies may lead to unexpected outcomes. For example, for pharmacist prescribers, their ideology emphasises their medicines expertise and commitment to patient safety. According to the International Pharmaceutical Federation (FIP), pharmacists, as the ultimate expert in medicines, play a crucial role in ensuring patient safety.[37] In a review of learning outcomes for pharmacy graduates across Australia, Canada, the US and the UK, findings suggested that in all four countries, achievement of the learning outcomes enabled graduates to become patient-oriented medicines experts.[38] This ideology involving medicines expertise and patient safety led to an emphasis on achieving prescribing competence, self-limiting prescribing practice to specific clinical areas and working within teams as a safer, more effective way of working.[1] It can be argued that a by-product of this ideology is to endorse an inferior role for pharmacists within the health care hierarchy which is dominated by doctors.

Pharmacists see themselves as safe prescribers, fully signing up to the notion of pharmacists' professional ideology with patient safety at its core. Pharmacists draw upon this ideology to argue their unique competence as a prescriber given their pharmacological knowledge,[35, 39] and attention to prescribing detail[35] which has enabled them to act as a 'safety net' in prescribing in detecting and resolving prescribing errors.[1,40, 41] The behaviours which flow from this ideology both facilitate their role as pharmacist prescribers but also delimits what they are able to do by implicitly advocating the pharmacists have declared

areas of clinical competence and for them to work within the broader health care team. This ideology, and the workplace practices that reinforce the superior role of the doctor, therefore facilitates medical dominance in the area of prescribing and, more broadly, clinical decision-making.

INDETERMINACY AND COMPLEXITY AS MEDICAL IDEOLOGY

With the development of non-medical prescribing, doctors' professional ideology has had to develop and adapt. When pharmacist and nurse prescribing became possible, doctors were initially quite vocal in their reluctance to support pharmacist prescribing.[42-44] Instead of arguing for the importance of prescribing to their professional role, medicine's focus initially shifted to emphasising the importance of diagnosis. When full independent prescribing [to include making diagnoses] became possible for non-medical prescribers, this focus again shifted from diagnosing to being able to manage complex patient cases as key areas of doctors' expertise.

This is similar to Kroezen's description of doctors' response to nurse prescribing in The Netherlands,[45] where doctors began to modify their position, from being against pharmacist prescribing to supporting prescribing by other health care professionals, particularly in clinical areas that were considered to be more routine or straightforward. In an interview study with 21 prescribers including GPs, nurse independent prescribers and pharmacist independent prescribers, nurses and pharmacists were considered to engage in a lower level of complexity in their clinical decision-making process than doctors and were thus suitable for more routine prescribing: continuing existing prescriptions or following standardised clinical protocols.[46] In a study exploring the role of physician associates in general practice, nurses were considered by GPs to be not very good at dealing with complexity.[47]

Doctors' source of professional status shifted slightly, with less emphasis on the singular ability to diagnose, to being able to deal with complex cases in all their variety. As noted in Weiss et al., a more nuanced role for GPs, as prescribers and diagnosticians needed to be developed.[46] This more nuanced role focused on the subtleties and indeterminacy of prescribing which could not be reduced to a protocol. As noted by a GP in Weiss et al.[46]:

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

Rather, this new metier for doctors was directed towards abstraction and the intellectual challenge of dealing with complex cases.[46] Medicine's gaze shifted from prescribing (in general) to 'subtle prescribing' in dealing with complex cases where their particular expertise was best suited. Thus complexity, or dealing with complex patient cases, became an integral part of medicine's ideology.

The idea that abstraction and subtlety are important to the professional work of doctors is not new. Previously, Jamous and Peloille proposed that professional work could be understood as having two dimensions, a technical element (technicality) and an indeterminate element (indeterminacy), the latter comprising the formation of expert judgements.[48] The work of a professional can be characterised by high levels of indeterminacy relative to technicality, described as a high I/T ratio.[48] In the context of medical knowledge, technicality refers to that knowledge which can be codified, broken down into its constituent parts and delegated.[45] Technical knowledge can include the formalised knowledge covered in clinical protocols which is able to be delegated to (lower

status) professionals such as a pharmacist or nurse with this codification enabling the labelling of such knowledge as routine prescribing. In contrast, indeterminacy is associated with professional judgement and the application of complex knowledge which cannot be reduced (e.g. through the use of technology) to codified knowledge. While Jamous & Peloille originally conceived of using the I/T ratio as a method of assessing the status of different professional occupations, Traynor argues that the I/T ratio is most useful in understanding professional ideology, for example when an occupation defends the importance of indeterminacy to their professional work.[3]

JURISDICTIONAL CLAIMS AND PRESCRIBING

Abbott, in his seminal work *The System of the Professions – an Essay on the Division of Expert Labor*, argues that control or jurisdiction over certain tasks is an essential part of being a profession.[6] He describes a jurisdiction as the link between a profession and its work. Prescribing can thus be seen as an area of occupational work which, before the passing of legislation giving non-doctors the authority to prescribe, was under full jurisdictional control of the medical profession.[1] Abbott argues that jurisdictional claims can be made in different arenas: the legal system, by public opinion or through interactions in the workplace. Jurisdictional claims over prescribing have been successfully made in the legal arena in the UK, Canada and internationally through the passing of legislation enabling the prescribing by professionals who are not doctors to occur.

The consequence of an increasing range of professionals able to prescribe is competing jurisdictional claims for prescribing. Abbott (1988) discusses five ways in which these contested areas of jurisdictional claims can be resolved or, if not resolved, settled.[6] The settlements (or outcomes) of contested claims of jurisdiction can include one profession having full jurisdiction over an area, for example a return to the days before the enabling

prescribing legislation was passed so that only doctors can prescribe. Competing claims can be settled by creating a *divided jurisdiction*, where a jurisdiction is divided into functionally interdependent but structurally equal parts or by the complete *subordination* of one profession by another. This latter settlement can be recognised in the earlier prescribing models of supplementary or delegated prescribing where doctors retained full authority for prescribing, granting pharmacists access to particular patient groups or signing off on agreements which delimit the pharmacist's area of prescribing. An alternative settlement is *intellectual jurisdic*tion, where one profession retains control of the cognitive knowledge of an area but allows, or is forced to allow, practice on a more or less unrestricted basis by several competitors. It could be argued that this is the current settlement in operation for pharmacist prescribing in the UK. Doctors have been forced, through legislation, to allow all pharmacists to prescribe but they still control the knowledge base of prescribing and, through a range of formal and informal workplace strategies, control how prescribing is managed on a day to day basis. Finally, there is *advisory jurisdiction*, where one profession seeks a legitimate right to interpret, buffer, or partially modify actions another takes within its own full jurisdiction and a jurisdictional settlement by *client differentiation* where different types of prescribers see different types of patients.[6]

MEDICAL DOMINANCE REBORN

Doctors' professional ideology emphasising the indeterminacy, complexity and subtleties of clinical decision-making is the basis for doctors' jurisdictional claim over prescribing. As pharmacist (and other allied health care professionals) prescribers have the legal authority to prescribe, this jurisdiction is claimed in the workplace and evidenced by the informal workplace practices that recognise doctors' cultural authority over clinical knowledge. Doctors' professional ideology emphasising indeterminacy is integral to their

cultural authority. Doctors have cultural authority in clinical decision-making because it is widely accepted that the clinical knowledge underpinning doctors' expertise has value, that it is valid and true and has meaning in being able to define, evaluate and treat illness.[49] This cultural authority underpins medical dominance and enables, where there are competing jurisdictional claims, a settlement on doctors having intellectual jurisdiction over prescribing and other forms of clinical decision making. This settlement on doctors having intellectual jurisdiction over prescribing is manifested by their control of the cognitive knowledge base needed to prescribe.

In 2001, prescribing was described as the battleground from where doctors' clinical autonomy will be defended.[50] However, even with the addition of a range of new prescribers who are not doctors, the landscape around prescribing has shifted and evolved rather than become a battlefield. Doctors have consented (or at least not strongly objected) to the addition of new prescribers, particularly in delegating areas of routine prescribing. As suggested by Nancarrow & Borthwick this may be partly due to high levels of unmet demand and partly due to the benefits blurred professional role boundaries have given a range of professional groups, not just the new prescribers.[11] In addition, the focus has gone away from a narrow emphasis on prescribing to how best to manage complex patients, and the challenges to clinical decision making that come from managing such complex patients. No longer just prescribing, it is in this latter area where medicine is making a jurisdictional claim supported by its cultural authority over clinical knowledge. This virtuous circle emphasising a professional ideology of complexity, indeterminacy and subtlety in clinical decision-making is an integral part of doctors' cultural authority over clinical knowledge. This in turn supports, and reinforces, medical dominance and medicine's intellectual jurisdiction over clinical decision-making, including prescribing. Professional ideology has

become a key influence in determining the outcome or likely settlement arising from competing jurisdictional claims.

Abbott describes having intellectual jurisdiction as being an unstable form of settlement, with a weaker form of control, advisory jurisdiction possible when a jurisdictional dispute occurs between two professions who already possess independent full jurisdiction.[6] Abbott gives the example of psychiatry in the U.S. post World War II, having a precarious form of intellectual jurisdiction over psychoanalysis through their control of psychoanalytic training. Precarious because psychologists and social workers were able to develop new psychotherapeutic programmes, aligned but distinct from psychoanalysis to marginalise psychiatry's intellectual jurisdiction over psychoanalysis.

Could pharmacist prescribers marginalise doctors' intellectual jurisdiction over complex clinical decision making and erode it to a form of advisory jurisdiction? In advisory jurisdiction, one profession seeks a legitimate right to interpret, buffer or partially modify actions another profession takes within its own full jurisdiction.[6] In the current political climate, a decline in medicine's dominance to the weaker advisory jurisdiction seems unlikely. Pharmacists have tried to lay claim to having medicines expertise as a core part of their professional ideology. However, this medicines expertise is twinned with a core commitment to patient safety which subverts this expertise by exhorting the importance of competence and for pharmacists to actively delimit their prescribing to specific clinical areas. Even if a pharmacist prescriber has medicines expertise across a range of clinical areas such as is required to address issues of polypharmacy,[51] this medicines expertise is not enough to give pharmacist prescribers cultural authority over clinical knowledge in the same way as doctors. This may be because medicines expertise is viewed as being a subset of the

clinical knowledge expertise claimed by doctors. Doctors still retain an overarching or overseeing role.

Under competing jurisdictional claims, advisory jurisdiction can be seen as the bellwether of inter-professional conflict: "sometimes a leading edge of invasion, sometimes the trailing edge of defeat".[6: p.76] Burrage and Torstendahl identify four important actors who shape the destiny of aspiring professions: practising members, universities, the state and users (both patients and the public).[52] Each actor has the potential to influence the outcome of professional goals. While a level of intra-professional conflict may exist, a common professional ideology helps ensure that professional aspirations will endure. Patients and the public may as yet be largely unaware of pharmacy's expertise as prescribers but, as discussed by Burrage and Torstendahl, political process has the greatest importance in shaping professional change.[52] Government policy has already been shown to influence the extent to which pharmacist prescribing has been taken up by the devolved countries of the UK.[16] Political process has already led to the legislative authority to prescribe for pharmacists. However this legislative authority has always been couched in terms of decreasing GP workload and to allow GPs to spend more time on difficult patient cases.[8] This implicitly sets up a hierarchy of time and knowledge, with GP time perceived as more valuable than independent prescribers', and with GPs having a superior form of medical knowledge which is able to cope with complex patient cases. Political process has thus supported GPs' superior form of clinical knowledge at the same time as legislation has enabled independent prescribing by non-doctors. Regulatory changes could yet go further to endorse pharmacists as primary prescribers for most clinical conditions, given their unique place and expertise within the health care system. With this, medicine could retain a form of advisory jurisdiction, predicated on its superiority over complex decision making,

but the authority to manage most of the prescribing would be taken on by pharmacist prescribers. In the future, an erosion to advisory jurisdiction may yet be possible.

CONCLUSION

With pharmacists and other health care professional now able to prescribe, this paper has sought to explore the changing context of prescribing, the shifting importance of prescribing in defining professional status and to understand why, given the influx of newer prescribers, medical dominance persists. Abbott's theories around jurisdictional claims and how competing jurisdictional claims might be settled, are useful in helping to understand this. In particular, this paper has explored the links between professional ideology, cultural authority and jurisdictional claims. The professional ideologies of pharmacy and medicine are key to understanding why medicine retains its dominance within healthcare and how the shift in medicine from valuing prescribing to valuing the indeterminacy involved in complex clinical decision making has illustrated medicine's ability to adapt and retain dominance. This professional ideology emphasising indeterminacy is integral to doctors' cultural authority in clinical decision-making; a cultural authority where the clinical knowledge underpinning doctors' expertise is accepted as valid and has recognised societal value. This cultural authority underpins medical dominance and enables, when there are competing jurisdictional claims, a settlement resulting in doctors having intellectual jurisdiction over prescribing and other forms of clinical decision making. This is most pointedly evident in informal workplace strategies which reinforce medicine's superior professional status and authority over complex clinical decision-making. Pharmacy's ideology, involving medicines expertise and an emphasis on patient safety, is not enough to give pharmacist prescribers cultural authority over clinical knowledge, possibly because

medicines expertise is viewed as a subset of clinical knowledge with doctors still retaining an overarching or oversight role. Abbott's work on jurisdictional claims suggests that settlements involving intellectual jurisdictions are unstable. Political processes have so far both supported GPs' superior form of clinical knowledge at the same time as legislation has enabled independent prescribing by non-doctors. Should political developments further favour the widespread acceptance of prescribing as a core part of the pharmacist's role, an erosion to an alternative settlement involving advisory jurisdiction may yet be possible.

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