

March 2002

**SMALL PHARMACIES AND THE NATIONAL HEALTH
SERVICE**

R Dingwall

P Watson

Trent Institute for Health Services Research
Universities of Leicester, Nottingham and Sheffield

DISCUSSION PAPER 02/01

Published by the Trent Institute for Health Services Research

© 2002 Trent Institute for Health Services Research, Universities of Leicester, Nottingham and Sheffield.

ISBN 1-900733-45-5

Referencing information:

Dingwall R, Watson P. *Small Pharmacies and the National Health Service*. Sheffield: Trent Institute for Health Services Research, Universities of Leicester, Nottingham and Sheffield, 2002. Discussion Paper 02/01.

Further copies of this document are available (price £15.00) from:-

Trent Institute Information Service @ SchARR
Regent Court
30 Regent Street
SHEFFIELD S1 4DA

Tel 0114 222 0703
Fax 0114 272 4095
E-mail scharrlib@sheffield.ac.uk

Please make cheques payable to "The University of Sheffield".

AUTHORS

Robert Dingwall is Professor of Sociology and Director, Institute for the Study of Genetics, Biorisks and Society, University of Nottingham.

Pamela Watson is a registered Pharmacist and former Research Associate, School of Sociology and Social Policy, University of Nottingham.

ACKNOWLEDGEMENTS

We are grateful to Alison Pilnick, Claire Anderson and Sue Ambler for their help and comments on earlier drafts. Responsibility for the final text is, of course, ours alone.

ABOUT THE TRENT INSTITUTE FOR HEALTH SERVICES RESEARCH

The Trent Institute for Health Services Research is a collaborative venture between the Universities of Leicester, Nottingham and Sheffield with support from NHS Trent Regional Office.

The Trent Institute:

- Undertakes, facilitates and promotes Health Services Research (HSR), adding value to the research through the networks created by the Institute;
- provides education and training in HSR for health professionals and career researchers;
- provides advice and support to NHS staff undertaking HSR;
- provides support to NHS staff in the application of the results of research;
- disseminates the results of research to influence the provision of health care.

The Directors of the Institute are: Professor R L Akehurst (Sheffield);
Professor C Jagger (Leicester); and
Professor H Williams (Nottingham).

Professor Williams currently undertakes the role of Institute Co-ordinator.

A Core Unit, which provides central administrative and co-ordinating services, is located in Regent Court within The University of Sheffield in conjunction with the School of Health and Related Research (ScHARR).

FOREWORD

This report was commissioned by the Trent Institute for Health Services Research in October 1996 to inform the development of a full-scale investigation of the social and economic position of solo practitioners in community pharmacy, their ability to deliver a high quality service and to meet changing NHS expectations about their role in primary care, and the likely effects of other changes in the market for medicines. Fieldwork was carried out during the spring and early summer of 1997. As a result of various career contingencies, the authors have not developed the envisaged programme of work. However, this agenda remains relevant and the lessons of the pilot study are offered as a resource to the health services research community and as an encouragement to others to take the work forward. In order to maintain the report's value to policymakers, the commentary and policy discussion have been extended to consider developments since 1997 until the end of 2001 in the light of the original findings.

The report is divided into four sections: a review of policy development by the Department of Health (DH) and the Royal Pharmaceutical Society (RPSGB)¹ from the 1986 publication of the Report of the Committee of Inquiry funded by the Nuffield Foundation until the General Election of 1997 as a background to the fieldwork; a review of previous literature on solo professional practice, drawing on studies of a range of professions, and an introduction to the design and methods used in this study; a report on the perceived conditions of solo practice in Nottinghamshire in 1997; and a conclusion reviewing government and professional policy developments since 1997 and discussing the implications of the findings for these.

¹ Strictly, the Society was only licensed to adopt the title 'Royal' from May 1988 but it will be used throughout this report to avoid confusion.

CONTENTS

Page

EXECUTIVE SUMMARY	1
1. THE PHARMACY PROFESSION AND GOVERNMENT 1986-1997	2
2. THE SOLO PRACTITIONER – HERO/HEROINE OR VILLAIN?	13
3. DESIGN AND METHODS	21
4. THE REPORTED STATE OF SOLO PRACTICE IN NOTTINGHAMSHIRE 1997	23
Why Solo Practice?	23
Solo Practice and the Professional Vision	27
The Cost of Autonomy	33
Temptations to Sin	36
Conclusion	39
5. THE PHARMACY PROFESSION AND GOVERNMENT 1997-2001	41
6. REFERENCES	49

EXECUTIVE SUMMARY

This report examines the social and economic position of solo practitioners (owner-managers) in community pharmacy, the pressures on their ability to deliver a high quality service and to meet changing NHS expectations about their role in primary care, and the likely impact of changes in the market for medicines.

The first section reviews relations between the pharmacy profession and government from the publication of the Nuffield Committee of Inquiry in 1986 until the change of administration in 1997. It notes the growing concentration of ownership and the increasing economic pressures on small pharmacies. This is followed by a review of the sociological literature on solo professionals. This casts them as both heroes or heroines, taking advantage of the opportunities to give innovative personal service, and as villains, providing marginal services to marginal groups in the community with frequent ethical and legal violations.

The third section describes the findings of interviews with 20/34 solo pharmacists in Nottingham and Nottinghamshire during the summer of 1997. These show that relatively few of these pharmacists claimed to be working in this sector from choice. Nevertheless, they had made considerable personal and financial investments in their business and emphasised the importance of personal autonomy in the way that they ordered their affairs. They achieved this at the cost of long hours and poor working conditions with few proper breaks, limited holidays and an invasion of their home life by paperwork. This left them reluctant to participate in professional activities or continuing professional development (CPD). There was clearly an important cultural gap between the rational bureaucratic thinking characteristic of civil servants, NHS planners or many HSR academics and the entrepreneurial spirit of the solo professional. If this was not properly understood, reforms could be difficult to introduce or have perverse consequences.

The final section reviews developments since 1997. It notes the initial policy neglect of pharmacy by the incoming government and the failure to think through its place in the new structures being created in primary care. To the extent that this has begun to change, thinking has not joined up with the commercial changes being imposed by the end of Retail Price Maintenance and the investigation of the restrictions on NHS contracts by the Office of Fair Trading. It argues that the solo pharmacy is unlikely to survive the combination of increased regulation and market uncertainty.

1. THE PHARMACY PROFESSION AND GOVERNMENT 1986-1997

The Nuffield Committee of Inquiry was set up in 1983, chaired by an outsider to both the profession and the health policy community, Sir Kenneth Clucas, formerly Permanent Secretary at the Department of Trade. It had twelve members - six pharmacists, three doctors, an academic economist, an NHS administrator and a consumer activist. The Committee's work is a convenient starting-point for a review of policy development because it was the first attempt in a generation to think fundamentally about the future of pharmacy and because its report has framed most of the subsequent debates between the membership of the profession, the leadership of their professional body, the NHS and the Department of Health (DH).

The Committee did not have the resources to carry out any research of its own and noted the limited amount of work that was available to inform policy debate, particularly 'information on what pharmacists actually do - as distinct from what they say they do (para. 1.11)'. Nevertheless, the report draws this together, along with the written and oral evidence submitted and its own members' investigations, in the best available picture of the state of the profession in the early 1980s. Although the report reviews the whole range of pharmaceutical work, we shall only discuss its analysis of community pharmacy here.

Community pharmacy, according to the Committee, is typified by 'the shop in the high street where prescriptions are dispensed and medicines sold'. At the time of its investigations, about fifteen per cent of these outlets were owned by large multiples (more than 20 branches), of whom the most prominent were Boots and the Co-Op. The typical pharmacy, for the Committee, would be owner-managed or part of a small chain, probably built up and owner-managed by a particularly entrepreneurial pharmacist. Most of these were engaged in the sale of a wide range of commodities, including toiletries, cosmetics and chemically-related items for gardening, photography and similar hobbies, although a small number were located in health centres and restricted to handling medicines and medical supplies. However, the Committee noted important shifts in the market which were bifurcating the profession. On the one hand, the larger multiples were increasingly diversifying into the sale of a much wider range of household and leisure goods, and supermarkets were seeking to add medicines and pharmacy services to their product portfolio. These pharmacies would represent a limited part of businesses whose main turnover was in other goods. At the same time, smaller pharmacies faced increasing competition from supermarkets, in relation to cosmetics, and from specialist suppliers, such as garden centres, in hobby markets. There were particular problems in rural

areas, where the Committee refer to the review conducted by Sir Cecil Clothier in an attempt to resolve conflicts between pharmacists and general practitioners over the right to supply prescription medicines and to the erosion of the market in non-prescription agricultural medicines.

Alongside these changes in the market, the Committee noted changes in technology. By the 1980s, community pharmacists were rarely required to undertake extemporaneous dispensing, preparing medicines to a doctor's prescription from ingredients held in the dispensary. Most medicines were now supplied in a ready-manufactured form and so the pharmacist's role involved decoding the prescription, assembling the individual supply from bulk stock and handing it over to the patient or their agent. The Committee noted the argument that counting tablets or pouring liquid from one bottle to another might not require expensive professional training, although recognising that advising the recipient on the correct use might require such knowledge and skill. This knowledge might also be important in providing a check on doctors' prescribing, although the Committee were unsure about the extent to which this resulted from medical errors as opposed to poor organisation in practices which left ancillary staff to write prescriptions which were not adequately checked by the prescriber.

The Committee predicted that six major areas of change would affect pharmaceutical work over the next twenty years (through to 2006).

- a) The continuing development of new drugs and delivery systems that would be more closely tailored to individual patients;
- b) Rising costs of hospital treatment leading to earlier discharge and pressure on general practitioners and community pharmacists to take over more complex medication regimes;
- c) Rising proportion of the elderly leading to more patients on complicated drug regimes which they would need assistance in understanding;
- d) Increased use of information technology and electronic communication within the health services;
- e) Increased co-operation between health care professions;
- f) Increased consumerism and demand for justification of therapeutic advice.

These developments were not likely to reduce the number of prescriptions but were likely to influence their content. 'Original Pack Dispensing' would become the norm with a further decline in the 'assembly' parts of pharmaceutical work as patients were given their prescriptions in a package that had been untouched since it left the manufacturer. Information technology would reduce errors in repeat prescriptions and alert prescribers to adverse reactions and interactions, cutting the need for the monitoring intervention of the community pharmacist. Prescriptions would be transmitted electronically and both prescriber and pharmacist would be able to access a shared medication record, possibly stored on a smart card. Mobile communications would make it possible for a pharmacist to be available to pharmacy staff without being physically present. Community pharmacists, the Committee urged, should take advantage of these developments to enlarge their role as advisers to general practitioners on safe and cost-effective prescribing and to develop their role in counter prescribing as the first port of call for people with minor ailments. They should become more actively involved in advising patients on the appropriate use of medicines, particularly older people or people with mental health problems, both groups thought likely to have complex medication regimes and difficulty in following them. The Committee also saw potential roles in the provision of domiciliary and residential care services and in health education.

Pharmacists are unusual in the UK health sector because of the way they combine professional and commercial involvements. The Committee was not opposed in principle to the involvement of pharmacists in commercial activities that were not directly related to the supply of medicines. This might contribute to an appearance of informality that made them seem more approachable than other health care providers. There might be a temptation to adopt a commercial attitude in professional work - selling medical products where they were not therapeutically necessary - but the Committee did not see that a restriction of the product range would affect this. They noted, for example, the promotion of panaceas in some overseas pharmacies that were wholly restricted to pharmaceutical goods. However, they were unhappy about pharmacies becoming a minor component of a retail establishment and losing their distinct identity. They also questioned whether the Code of Ethics was really a sufficient restraint on the temptation to sell medicines for the pharmacist's profit rather than the patient's benefit, especially when the remuneration system accentuated this.

The Committee recommended a portfolio of changes. The present rules on the pharmacist's personal control of their pharmacy should be relaxed to allow short periods of absence to fulfil other professional duties while remaining in contact by means of mobile communications. Enforcement of premises standards should be strengthened so that pharmaceutical work was clearly distinguished

from other retail activity and space for confidential consultation was made available. Dispensing work should be reviewed to define those tasks that should be reserved to the pharmacist and those which could be delegated to a suitably regulated technician grade. The classification of medicines should be liberalised to allow pharmacists to supply a wider range on their own authority rather than requiring a prescription. The remuneration system should be reformed to reduce some of the incentives for maximising prescription throughput and to reward the performance of other activities. In general, there should be an attempt to reduce the number of pharmacies and plan the distribution of NHS contracts: where small pharmacies were considered essential, they should be maintained by a specific subsidy.

A number of the environmental changes envisaged by the Committee have been much slower to develop than they anticipated: pharmacies were early adopters of computers but the failure of the NHS to develop electronic communications is notorious; original pack dispensing is not yet in force, although many products are now supplied in this form; individually tailored medications are an anticipated benefit of the Human Genome Project but are still some years in the future and their economic viability is unproven. Other changes have run on apace: earlier discharge of patients; a growing number of elderly patients on complex medication regimes; increased consumerism. However, the Committee does seem to have completely failed to anticipate the growing concentration of ownership. In summarising their conclusions on community pharmacy, they note that, 'community pharmacy in this country has developed in a way that has required the pharmacist also to be a shopkeeper (para. 3.106)'. Although they question the proliferation of small outlets, the comments on the need to preserve the primacy of professional activities in a retail context and on emphasising independent professional responsibility, rather than detailed statutory controls, are more consistent with a model of owner-management than with employment in the large corporate chains that have become increasingly important over the last fifteen years.

Blenkinsopp (1992) describes the response of the profession and the then Government, which devoted a chapter of a White Paper, *Promoting Better Health*, published towards the end of 1987 to setting out its own view of the future place of pharmacy in primary care. The Department of Health signalled its broad acceptance of the Nuffield programme, including the relaxation of supervision requirements and payment for a range of extended duties by the NHS. Although the leadership of the Royal Pharmaceutical Society (RPSGB) were generally in favour of the recommendations, a substantial element of the rank and file were opposed to the relaxation of the requirements on personal supervision of dispensing and sales of pharmacy-only medicines. There was also considerable anxiety that the proposed expansion of the role of suitably-accredited technicians would

lead to a reduction in the employment of pharmacists. The emphasis on personal responsibility was seen as an important restraint on unethical practices by less-scrupulous members of the profession, who would take advantage of relaxation not to extend their role but to cut costs or to take on additional businesses. Debate raged in the profession for three years until the leadership's line was defeated at a Special General Meeting of the RPSGB in the Spring of 1989. The Society's Council accepted this in a statement from their October 1989 meeting. Although, in principle, this cleared the way for an extended role, it negated the compromise envisaged by the Nuffield Inquiry to release pharmacist time for it. In effect, it meant that only those pharmacies which were large enough to employ more than one pharmacist for at least part of the time would be able to take up many of the opportunities offered by the extended role, unless the pharmacist's working day were to be prolonged beyond the contracted opening hours.

A further review of pharmacy was undertaken by the National Audit Office (NAO) in 1992. This noted the continuing development of extended role services as a result of the strategy developed by a DH working party following the 1989-90 pay settlement negotiations. However, limited remuneration, the lack of a second pharmacist in many businesses and the lack of time and resources for appropriate training (which may all amount to dimensions of the same problem) were reported to be major constraints, according to a survey of community pharmacists commissioned for the report. The NAO also discussed the changing structure of remuneration and controls over the distribution of NHS contracts. From the foundation of the NHS, pharmacists had been paid on a cost-plus basis - the cost of the drugs dispensed plus a proportionate allowance for overheads and profit. Over the years, this had been modified in various ways by the payment of fees for specific services, by the introduction of a special subsidy for essential small pharmacies in 1977 and by the introduction of a basic practice allowance in 1980, a standard fee payable to all pharmacies, other than those starting up within one kilometre of an existing pharmacy, intended to recognise the availability of the pharmacist for providing advice and services other than dispensing during working hours. The cost-plus system and the basic practice allowance were abandoned in 1987. The NAO discusses a number of justifications for this including the lack of incentives for efficiency and the way in which the basic practice allowance was seen to have encouraged a proliferation of small and inefficient pharmacies. The essential small pharmacies scheme was continued, however. This provided support on application to the relevant family health services authority to pharmacies dispensing between 6,000 and 16,000 items per year and situated more than two kilometres from the next pharmacy and to pharmacies dispensing fewer than 6,000 items that were considered essential. The scheme subsidised about 125 pharmacies in England in 1990-91, protecting existing outlets without being sufficiently generous to encourage new entrants or relocation of existing businesses to under-provided areas.

The payment system changed again in 1992. Although there were detailed amendments subsequently, this was still essentially the model in force in 1996/97 (Axon 1996b). The NHS Executive and the Pharmaceutical Services Negotiating Committee agreed a fixed global sum for the pharmaceutical service. Each contractor was paid for the cost of medications provided, a fixed fee per item dispensed and an allowance for containers. Fees remained for various services and there was a generic 'professional fee' paid on a sliding scale for pharmacies dispensing between 1,100 and 1,600 prescriptions per month at which level it remained constant. The objective was to remove the former incentive to set up small pharmacies while acknowledging the lack of economies of scale at lower volumes.

The NAO devoted a good deal of its report to questioning the need for the number of small pharmacies to be found in England. A declining trend had been reversed by the introduction of the basic practice allowance in 1980, which appeared to have encouraged the establishment of about 1,200 extra pharmacies by 1987, disproportionately in individual or small chain ownership. Up to 1987, there had been no control over entry into NHS contracts - any pharmacist could set up a business anywhere (except in rural areas) and then had a right to be included on the pharmaceutical list and receive payment from the NHS. This led to a good deal of 'leapfrogging', where pharmacists competed to locate businesses closer to doctors' surgeries or health centres regardless of the impact on established outlets. After 1987, health authorities could only grant such applications if they were satisfied that it was 'necessary or desirable' to do so in order to secure the provision of NHS services in the 'neighbourhood' (Axon 1996a). The situation in rural areas had long been more closely regulated to protect the economic position of 'dispensing doctors', general practitioners who also supplied medicines direct to their patients in areas whose population density was thought otherwise to be too low to support primary medical care services purely from capitation payments. Both restrictions have been vigorously contested throughout the 1990s, including a number of actions for judicial review, mainly from supermarkets and larger chains (Superdrug 1999).

The NAO report notes that pharmacies opening between 1980 and 1987 tended to be less than 1 kilometre from their nearest neighbours, while those opening after 1987 were predominantly more than 1 kilometre distant. NAO consultants found that there were still a large number of low-volume pharmacists close to their neighbours, making no contribution to the accessibility of the service but increasing costs significantly. In Lancashire, for example, 77 out of 305 pharmacies seemed to be surplus to requirements, leaving aside those targeted by the essential small pharmacies scheme. The problem of over-supply was even greater in London, which contained 20 per cent of all pharmacies

but only accounted for 12.5 per cent of NHS prescriptions dispensed. The NAO thought that there was considerable scope for savings without compromising the accessibility of pharmaceutical services and urged changes in the remuneration structure to favour pharmacies dispensing 40,000 or more items per year and to encourage the closure of smaller providers, except where there was a local policy decision to sustain them on access grounds.

The report concluded by urging the NHS to take a more robust approach to the planning and cost-effectiveness of the community pharmacy service as part of an integrated strategy for the delivery of primary and secondary health care, rather than simply managing contracts with small businesses in a model essentially unchanged since 1948. This would, however, require investment in retraining and professional development. Although the then government had reservations about the extension of service planning, pharmacy benefited considerably from its proximity to the market.

The Department of Health's policy interest and sustained investment during the early 1990s was unprecedented in the history of pharmacy under the NHS. It appears to have been stimulated by two concerns. Contemporary conversations with DH staff suggested that one was the ability to represent concern for pharmacy as consistent with the Conservative administration's desire to encourage private sector providers in health care. While other NHS professions were seen as wedded to inflexible producer-driven models of provision that were unresponsive to consumer interests, pharmacists could be presented as the archetypal heroes and heroines of British Conservatism, robust petty entrepreneurs with a commercial sensitivity to the provision of a cost-effective and cost-efficient service attuned to patient demands. The other was the Department's own search for a more cost-effective skill-mix in primary care. Its limited leverage over general practitioner service costs was seen as a constraint on the efficient use of professional labour. An enlarged role for pharmacists in the management of minor and largely self-limiting illnesses would free general practitioner time from dealing with alleged trivia and transfer the costs of treatment from the public purse to the individual purchaser, who would have a proper incentive to consider whether medication was really necessary and effective. The leadership of the RPSGB saw an opportunity to sustain and enlarge the professional aspects of pharmacy practice. Both the Department and the Society promoted a number of initiatives designed to encourage change. The Department created the Pharmacy Practice Enterprise Scheme, a programme of investment which funded small research projects, mostly investigating possible services outside the NHS contract, and health service research training fellowships for pharmacists. The Centre for Pharmacy Postgraduate Education (CPPE) was funded by the NHS at the University of Manchester from 1991 to encourage continuing education. Its efforts

were reinforced by developments in the College of Pharmacy Practice, which, although formally independent, had been founded under the auspices of the RPSGB in 1981. The college launched a Continuing Professional Development Portfolio and Credit for Learning supplements in the *Pharmaceutical Journal* from 1995. The Department also made some direct allocations to health authorities for developments in pharmaceutical services. Nottinghamshire was one of the beneficiaries from this investment, for a scheme to develop community pharmaceutical care for people with mental health problems (Aldridge et al. 1996).

Small pharmacies nevertheless came under increasing economic pressure. The pages of the *Pharmaceutical Journal* recorded their difficulties with increasing gloom during 1993. An editorial on 13 February noted that:

It is not a good time to be a small pharmacy contractor... Nobody seems to care about them much. The National Audit Office regards them as expendable. The Department of Health does not want to give them any special treatment. The Pharmaceutical Services Negotiating Committee has all but given up on them... (Editorial 1993).

The author went on to note how little was known about the circumstances of small contractors and the need to find out more about their circumstances before they were forced out of business. The former regional pharmaceutical officer for Trent wrote on 20 February, arguing that the issue was access to pharmaceutical services rather than the support of small pharmacies (Furber 1993). Access had to reflect the changing needs of populations and the location of other services, which meant that there was a role for a range of types of provider. The following week a small pharmacy activist and former member of the Society's Council defended their interests (Walker 1993).

It is my submission that the small contractor...is the only pharmacist able to give the quality of pharmaceutical care that patients increasingly demand and deserve. It is he who has the necessary time to spend on patient care, and time for distance learning or postgraduate education, thereby achieving credibility with patients and health professionals alike.

He went on to identify these small contractors as the principal service providers in 'derelict inner city areas, unattractive housing estates and in villages and market towns where doctors have creamed off all the NHS prescriptions outside the one-mile limit but the whole population still requires access to proper pharmaceutical care'. Two weeks later, an article by a staff reporter described a small piece of market research commissioned by a four-pharmacy group in Hertfordshire, focussing on the value attached by a neighbourhood to the smallest branch, in St. Albans (Thompson 1993). Shortly afterwards, however, Lord Peston, who had been the economist member of the Nuffield Inquiry, underlined the implications of the government's response to the NAO report and the effects of changes in remuneration on small pharmacies.

Hard times were here to stay and the days of the small single proprietor pharmacist were over, Lord Peston, said, adding that there was no pleasure in speaking such a truth but the reality was unavoidable. (Meetings 1993)

The decline of the self-employed independent contractor was underlined in a labour force study by Magirr and Ottewill (1995). They estimated that less than one third of community pharmacists were self-employed by 1993. The remainder were employees, increasingly of large chains. Policy debates, however, had failed to catch up with this phenomenon. Pharmaceutical service delivery was shaped by commercial rather than professional strategy. The Code of Ethics, the expectations encouraged in professional socialisation and the qualities valued for career advancement were all being affected. Accountability to the NHS for contractual performance was being diffused within organisations rather than being located in named individuals. Patients were losing the opportunity to have one-to-one relationships with pharmacists, whose careers were defined by corporate personnel policies that favoured mobility over local affinity. As we shall show later, the profession's associations have had some difficulty in adapting to this change, mainly, it seems, because of the differential level of activism among self-employed and employee pharmacists. It appears that Magirr and Ottewill were right to draw attention to the way that employee pharmacists were more likely to look to their employing organisations as a focus for activity than to their professional bodies.

The profession's leadership tried to encourage a collective response to the changing environment, in terms both of its threats and of the opportunities that it seemed to offer. This was the 'New Age' exercise, which was launched with a discussion paper from the Council published in October 1995 and concluding with a strategy document published in September 1997, both circulated to all members of the profession. In between, six articles were published in the *Pharmaceutical Journal* and

a large-scale consultation exercise was carried out, with contributions received from over 5,000 pharmacists (from a profession of about 30,000 active members). In many ways, this initiative was a remarkable achievement with its recognition of the need to stimulate a wide debate about professional strategy and with the scale of member participation that it generated.

Pharmacy in a New Age (PIANA 1995) listed a range of environmental changes that were likely to have an impact on the profession's work: public esteem; health care financing; contracts with the NHS; relationships with doctors; relationships with other health professions; boundary shifts between care sectors; co-operation in a competitive environment; access to patient information; balance between professional and non-professional services; changes in drug licensing moving products along the classification POM to P to GSL; the future of Resale Price Maintenance; the impact of technology. It spelt out three scenarios for the future. One represented an evolution of the status quo. Community pharmacists would become free-standing medicine managers with planned distribution and co-operative resource sharing between smaller pharmacies to meet service expectations. The second scenario envisaged the effective nationalisation of community pharmacy with most services being provided through health centres, either on a partnership or a franchise basis, with pharmacists working as fully integrated members of the primary care team. The third scenario saw the replacement of most community pharmacies by mail order online with direct delivery to the patient or pick-up from general retail outlets. The back-up papers (PIANA 1996a) reviewed the political and commercial environments; consumer expectations; technological developments; the adaptation of other professions; and changes in hospitals. Taken together with the summary of responses (PIANA 1996b), these underline the limits of the RPSGB's ability to influence issues affecting the profession, partly because of the legal constraints of its unusual combination of membership association and regulatory body. The Society could deal with matters of education and professional standards but could have little impact on the policy and commercial environment. In terms of community pharmacy, there was clear pressure to give more market protection to members, particularly by planned distribution and the elimination of doctor dispensing, as the basis for movements towards the recruitment of second pharmacists in most outlets and the provision of a wider range of professional services. However, the implications of the restructuring of the profession by market forces do not seem to have attracted much comment, although they are noted in the background paper on the commercial environment (PIANA 1996a: 7-8). The RPSGB Council's (PIANA 1996c) action plan included sections on access to pharmacists' services, remuneration and distribution, although acknowledging that it could only encourage discussion on these issues. In the final strategy document (PIANA 1997), the emphasis has shifted further towards a vision of the profession's work in the future but there is virtually no consideration of the organisational forms by which this will be achieved.

Implicitly, it seems clear that the small pharmacy is expected to continue to decline, particularly with the discussion of the desirability of two pharmacists per pharmacy. However, the professional vision is developed in equal isolation from its implications for the bureaucratic environment of corporate pharmacy.

The RPSGB, the National Pharmaceutical Association and the Pharmaceutical Services Negotiating Committee did meet to explore the implications of government policies for the distribution of pharmacies and, by extension, for their accessibility. In December 1997, they submitted a joint report on these issues to the Department of Health (Supplement 1997). For present purposes, it is relevant to note their consensus on the need to provide routes for small pharmacy providers to leave the market either by offering incentives to amalgamate or to close their businesses. Developments since 1997 will be discussed in the concluding section of this report.

In summary, then, the background to this study is one of apparently increasing economic pressures during the early 1990s on the traditional solo, self-employed, pharmacist, leading to the decline of this type of provider. At the same time, there was a clear sense that something important might be lost as a result. This could be a concern about access, that small pharmacies served communities that would be unattractive to corporate providers, either because of their poverty or their low population density. It might also be a concern about the decline of professionalism. Would this amount to more than the rather dubious claims about a relationship between autonomy and social status or would something of a profession's ethic of disinterested personal service be lost as well? Despite the calls from the *Pharmaceutical Journal* and the obvious importance of the rhetoric of solo professionalism to the Enterprise Scheme and the New Age movement, relatively little seemed to be known about what was going on at grass roots level. The present project was conceived as a contribution to filling that gap, complementing Magirr and Ottewill's work by interviews with pharmacists at the edge of this fundamental social change.

Before presenting that work, however, it will be useful to review the issues emerging from previous research on the nature of solo professional practice. What concerns does this suggest?

2. THE SOLO PRACTITIONER - HERO/HEROINE OR VILLAIN?

The solo practitioner has a central place in the image and ideals of professional work. Traditionally, the term 'professional' has connoted someone who works independently to serve the interests of individual clients (Barley and Tolbert 1991).

It [individualism] may mean the belief that the individual is the true unit of service, because service depends on individual qualities and individual judgement supported by individual responsibility which cannot be shifted onto the shoulders of others. That, I believe, is the essence of professionalism and it is not concerned with self-interest, but with the welfare of the client. (Marshall 1963: 158-9)

This picture has, however, become increasingly unrealistic as professionals have moved into larger organisations and come to deal, directly or indirectly, with corporate clients. Pharmacy in the UK is typical. It has been transformed from a situation where most community pharmacists were small entrepreneurs owning and managing their own businesses in the shadow of just two large chains - Boots and the Co-Op - to one where most are salaried employees of these or other large chains or supermarkets. At the same time, pharmacists' relationship with the NHS has been redefined. Where the NHS once simply administered payment for work done, it is now behaving more like a corporate client, seeking to influence the style and quality of professional services.

Pharmacy is an occupation that has been relatively neglected by sociologists, despite its strategic location at the intersection between the world of professionalism and the world of commerce (Thorner 1942; McCormack 1956). For this reason, literature relating to solo practice in other professions will also be used to help identify potential research questions. Although some writers have questioned the status of pharmacy (Denzin with Mettlin 1968; Birenbaum 1986), by any conventional sociological definition, it can reasonably be analysed as a profession (Dingwall 1995; Dingwall and Wilson 1995). At the same time, its commercial elements remind us of the traditional approach's neglect of the economic basis of professional work. Professionals can only provide their personal services by engaging in business, recruiting clients, marketing their skills and seeking to generate enough income to make a living without cutting ethical or regulatory corners and losing their licence. Their apparently studied indifference to these material realities forms part of a status claim, a gentility that distinguishes them from mere traders. This claim has been remarkably persistent and also contributes to the

internal differentiation of the professions themselves. In pharmacy, for example, Becher (1990: 138) records the disdain of academic pharmacists for the retail sector that will employ most of their students as 'graduate grocers' who compromise the profession's image by 'selling cosmetics, contraceptives, hot water bottles and sunglasses'. Holloway et al. (1986:324) report a similar suspicion of community pharmacy among hospital pharmacists. In the words of one of their informants:

People in hospital pharmacy despair of the practices in retail - money grabbing, their lack of concern with professional ethics and the presentation of drugs to patients. Their job is so different from ours. The job of retail pharmacy is really what technicians do here - counting tablets and balancing books - which is NOT what pharmacy is about at all!

Both academic and hospital pharmacists have, of course, traditionally been insulated from the market by their salaried employment in professionally-dominated organisations. They need not refer to the material base for their work and their organisations have had to pay only limited attention to the market for their services. Although both academic and hospital settings have changed considerably in the last fifteen years or so, the extent to which the markets for health and education are managed or regulated in most advanced countries has not encouraged sociologists of the professions to look closely at the interaction between practice environments and professional behaviour. The study of law has been something of an exception to this, because of the more open nature of its markets, so that literature on the market for legal services, and its implications for professional work, will also be used to identify issues for the study of pharmacy.

As the quotation from T. H. Marshall suggests, solo practice and the personal relationship between professional and client is a central feature of the way in which we think about professions. In Britain, the image of solo general medical practice has a strong literary tradition from the novels of AJ Cronin in the 1920s to John Berger and Jean Mohr's (1967) collaboration on the photo-documentary of *A Fortunate Man*. Statistically, however, solo practice has been in long-term decline: the proportion of GPs working alone fell from 43 per cent in 1952 to 14 per cent in 1980 and 11 per cent in 1994 (Lunt et al. 1997). The same is broadly true of solicitors. The profession saw a polarisation between 1987 and 1997, with both solo and large (11 or more principals) firms increasing in numbers at a similar rate, at the expense of intermediate scales of practice (Cole 1997). Since then, however, the number of solo firms has begun to follow the decline of intermediate scales of practice, while the number of

larger firms has continued to grow apace, especially among the largest - with 26 or more partners (Law Society 2000).

The solo GP seems to have been considered an anachronism by the time that medical sociology developed in the late 1960s and has attracted little research interest (Cartwright and Anderson 1981). Horobin and McIntosh's (1977; McIntosh and Horobin 1978) work on rural general practice in Highland Scotland in the 1970s is a rare exception. They interviewed 28 GPs and drew a portrait of a set of well-satisfied practitioners, who enjoyed the life-style and professional challenges, even if they were sometimes troubled by the clinical risks of working at a distance from specialist support and the continuous commitment that was the downside of living in a remote community. Green (1993) found that inner-city practice could yield satisfactions comparable with those found by Horobin and McIntosh, particularly given her informants' reported bad experiences of partnership. Cutchin's (1997) work in Kentucky presents a similar picture, based on interviews with 14 primary care physicians and 21 key 'community informants', although he emphasises how much depends upon the ability to integrate successfully with the local community and to manage relations with neighbouring physicians. Byrt (1996) describes the situation of pharmacists in Dyfed, a rural county in Wales. She interviewed 21 pharmacists working in market towns and villages, of whom 18 were owner-managers. Most reported that they had made a positive choice of location, often because they came from a rural background themselves. They valued the life-style and the community involvement that their work gave them. However, relations with GPs could be tense because of the financial incentives for rural doctors to extend their dispensing in ways which threatened the viability of local pharmacies. Even in an area like this, the movement towards concentration of ownership was visible: Byrt records that one fifth of the market town pharmacies had been bought up by chains between her fieldwork in 1993 and publication in 1996.

Alongside this positive vision of solo practice, however, there are also studies that suggest that it may also contribute disproportionately to low-quality professional services. Lunt and colleagues (1997), for example, identify solo medical practice in the UK with poor inner-city areas, where ageing doctors, often from overseas, struggle to deliver an adequate service to a deprived and medically demanding population. This theme is particularly prominent in studies of the legal profession. Carlin's (1994) interview study of 93 solo lawyers in Chicago, first published in 1962, is widely cited as typical. Solo practice was where professionals from marginal social groups, or whose competence was marginal, found an accommodating market niche, serving clients who share their marginality. He questioned whether the solo professional could sustain the traditional ethical values and standards of practice

promised by, and expected of, a profession. Returning to the topic for the 1994 edition of his book, he saw no reason to change his conclusion. Solo lawyers still tended to be first-generation professionals from blue-collar immigrant backgrounds who attended low-status law schools. Their work involved little professional skill, was poorly remunerated and involved a large element of brokerage on behalf of clients with other lawyers, local officials or local politicians. As a result they often came under pressure to violate ethical and professional norms and had few incentives or supports to resist. Some of these pressures had been weakened by the greater social distance brought about by the computerisation of law offices and by anti-corruption efforts in the Chicago courts but Carlin questioned whether the structural temptations for the solo lawyer had really changed. Their market was more competitive and depended upon the constant recruitment of new, low-status, clients and deference to those who represented any measure of security through repeat business. There is, in effect, a moral division of labour - sometimes quite explicitly so in the practice of large firms referring 'dirty work' to outside solos in the knowledge that their own reputations and prestige can be left intact.

Seron's (1996) research in New York, based on interviews with 102 solo and small-firm lawyers during 1989 and 1990, qualifies Carlin's analysis somewhat. Although she also identifies a similar constituency of solo lawyers serving traditional blue collar and minority neighbourhoods, she notes that solo practice is sustainable in suburban locations and in gentrifying inner city areas, where the wealth of the global city spills into home purchases, small businesses and start-up companies. Taken as a group, the solo and small-firm lawyers she interviewed divide in much the same way as the profession as a whole. Some are essentially traditionalists, who tend not to advertise and rely on word of mouth for their client recruitment and whose firms make little or no use of technology. They get their business by offering a very personal service. Others are entrepreneurs, who may actually preside over quite large organisations of paralegals, seeking mass business by heavy advertising and using state-of-the-art information technology to process the routine work characteristic of small-firm practice. Within this broad framework, there are also more specialised niches. Some lawyers, for example, sustain a boutique practice on the basis of a distinctive skill, which others need to buy occasionally but cannot easily support in-house.

There is a lack of comparable UK work but some hints about the relevance of these studies may be derived from survey data on solicitors in England and Wales. At the time of our fieldwork, the Law Society's Research and Policy Planning Unit (Sidaway and Cole 1996) estimated for 1994/95 that about 2 per cent of all solicitors' firms were operating at a loss but, since these were almost all solo practitioners, 7 per cent of this group were losing money. 25 per cent of solo firms made a profit of

less than £10,000 per year. The most profitable 25 per cent averaged £53,000 profit per year, about the same as the average profit per partner of the worst-performing 25 per cent of 11-25 partner firms. The same Law Society survey found that almost 20 per cent of solo firms had no computers and those that did used them almost exclusively for word processing and basic accounts rather than client databases or time recording. One would not necessarily expect pharmacists to have such a low level of technology given the regulatory requirement for machine-printed labelling and the enforcement activity of the RPSGB's inspectorate, although a 1996 survey for the RPSGB found that large firms tended to have better systems (Blenkinsopp 1997). The solo law firms lagged similarly on all the management and service quality items measured by the survey, even where these were required by the Law Society. The Office for the Supervision of Solicitors reported that 102 out of 115 interventions in 1997-98 to take over the running of firms related to solo practitioners, although a small proportion of these related to ill health or death rather than dishonesty or mismanagement (OSS 1999).

Little work has been done to indicate whether there might be a similar distribution of poor service or professional misconduct in pharmacy, although there is certainly an impression among members of the RPSGB Statutory Committee, which is responsible for professional discipline, that solo practitioners are disproportionately represented in its workload. This may reflect the degree to which corporate pharmacies have better internal control systems to give them early warning of difficulties and to intervene. It is also said that they are reluctant to use the formal disciplinary machinery because of the negative publicity that may be generated by a hearing. However, it is equally arguable that solo pharmacists find themselves under greater pressure to compromise professional standards, particularly when their livelihood is under such direct threat. Quinney (1963), in a study of New York pharmacists, found an association between the extent to which pharmacists emphasised business rather than professional concerns and the likelihood of prescription violations. Unfortunately, he assumed that the priority given to professional or business goals was an attitudinal difference rather than possibly being related to the market situations or organisational environments in which the pharmacists worked. The study does not test this as an alternative hypothesis, although it would be more consistent with other work on professional standards (e.g. Kronus 1976; Freidson 1975). Sitkin and Sutcliffe (1991) surveyed pharmacists in Texas. They found some indications that pharmacists employed in corporate settings might offer a 'more impersonal, production-line approach' and offer less drug-related information that would slow this process. However, their sample seems to have been too small to go much beyond Quinney's observation that there were differences between pharmacists who emphasised professional and commercial values and investigate whether these differences were systematically related to employment settings. Anderson (1995), reporting on the experience of Swedish pharmacies since nationalisation in 1981, shows that it is not necessarily the case that

commercial values are tied to corporate environments. Public ownership had led to significant gains in productivity and innovation and appeared to be accompanied by high levels of both employee and consumer satisfaction.

Finally, there is the question of social marginalisation. Who are solo practitioners? Work on the legal profession has emphasised their difference from large-firm lawyers. Carlin's interview data has been reinforced by two later surveys of the Chicago profession, in 1975 and 1995. Heinz and Laumann (1994) found such a high degree of stratification between those working in large firms serving mainly corporate clients and those in small and solo firms which serve mainly private individuals or small businesses that they were led to talk of two 'hemispheres' which

...include different lawyers with different social origins, who were trained at different law schools, serve different sorts of clients, practice in different office environments, are differentially likely to engage in litigation, litigate (when and if they litigate) in different forums, have somewhat different values, associate with different circles of acquaintances, and rest their claim to professionalism on different sorts of social power... Only in the most formal of senses, then, do the two types of lawyers constitute one profession. (p.384)

Heinz et al. (1998) found that the hemispheres had become internally more differentiated: corporate lawyers were more likely to specialise and the private client sector had been invaded by franchise firms offering low-cost, high volume service for routine legal issues (see also Van Hoy 1997).

However, this work did not find exactly the pattern of discrimination that might have been expected. Carlin had noted the prevalence of Jewish lawyers in solo practice in the 1950s as a result of discrimination by larger and more prestigious firms but acknowledged that this had long disappeared by the 1990s. Both women and African American lawyers were more likely to be employed by government agencies or other large organisations than to be in law firms or to be working as solo practitioners. Brown et al. (1992) suggested from a sample survey of practitioners in England and Wales that women pharmacists would be more likely to seek employment than self-employment. Seron, however, notes the attractions of solo practice for women, partly because of their willingness to trade flexibility of working time and conditions against income, particularly in a two-earner household, an argument echoed by some of Collin's (1995) work on pharmacy in Quebec. Similar arguments may

be made in relation to employed work, where the formal protections and due process of large bureaucracies may offer more favourable opportunities for flexible working and predictable career advancement, at some cost to earnings prospects (cf. Heinz et al. 1999). The relative balance of 'push' and 'pull' factors in solo practice has also been discussed in relation to inner-city general practice in the UK, which depends heavily on doctors from the Indian Sub-Continent who migrated during the 1960s (Smith 1980: 104-20; Green 1993). Had they colonised this ecological niche in general practice as a result of 'push' factors, implicitly racism in the UK medical establishment of the time, or 'pull' factors, that they had taken over practices which were coming to serve communities that shared their language and culture?

The issues of discrimination in relation to solo practice have received some attention in research on pharmacy. Hassell and colleagues (1998) report on a large survey of white and minority pharmacists. They found that East African Asian, Indian and Chinese pharmacists were significantly more likely to be working in retail pharmacy as owners of their own business, mostly solo practitioners in the sense of this paper. Other minority groups were closer to the pattern of white respondents. Women were less likely to own businesses, although proportionately more minority than white women were owners - the numbers were too small for a robust breakdown by ethnic group. The authors concluded that earlier cohorts of minority graduates, particularly those from East Asian backgrounds, had been pulled into solo practice by their own preferences for self-employment and their ability to mobilise commercial expertise within their networks and to raise capital for the purchase of the business, although family resources played a smaller part in this than expected. However, the rise of large chains and supermarkets had bid up the price of pharmacies and reduced the supply of viable businesses. More recent graduates, now mainly of Indian rather than East African origin, still valued self-employment but were finding their opportunities increasingly restricted, at the same time as they were reporting a greater awareness of racism as employed pharmacists. To the extent that they were able to acquire businesses, it seemed that 'push' factors were playing a larger role and, by implication, that the businesses available were less desirable because they were seen as unlikely to yield sufficient profit for a chain. Minority pharmacists showed some concentration in inner-city areas of minority settlement, although it was not clear whether this represented a positive focus on an ethnic market or the differential availability of affordable businesses. There were also suggestions that the profession's disciplinary processes were bearing more harshly on minority pharmacists, a view later endorsed by the then chairman of the Statutory Committee, Gary Flather, QC (Statutory Committee 2000). Hassell et al. do not, though, consider whether this was simply a result of their ethnicity or of their disproportionate location in ethically vulnerable businesses.

In summary, the literature on solo practice in professional work seems to portray two images. On the one hand, solo practice is celebrated as the repository of traditional professional values of autonomy, personal service and community affiliations. On the other, questions are raised about its economic viability, about its ability to deliver quality care and about the extent to which its practitioners have found themselves in this niche through personal choice or as a result of various exclusionary processes, whether based on competence, ethics or prejudice. Even the apparently idyllic world of rural solo practice seems unable wholly to escape these questions.

3. DESIGN AND METHODS

As an exploratory study, qualitative interviewing was considered to be the method of choice, building upon Pamela Watson's (PW's) previous experience as a locum pharmacist in small pharmacies. Lists of pharmacies holding NHS contracts were obtained from the health authorities covering the city and county of Nottingham and Nottinghamshire. On most social, demographic and economic indicators, this geographical area lies close to the median for England. 178 businesses held NHS pharmacy contracts, of which telephone screening identified 34 as single independent pharmacies. Letters were sent to all 34 of these pharmacists and 20 agreed to be interviewed for the project. This represented 19 businesses - one was jointly owned and job-shared between two women. All participants were paid a fee equivalent to two hours' locum cover for their participation: the experience of previous work with pharmacists had shown that this was essential for securing uninterrupted interviewing time (Aldridge et al. 1996). Six of the pharmacists interviewed were women and five from minority backgrounds - all men. Their post-qualifying experience ranged from 7 to 42 years, with most (12) having 11-20 years in practice. In contrast to the pharmacies studied by Byrt in Wales, these were mostly urban, with one in a large industrial village. All interviews were conducted by PW, taped and transcribed.

The place of interviews in qualitative research needs to be carefully defined. Recent commentators (e.g. Dingwall 1997, Silverman 2001) have emphasised the problems of simply assuming that interviews are literal descriptions of some underlying reality. The interview is a social situation in which informants or respondents present an account of their lives which they expect the interviewer, and the audience which the interviewer represents, will find rational, reasonable and comprehensible. The general pressure of what Goffman (1983) calls 'Felicity's Condition', that we not act in such a way as to disconfirm other people's assumption of our sanity, constrains these accounts. Informants cannot without justification or excuse depart too far from what is either expectable from them as authorised producers of the narrative that the interviewer is seeking to elicit or observable in the context and environment of the interview. In the present case, for example, the interviewer, PW, acknowledged her own experience as a pharmacist with wide experience of the sorts of small pharmacy that the informants were operating. She was a knowledgeable member of this social world and capable of noticing potentially accountable features of a narrative or discrepancies between, say, the informant's description of their business and the conditions of the shop - most of the interviews were carried out on the pharmacists' premises. Felicity's Condition would, then, tend to require the production of 'insider versions' rather than 'public versions' of the condition of small pharmacy practice. (It is, of course, important not to assume that either of these is 'truer' than the other.) At the same time, her

position on the professional/business continuum was left ambiguous. Informants were told that the pilot was intended to look at the possibility of studying the implications for solo pharmacies of the visions of the Department of Health and the RPSGB. Coming from a social science department, rather than a pharmacy practice programme, PW's own stance in relation to these visions could not easily be read off. The 'right' answer to some questions was uncertain and the interest lay in the account given to justify the informant's choice. However, that account was not randomly generated: it is the report that one small pharmacist would give to another rather than to a representative of the RPSGB or to a journalist or consumer affairs investigator. To the extent that it demonstrates a disjunction between those versions, there is evidence of a potential problem in reconciling the profession's practice with its aspirations. The well-known literature on the death of idealism in professional training (Becker et al. 1961; Psathas 1968; Shuval and Gilbert 1976) reminds us that we should not expect a total identity: one aspect of professional socialisation seems to be the ability to self-present as both realist and idealist in different contexts with different audiences. Nevertheless, an invitation to reflect upon this necessary compromise, of the kind created in these interviews, may give some clues as to the informants' approaches to practice, which can, of course, only be fully validated by direct observation.

The data extracts that follow have been edited for anonymity. Where a cut has been made to remove irrelevant or identifying material, this has been indicated by (...).

4. THE REPORTED STATE OF SOLO PRACTICE IN NOTTINGHAMSHIRE 1997

Why Solo Practice?

The literature discussed earlier suggests that the choice of professional segment may involve either or both 'push' and 'pull' elements. It may be a response to the intrinsic attractions of that area of practice or the result of a failure or inability to enter a preferred segment. With the exception of one pharmacist who took over a family business in a small market town, almost all of the informants represented their decision as the result of failure, dissatisfaction or frustration in other segments.

PW When you got to the stage of wanting to run your own pharmacy, do you think it was because you wanted to be...

P1 I didn't always want to

PW You just got to the stage of wanting to do it?

P1 I was quite happy with (Chain) and then one day (Chain) called 'Off with the TGMs' and fired them or retired them...

PW So that was territorial general managers was it?

P1 Yes, and then the next day, oh no, the second day, they fired half of them and the first day they reallocated all their jobs and I just thought 'sod this', you know and I spoke to two territory managers and asked them, if you had to do it again, what would you do, and both of them said, I would have got out a long time ago and I just thought, well if it's good enough for them, it's good enough for me. So that was the end of the day with (Chain) as far as I could see. There was bad feeling.

PW When you were doing this [degree], was your eye very much on running a business at the end of it or just being a pharmacist in general?

P6 No. It was being a pharmacist in general, I suppose. The industrial side of it appealed to me more than anything else. I never thought I'd end up here. It sounds awful, doesn't it? I never thought I'd end up with my own business, that really didn't enter my mind at all (...)

PW So at what point did you decide it was going to be community pharmacy?

P6 When I was doing my pre-reg at (Hospital 1). It was a horrible pre-reg, it was dreadful.

Do you know the people who work there?

PW Not now, no.

P6 Right, I can say what I like about them. It was such a shitty atmosphere, I mean fortunately I spent five weeks at (Hospital 2) and five weeks at (Hospital 3), that was great, (Hospital 3), because everybody was in to having a laugh. I don't think they understood what humour was at (Hospital 1), it was dreadful. But I didn't really want to work... I thought, this is typical hospital pharmacy and also hospital pharmacy, it's just a waste of time in some respects because it's just a supply function. I mean you can argue that community pharmacy is a supply function but here with the customers, you really get to know them. Hospital pharmacy just seems to me scuttling around wards and filling up trolleys and all this clinical stuff that they do, why? It's only going to be any use if they're actually volunteering information to people and if people are interested in hearing what they've got to say and I don't think either of those things are applicable. If they're scuttling around and filling trolleys up, they haven't got time to get to talk to people and get to know them, plus they're rotated every three months, so how the hell are they going to get to know anybody in that length of time?

PW When you were thinking of doing pharmacy, was it your aim at that time to have a pharmacy of your own?

P7 No, it wasn't really. Initially, I thought I didn't want to work for myself because I'd seen mum and dad do it and at that age of course I'd seen all the down side of it (...) So I really did think I was going to avoid that and push back the frontiers of science and I would be an academic or join ICI and find a new wonder drug. The reality didn't turn out that way. I went for an interview when I graduated with (Company) and the result of that was that I didn't like the look of (Company) at all and what they were doing. I don't think (Company) liked the look of me (...) So I went on to (University) (...) to do academic research (...) I wasn't making very great progress and I wasn't overly happy in general with the situation, this was postgraduate work...

P7 went on to describe how he had become a manager in a chain and then been presented with the opportunity to purchase this business 'out of the blue'. Other informants described their unhappiness with the pay and conditions of hospital pharmacy or the pressures and inflexibility of chain pharmacy work. Even the one informant who came close to what Hassell et al. (1998) rightly note as a

stereotyped view of Asian-origin pharmacists, having acquired his own business relatively quickly with the aid of family network capital, considered that he had been pressed rather than volunteered for this way of life.

PW When you went into pharmacy, was it very much with the idea of getting your own business?

P12 Not really. I got pushed in, if I look back on it. My mum and dad said, you want to get a job there and I said, no I'm quite happy...and now I suppose I'd find it hard to work back again the other way.

PW For other people, now?

P12 I think so, yes.

In effect, these responses concede the problematic position of the small pharmacy as represented by previous literature. Talking with an insider, there is no acceptable way to describe this career choice as an obviously rational and reasonable thing to do. Solo practice is not a goal so much as something you do when other segments lose their attractions, even for those who might be thought to be enjoying a measure of success. Informants whose families had a tradition of self-employment presented the transition as more straightforward than those who lacked comparable cultural resources, for example in negotiating bank loans and accepting the element of risk implied in the charges taken by the banks on their homes.

PW And so was finance possible?

P5 Yes

PW Because of the state of the business or was it...?

P5 Yes, as always, the banks, the assets bring ten per cent, well we'd been saving money and what have you, we had a rented flat in (City), we'd been saving money and we had together a reasonable size deposit so that wasn't a problem, but then to raise the rest of the money when you look at all the financial stuff, you look at it and, oh you know, unsecured loans up to whatever value and then you want some sort of security, and I said, well hang on a minute, didn't they secure me... they couldn't really...oh well, you know, suddenly it was double speak stuff. So, yes, we had to raise the money, I've raised some against my parents' house and used that as security, which...My parents

themselves have always been self-employed, so they understand the problems and to them it wasn't a problem because they understood what it was all about, so they said, yes, that's fine, go ahead and do it. So that's what we did.

However, these informants still shared the view that the decision to go solo looked a potentially perverse one and needed justification. All of the informants had difficulty in formulating anything positive about their original choice and tended to use a rhetoric of luck, fate or chance in relation to the business that they had acquired, even when their descriptions actually implied a more rational search process with other potential businesses being considered and discarded as too expensive or unlikely to succeed commercially. This is particularly striking, given that some of the pharmacists had been in business for a long time: twenty years ago the situation would have been very different and it would have needed a particular kind of vision to anticipate the rise of other multiples or the incursion of supermarkets.

PW Did you always want to stay in this area?

P14 Well, not particularly, it was just purely chance, I suppose. There used to be a pharmacy here and it had closed down nine years prior to me coming here. There was still a bit of a doctor's surgery but not much. (...)

PW So you actually reopened, then?

P14 Yes, I was just driving past one evening and saw a For Lease sign on the door and so I thought...I asked the landlord how much he wanted and it was £20 a week, I thought, I can afford it, so I set to and sorted the shop out (...)

P7 (...) [I] saw the opportunity to get this business in (year). It wasn't located in this unit, it was in a smaller, older unit further down the road. The pharmacist was terminally ill and the shop had actually shut and I came to hear about it through a local GP, my as then wife did, and came home to tell me about it and we sort of got excited and managed to get the package together to buy it. (...)

PW Was the idea at the time that you were really looking, or were you not very actively looking?

P7 This was an opportunity that presented itself, yes, almost out of the blue. My wife went and seen the doctor and discussions - oh your husband's a pharmacist - and so it came.

However, as P7 went on, it emerged that he had actually been looking for a business previously, with the offer of finance from friends in the local medical community but had been put off by the complexities of moving from employment to self-employment, the implied obligations and the potential conflict from 'leapfrogging' prior to the 1987 reforms.

The difficulty of talking about solo practice as a positive choice is not entirely surprising. The major chains provide almost all the placements offered to pharmacy graduates in order to complete their professional licensing requirements. As a result, whatever the drift of academic pharmacy practice courses, the first job for any newly graduating pharmacist aiming at the retail segment is likely to be as an employee. Leaving the corporate sector may be seen as a form of deviance, something for which persuasive accounts are notoriously difficult to produce. Moreover, would-be solo pharmacists also read the trade press and know about the economic pressures on small pharmacy, the growing concentration of ownership in the hands of multiples, the expansion of supermarket pharmacies and so on. The longer-serving pharmacists have lived through these changes. The experience reported here is consistent with more recent survey data from Boardman et al. (2001). Although their category of 'owner' does not map precisely onto our category of 'solo', they found that, while 51.3 per cent of owners had been satisfied by their career in pharmacy, only 32.2 per cent would choose the profession, with their time over again. Owners were also the least optimistic about the future of the profession and least positive about the 'New Age' strategy. What rational person would volunteer for this segment of the profession? Having made that choice, however, the solo pharmacists were constrained to find sources of satisfaction that would justify the decision. How did they achieve this?

Solo Practice and the Professional Vision

The accounts given by these pharmacists have some important common elements. The most obvious is what might be called the 'hero or heroine story'. It seemed that every pharmacy, with the exception of the inherited business and one in a health centre, had been run-down as a business and physically neglected as a property at the time the informant took it over. All these informants described the way in which they had begun by physically reconstructing the premises and then tried to develop the

business by identifying new sources of income, cutting out unprofitable lines of stock and searching for niche markets in the shadow of the multiples or supermarkets. P11 is typical:

PW So what have you changed since you've been here?

P11 Everything. He (*the previous owner*) said to me, oh don't change it, people don't want a change, but it was a tip, that's being fairly polite, he was still using the fixtures that he got that was used for the fruit and veg. In fact that behind you is an example of what it was like, plain pine wooden shelves, it's a bit better because I've put some Formica on it. The only bit of equipment that is still here which was his is the fridge. So I did a complete refit and it was quite traumatic. (...) We were typical 70s, a bit of everything in the chemist shop. With the change in shopping habits, I've thrown out most of the cosmetics. I've kept Rimmel, a cheap range, no perfume, that's all gone, a couple of Christmases and you realise that the gift sets have not gone, stuff sitting on the shelf an awful long time, you realise that you've got X hundred's worth of stock on the shelves which isn't doing anything. So we had a rethink and decided to sling those out. Same with Scholl sandals...

P11 went on to describe short-lived experiments with offering diagnostic tests for cholesterol, blood pressure and diabetes which had been abandoned as unprofitable.

P17 described how he had moved within an expanding village, partly to follow the movement of its medical practice and partly to be closer to a small supermarket that had opened.

PW So when you changed your premises, did you deliberately go for very different kind of ranges of stock or did you keep much what you had?

P17 Pretty much the same except at the old shop I sold all sorts of things that weren't really traditional chemist lines because being a village there isn't a wide range of shops and my predecessor had gone in for garden chemicals and seeds and that sort of thing, and I extended a bit on that and found a good cash and carry and did quite a good business, garden tools and everything as well (...) one, I wanted the [new] shop to be more professional, two, I knew I was going to be a lot busier with prescriptions and I wouldn't really have the time and for the staff to be dealing with these things and I knew

I hadn't got the space (...) the other thing was on the contract, now I would imagine (supermarket) were responsible for that, it actually said that I should only sell pharmacy lines, I shouldn't sell hardware things.

P2 (...) [I've tried] to tailor for local needs.

PW Which you would characterise as what? I mean have you got a lot of elderly around here?

P2 A lot of people on income support

PW So you're actually looking for lower-priced goods?

P2 Lower-priced goods and Afro-Caribbean, some of them tend to go for very old-fashioned remedies like homeopathy and herbal, so I've tried to introduce some of the herbal range.

P14 Well, when I came in the shop, we turfed out nearly all the toiletries and cosmetics and things and we've actually, the shop went back, well we've reclaimed off the shop, half the shop and made the dispensary twice the size. The main area of the shop is medicines all the way down. That is an old fashioned medicines counter if you like where you stand behind it and that was my idea to get back to the basic because we ought to be doing what we can do well and it isn't selling nappies and baby foods.

PW And did you do it because the market dictated that or really because it was a very positive choice on your part?

P14 It was a positive choice. It was brought about by a comment that someone made, two things, a comment that a customer made one Saturday morning when she came in for some baby food and she said, 'Do you know, I know you're cheaper than (supermarket) but when I go to (supermarket) I just chuck it in me trolley', and I thought, yes, that's the attitude, I thought right we'll just chuck all this lot out and do something that we can do better than (supermarket) and that is doing what we do now and we've thrown out all the baby stuff except for a few bits and bobs, we've got rid of nearly all the toiletries and it hasn't affected our turnover one jot. So all I can say is whatever we're selling now, it's obviously got to be OTC medicines and we're selling more of them. So we're obviously doing that job better.

Those informants who had not modernised their premises acknowledged the force of this story by reference to difficulties with their landlords over their leases, which made the investment inappropriate.

P5 (...) it does need a refit, yes it does. We've changed the carpet, given it a lick of paint and things like that over the last few years, just to sort of keep it going, but I'm on a lease until 2001, the leaseholder won't sell me the property and I'm begrudged to pay £20,000 - £30,000 to do up his property, so I'm looking at alternatives at the minute.

In referring to these narratives as a 'story', we do not need to cast doubt on its likely material base. The capital represented by stock, premises and goodwill is also a significant part of a pharmacist's pension fund and would be an incentive to remain in the business as long as possible in order to maximise the value of an annuity or other pension vehicle purchased with the proceeds. Several of the informants referred to the death or long-term ill-health of the previous owner as a factor in the state of the business when they bought it. P4 had found the only business she could afford as a result of the previous owner's troubles with it.

P4 (...) The lady that was here before, she's got about three shops and this was the one that she disliked because it got broken into so many times and I think she had staff problems and she had problem after problem with the shop, so she lost interest in it, so there was no stock hardly, she didn't spend any money on anything basically, everything was just boded up and she just wanted to get rid of it because she was selling it for that long, she just wanted to get rid of it, so she really did neglect this shop badly. So it was quite easy for me to come in and improve a lot of things.

Conversely, a well-run and well-founded business may have been too expensive for entrants to the market relative to those who could, in the past, raise cheaper loans against other properties in a small chain or, increasingly, have access to lower-cost capital from the internal or external resources of a large multiple. However, what is important here is the evidence of the personal investment of the pharmacists in their businesses. Because of their shortage of initial capital, they had done much of the refitting themselves and there were recurrent reports of late nights and weekends working around an open business to smarten it up, even if specialist tradesmen had been brought in for plumbing, electrical or major structural alterations.

The emphasis on personal involvement was hinted at in the extract from P11 and P14 above and their ability to make their own decisions about opting in or out of areas of business. The pharmacies varied quite a lot in the directions of diversification or innovation that they had adopted. The provision of oxygen supply or a prescription collection and delivery service has been important for some solo pharmacies in competing with the multiples. Although many had been pushed out of the supply of drugs to residential and nursing homes by an initiative from one of the large chains a few years earlier, some of this business had been won back by the development of a more personal and responsive service. However, there was also scope for one pharmacist to declare:

- P8 (...) I feel that my place is in the pharmacy and not going out delivering oxygen and servicing nursing homes which would be cost effective but to my mind aren't in the interest of the community that you serve. Unless things change and you can have two pharmacists.
- PW To enable you to do those, yes. You don't have an oxygen...?
- P8 No. These things, they are local initiatives and I know this is the way it will go but I still say that while I'm looking after one patient who needs oxygen, I'm probably not looking after ten people who have come into the shop.

The issue of personal autonomy was particularly strongly expressed in relation to medicine sales. Some of the pharmacists had developed a business in herbal and homeopathic products. Others flatly refused to get involved. This pharmacist worked in a depressed mining town:

- P14 (...) You know what they've got in their pocket and you're not going to sell them something which may just be a fad and I'm certainly the first to point out the pitfalls of the fads. I've got no time for homeopathic medicines whatsoever, you won't find me selling (product name) or any crazes which come and go. I'm not very keen on recommending multi-vitamins. I ask people if they're having a decent diet, are you eating well, well, no you don't need them if your diet is as good as you say it is, then you don't need them unless you've got some particular disease. So in that respect, I'm not a very good salesman but at least I can say at the end of the day with hand on my heart that I have never sold anybody anything that they didn't need or deserve to have and certainly couldn't afford. That might sound a bit pious but it's true.

These extracts from P2, P5 and P9 sum this up for most of the informants:

- PW Was it important when you wanted to buy your own business that you were wanting to run your own business or being your own kind of pharmacist?
- P2 My own kind of pharmacist, I think that's just my nature, I've always helped people and I've got more pleasure out of helping people than actually, well remuneration is important but even when, I remember I was doing a paper round at school, old ladies who were housebound, I used to do their gardening for them just for the sake of helping them, and I get pleasure out of that, maybe it will change with time, I don't know. And because of that attitude and because I knew that in a community pharmacy, people do ask for help; and I do my best to help as many people as I can.
- PW And you thought that you could do that better in your own business than being in somebody else's?
- P2 When you're working for somebody there is a constraint and you have to work within that boundary. I experienced that when I was working for the multiple, I think at one particular stage in the process of actually dispensing I was told that I could not use this particular brand of product because it was less profitable and things like that.
- PW And you didn't want anybody actually making those decisions for you?
- P2 No, that's right.
- P5 (...) My father had always been self-employed, he's an accountant, and he always used to say to me that being self-employed as long as I've got ten quid in my pocket when I get out of bed in the morning, and I know what he means, I mean I can sit here and talk to you or I can have a mate of mine come in and I can sit here and talk to him all day if I want and I don't care who comes through the front door, I'll serve them and look after them but I'm not concerned or stressed about it because it's my business, if that's what I want to do, that's what I want to do.
- PW So what was it that prompted you to buy your own? Was it because you wanted to run your own show or you wanted to be a kind of pharmacist that you thought you could only be by running your own business?
- P9 I think it was the independence. I was sick of people controlling my life, it was from that

angle. However, I do like to have...I'm passionate about certain professional opinion and I don't like anything getting into the way of it (...)

The Cost of Autonomy

The autonomy comes at a price, however. Like other small shopkeepers, community pharmacists work very long hours which are difficult to adjust. Typically, the pharmacists reported opening from 09:00 until 18:30 or 19:00 five days a week, with a half day on the sixth: the pharmacist must be present throughout this time if medicine sales are to be made. Although some closed at lunchtime, this was often so that the pharmacist could go out to service nursing homes. Many of them worked throughout without a break or, at best, a sandwich in the dispensary. Much of the business paperwork could be done during slack periods but was always vulnerable to interruption. It was hard to avoid taking some paperwork home.

P17 Yes. I did an eight hour day and now it's a ten hour day. I do nip next door most days and just sit and have a cup of tea and a cake for about quarter of an hour or twenty minutes and this is when my dispensary assistant comes back from lunch about quarter past two and one o'clock I nip and get a sandwich and eat it in here. But I gather that it's quite common nowadays a lot of pharmacies don't close for lunch (...) I do all my paperwork at home. I've permanently got stuff all over at the side of my armchair, but most nights I sit down and do something, it may be I've taken a pile of invoices home and I'll file them in alphabetical order or another night I might at the end of the month, I shall be picking out all the July invoices for VAT and the next night I shall write all the cheques and then the following night...I try to do a little bit at a time instead of ...but then when it comes to doing my VAT return, then I'll probably stop up until 3 or 4 in the morning to get it finished in one go rather than stop half way through and this is every month. Bundling all the prescriptions up is another late night stint. These month ends seem to come round quite quickly (...)

P17 ran one of the busier pharmacies in the sample with over 2000 scripts per month and this volume of paperwork was not typical. More commonly, paperwork was done in the shop on a Saturday or on an early-closing day, where these were still observed. One respondent described how she had agreed a Sunday opening with the health authority because she was in the shop doing her paperwork anyway and thought she might as well get a fee for it. Overall, the typical working week for these pharmacists

would be 50-60 hours, except for one or two of the longer-established businesses where the lower levels of debt meant that the owners could forego some income for shorter hours, either by employing locums more freely or by shortening the opening times. A more recent survey in the West Midlands found more than two-thirds of employer/owner pharmacists to be working in excess of forty hours per week, many substantially beyond the 48 hours envisaged as a maximum by the EU Working Time Directive (Blenkinsopp et al. 1999).

All the pharmacists reported difficulty in getting safe, competent and affordable locum cover for time off, sickness or holidays. Very few could report taking a holiday within the last few years and several talked about being propped up in the dispensary when sick so that legal requirements were met, even if an unqualified assistant was doing the actual dispensing work. The only pharmacy that seemed comfortable in this respect was the job share, although the partners pointed out that this had begun out of a friendship and that they now found it very difficult to arrange social time together because one or other always had to be in the shop. Inevitably, this had an impact on the pharmacists' willingness to engage in continuing professional development (CPD) activities, particularly for those men and women with younger families and domestic commitments.

PW Have you been to any of the courses in the evening?

P2 I used to do about five years ago but it's just, it's getting to a stage where you have 12 hours during the day and the last thing you want to do is go out and...I used to do it on a Sunday but now I've a young family so it's so difficult because they're always moaning that I'm never there (...)

PW Are you one of these keen people who goes to courses?

P18 I don't know how people get time. If you've got a family and you're running your own business even on this sort of scale, I don't know how people find time because by the time I get home it can be anytime between 7:00 and 7:30 when you've done your deliveries. You then put the children to bed, have a bite to eat and then you've got paperwork that you've brought home and then it's time to go to bed (...) you've got to have some kind of family life. There's just no time, you've got to fit so much in. I do what reading I can and that's it really. Occasionally I go out to something in the evening, but they're not organised very regularly.

Most of them claimed to read the professional and trade press but were distinctly unwilling to give up evenings and Sundays for courses. Distance learning packs were more favourably received but found themselves in competition with business paperwork during quiet hours in the pharmacy. The informants said that they rarely went to RPSGB branch meetings and seemed to have few, if any, professional contacts with other pharmacists.

The pharmacists went to some pains to present themselves as willing in principle to participate more actively in CPD and professional networks but as quite overwhelmed by the structural obstacles to doing so. Even in an 'insider' interview, it seems unlikely that members of a contemporary profession would declare themselves opposed to CPD. However, the obstacles seem genuine. If NHS contracts require men and women to work in excess of 50 hours every week and do not deliver a sufficient economic surplus to buy out some of this time or a means of obtaining reliable quality-assured cover for absence, then it is difficult to see how most solo practitioners can participate in CPD, professional governance or similar activities. To the extent that they do, this is likely to reflect a particular investment at the expense of domestic or recreational life. DH and RPSGB policies simply fail to engage with the circumstances of many solos. P7 goes further than most of the pharmacists but he expresses a view which is present in many of the interviews:

- P7 I'm not interested in pharmacy full stop. It's a living, it's made quite a reasonable living, I feel I've put a reasonable effort into it to earn that...
- PW But you're not going to put 105 per cent in...
- P7 ...beyond that I don't actually find it interesting in its own right.
- PW So in a sense you're much more interested in making your business work?
- P7 I'm interested in earning a salary to get on with my life outside of this shop (...)

P7 elaborates that by 'lack of interest in pharmacy', he is referring to the scientific basis of the profession that he learned as a student but which he does not see himself as using when he is advising people about their medication. Like P2 above, he presents himself mainly as a helper of the community.

Temptations to Sin

The economic marginality of solo pharmacy is a repeated theme. Most workers consider themselves underpaid. Even within this small group, there is a clear pattern of variation between those for whom pharmacy is the main household income and those for whom it is a secondary source of support. The importance of the latter group, mainly women, to solo practice has been noted by Seron in relation to law and is also picked up by Collin's work on pharmacy in Quebec. We did not ask direct questions about the profitability of the businesses but noticed the way in which those pharmacists for whom it was a second income linked this to the avoidance of temptations towards professional deviance. P4 volunteered information about the economics of her business - the following extracts are out of sequence in the interview to bring out the point:

- PW So when you came here was it because you wanted to practise pharmacy in a special way or because you wanted to run your own business?
- P4 It was both really because when you're working as a locum and for somebody else you have to do things their way whether you think it's right or wrong. So it was partly that. And partly with the view to if the business was successful then I wouldn't have to work full-time in the long-term although I recognised that it would be hard work to start with but the idea was that the shop would still be making money when I wouldn't be here if I wanted to have a family. So that was the long-term plan really, not to have to work 60 hours a week for ever.
- P4 (...) All the time I've been here (*18 months*) I haven't taken any wages, depressing isn't it.
- P4 (...) The only dilemma I have is if somebody brings a prescription and they tell me they don't want the middle item, now I'm sure a lot of pharmacies don't write 'not dispensed' on there (*i.e. claim reimbursement from the NHS*). I'm sure I must be the only one writing 'not dispensed' on exempt prescriptions, I'm sure I am. Then when I'm doing it, I'm thinking I'm a fool, I bet everybody else doesn't do this, so that is my dilemma.
- PW That you're doing the right thing all the time but always just wondering why you're doing it.

P4 I do try to and I'm thinking of my loan repayments and I'm thinking I bet nobody else would do this surely. (...)

The fieldwork took place around the time of a television programme which had suggested that prescription fraud of this kind was widespread and that only large chains could be expected to behave in an ethical manner. Most of the informants had seen or heard of this programme and were predictably angry, especially since a number of them provided a service to precisely the kind of poor communities with large numbers of prescriptions exempt from patient charges, which offered the fewest opportunities for fraud. Nevertheless, P4 was not the only one to talk about the enticements.

P6 (...) when I endorse things, I put 'not dispensed' and I sometimes think I'm stupid, I must be the only pharmacist in the world doing this, you know.

This sense of 'ethical loneliness' ran through responses to questions about the temptations facing pharmacists. P16, for example, struck a very similar note in a quite different context.

P16 (...) the other day, I ordered half a dozen Chanel No.5 toilet water, about £35 a bottle, and they sent me six boxes of six, so of course I rang up to tell them so. Because there was nothing on the invoice, I could have just kept the things and sometime later, this year, one of my staff was telling somebody about this and they said, it wasn't on the invoicing, why on earth didn't you just keep it? You see this is where business has gone to now, there isn't the honesty about that there used to be (...)

Others referred to the difficulty of discarding outdated stock, representing an economic loss, and the flashes of temptation to use it that had to be guarded against.

P5 (...) I must admit there are times when the girls go, do you realise this is out of date, and I go, just throw it away quickly before I change my mind because it's expensive, just bin it quick and once it's in the bin, I can't do anything about it.

One pharmacist described the problems of getting drawn into collusion with others' misconduct:

P17 (...) Then he started, this new doctor, coming in and I used to have my prescriptions on a clip and he'd come in and say, oh what have you got, oh, yes, Mrs So-and -so, and he'd add things on to a prescription that I'd already dispensed and say, can I have those then, please, and these were things that he wanted himself you see, and he kept doing this and doing this and I thought, I don't like this because a lot of the prescriptions had been written by a receptionist and he was coming in and writing and I was having to alter the number of items on the bottom and I thought, somebody is going to query this, so I put up with it for a few months and then one day he came in and did the same thing and I said, yes, but why don't you...haven't you got a prescription pad with you to do a separate prescription. No, I've left it in the car, so eventually, I thought, why should I risk being involved in anything suspicious (...) I said, I've been a pharmacist for (NN) years, I'm not going to risk getting into trouble over him, so when he came in the next time, I said, I'm not happy about this, if you bring me a prescription in for whoever and ask me to dispense it, that's fine, whether it's for yourself or not, I'm not interested, you bring a prescription for Mrs Jones and you say you're going to visit Mrs. Jones, then that's all right. I don't want to know if it's for yourself, but this looks too suspicious, you coming in regular and doing that, and he said, why, are you frightened of getting caught out, so I said, yes, my reputation means something to me, I don't want to be involved in any sort of fraud or anything. Oh, all right then, he says, he didn't come in any more, did he (...)

P17 went on to suggest that this GP had found a more accommodating pharmacist and had begun, contrary to NHS regulations, to encourage his patients to use the other shop for dispensing their prescriptions.

Since these pharmacists shared a view that the combined surveillance of the NHS and Royal Pharmaceutical Society regulatory systems bore more heavily on them than on the multiples, large or small, risks were not worth taking. This was not without some justification: the criteria used by the Prescription Pricing Authority to trigger investigations for some potential frauds would bear disproportionately on the sorts of pharmacies represented in this study (News 1997). Despite PW's anxiety over raising the question of professional deviance, none of the informants had any difficulty in talking about or identifying experiences that troubled them. This was not a problem that only

concerned other people but a real one for them, something that they struggled with regularly. However, they struggled as individuals, or possibly with the help of other individuals in the profession. Help might be sought from the National Pharmaceutical Association but the health authority was seen by all but a few LPC activists to have little to offer and the RPSGB was positively mistrusted.

P0²(...) I was a bit annoyed when the medicines inspector came round, oh you've taken over, I've come to meet you, this is a friendly visit, blah, blah, blah. He came unannounced in the first week. He was very friendly and then a few months later he came unannounced again, there was boxes everywhere, a bit like it is now, and he said, it's all right, I know you're having difficulties, you haven't got a Martindale and the shop was in a bit of a mess, and he was very friendly about it, then the next week I got a nasty letter from the RPSGB with a formal warning in it (...) I was upset basically because he was chatting just like you and I are chatting and I was thinking, oh he's all right, he understands, he's friendly and the next letter I was getting a ...I think it was a formal warning.

This was not an isolated account, although it must be stressed that we do not have the local inspector's version of events. It is, however, indicative of a lack of confidence that reporting a problem would not be used as evidence against its reporter.

Conclusion

The best single way of understanding these accounts is as stories of survival. The pharmacists were generally aware of the visions of their leadership - several commented explicitly on the New Age agenda, and, to some extent, of the lack of concern shown up to that time by the New Labour government for them, as we discuss in the final section. However, they could not connect with these. They described being almost overwhelmed by the long hours, the low economic rewards and the general struggle for existence in serving poor and marginal communities who were below the threshold of interest for multiples or supermarkets. Their non-working lives, especially their families, came under severe pressures from the demands of the business. It ate into evenings and weekends and meant that they were unable to take the sort of holidays that other professionals would expect as routine. They felt guilty about being unable to maintain their knowledge to the level that they thought

² The identifier has been withheld in order to prevent possible identification of the source from cross-referencing.

was desirable. At the same time, the autonomy and human relations aspects of the work were said to offer compensating satisfactions. These pharmacists spoke with great warmth about the communities that they served, whether these were pleasant dormitory villages or difficult inner-city areas. They projected a strong sense of integrity, of serving patients and an often indifferent NHS rather than seeking to exploit either by manipulating their position for greater economic gains. The question for each pharmacist was the balance. Four intended to give up in the near future: one was training for another career with a large human relations element; one was planning to work as a locum, which he thought would bring a higher income with less stress; one was retiring and did not expect to find a buyer for their business; and one was simply contemplating the slow decline of his business in a state of some despair. Only two or three of the others could be described as genuine enthusiasts and they were relatively new to the life. Nevertheless, all had a real attachment to their businesses. These were *their* creations, reflecting *their* labour and *their* sacrifices. Even if they questioned the individual and collective future of solo pharmacy, most of them would only consider letting go on their own terms.

It is important for public policy to understand this sense of individual investment. The development of policy tends to be the preserve of rational bureaucrats, who can adopt a degree of disinterest that is not available to those who are actually engaged in the struggle to make a living in the marketplace. The Lord Chancellor's Department, for example, commissioned a recent report on the culture of the legal profession, partly because of concern that its reforms were not being received in the intended spirit. Reforms were, instead, being scrutinised closely by members of the profession, which, of course, specialises in the analysis of rules, in order either to minimise the impact on their current business or to identify where new sources of revenue might replace those curtailed by change (Lewis 2000). Career civil servants had found it very difficult to engage with this entrepreneurial mentality and with the need to design reforms that either worked with its grain or which at least anticipated and sought to control the possibility of subversion. Arguably, the post-1997 reforms of primary medical care, which we shall discuss shortly, have been more skilfully designed from this point of view. However, the relative neglect of pharmacy policy by the NHS, and the distraction of the RPSGB by its internal conflicts, over the same period, seem to have resulted in a vision of the future whose achievability may be distinctly limited.

5. THE PHARMACY PROFESSION AND GOVERNMENT 1997-2001

The same factors that made pharmacy attractive to the outgoing Conservative administration seem to have led to its initial neglect by the incoming Labour government, although the situation cannot have been helped by the rundown of DH and NHSE staffing for professional advice on policy towards this profession. The Labour government's initial strategy document for the NHS, the White Paper *The new nhs - modern and dependable*, published in December 1997 made no reference to pharmacy at all despite its announcement of a major agenda for primary care reform. This silence continued to the point where the chairs of two Local Pharmaceutical Committees wrote an open letter to the Secretary of State in September 1999 about their increasing desperation at this policy vacuum (Patel and Boorman 1999). The lack of a strategy was, they argued, leading to the increasing demoralisation of pharmacist owners and an accelerated corporatisation of the profession. In the absence of central direction, health authorities were refusing to invest in pharmacy developments and pharmacists were being excluded from the local planning of the new structures for primary care.

Labour health policy has been through a number of twists and turns since 1997 and it is difficult to reproduce all of these in a summary account. One can, however, contrast the broad visions of Conservative and Labour administrations. Before 1997, the NHS was being run as a 'managed market'. In theory, each institutional provider, whether a hospital trust or a general practice group, was competing to supply services under contract to a health authority purchasing those services on behalf of the population living in a geographical area. In practice, local monopolies and the political costs of 'market exit' meant that there was very little real competition. Health authorities mostly had to deal with existing providers, either because of the costs and inconvenience for patients of going outside the area or because of direct pressure to avoid the controversy arising from the closure of major local services (Hughes et al. 1997). As part of this system, continuing a trend that could be traced back at least to the late 1960s, general management tended to displace professions as the key source of power and authority within the system, other than in primary care. Not surprisingly, this change was not popular with the professionals.

The situation in primary care was somewhat different. In theory, the same principles required general practitioners to compete for patients and some of the historic controls on patient movement between practice lists and on marketing were relaxed to encourage this. In practice, general practitioners showed little interest in doing so. The Conservative government's response was to develop the concept of 'fundholding', where general practitioners became proxy purchasers of all the health care

required by patients on their lists. This significantly changed the relationship between general practitioners and hospitals, because GPs found it much easier than health authorities to move business around or to set demanding quality standards. (Because each GP was a smaller proportion of the hospital's business, changes were less likely to be radically destabilising and attract critical public and media attention.) Although fundholding was widely disliked among GPs because of the inequalities and inequities that it introduced, depending upon a GP's bargaining leverage with local hospital Trusts, and because of the administrative workload involved, the fundamental concept of GP purchasing was shown to be workable and attractive. Clearly GPs could perform the task successfully. Moreover, it shifted responsibility for the micro-allocation of resources from mistrusted politicians or lay managers to the medical profession.

The incoming Labour government had made a critique of the Conservatives' stewardship of the NHS into an important plank of their electoral platform. They were pledged to sweep away the structures of the managed market as unnecessary overheads that implied a possible route to privatisation. They also took up the recurrent populist mantra of 'power to the professionals - or, more particularly, to the doctors', which conveniently unites both the uninformed public and the professions in a single mobilising act. The realities of subsequent developments are, of course, more complex and at least some of the professionals suspect a distinctly Faustian bargain. In effect, Labour began by embarking on a course that would make the general practice segment of the medical profession into a collective fundholder. Although individual fundholding *per se* would be abolished, general practitioners would be formed into Primary Care Groups, each covering about 100,000 patients, which would move towards purchasing - in the preferred new rhetoric 'commissioning' - care on behalf of those patients. This took at face value the profession's claim to be able to govern its members more effectively by peer pressure than by outside monitoring. Inefficient, ineffective or incompetent GPs would be forced into line by their colleagues in the PCG and their collective market power would be used to drive improvements in the quality and responsiveness of hospital medicine. In this initial phase, the political imperative was the incorporation of the GPs and almost all of the relevant policy attention was devoted to them.

It rapidly became clear that the idea of a GP-dominated NHS was something of a sham. The old habits of political micro-management began to reassert themselves and the failings of hospital medicine proved to catch the populist mood more than the successes of primary care. Barely had PCGs been established than they were being restructured as Primary Care Trusts, merged to serve larger populations and with GP control diluted to incorporate other interests. Rather than trusting local

commissioners to make the right decisions with the provision of central information, advice and consultancy, new forms of central control were devised: sometimes it seems as though there will be a Czar for everything! Although the attack on lay public management has continued, the government has increasingly taken reserve powers to replace professional control with private management in the future (Pollock 2001).

What has this meant for pharmacy? Initially, as we have seen, very little. However, as Primary Care Groups began to operate during 1998, a number of them began to involve pharmacists and to stimulate Pharmacy Development Groups (PDGs) (Forum 1999). These implied two rather different roles for pharmacists. Some PCGs employed pharmacists directly, as a means of encouraging the movement of their members towards a common, cost-efficient approach to prescribing. The PDGs, however, might be better seen as a parallel development to PCGs in the search for a common, co-operative approach to pharmaceutical care issues in a particular locality. This vision of professional co-operation also marks the RPSGB's approach to clinical governance, another major theme of Labour health policy since 1997 (RPSGB 1999; The Society 1999). However, there was no explicit policy statement about pharmacy in the National Health Service from May 1997 until September 2000.

Pharmacy in the Future (DH 2000) has four sections. The first looks at access to services. The government envisages that there will be further extensions in the classification of medicines for sale over the counter (OTC). There will be closer links with NHS Direct to refer patients to pharmacies where appropriate. These extensions of self-care will increase opportunities for health promotion in areas like contraception and smoking cessation. Pharmacists will also play a larger role in supervising drug misusers. By 2004, the NHS expects to have created 500 new 'one-stop' primary care centres, particularly in inner-city areas. A substantial number of these will include community pharmacies. Out of hours access to pharmaceutical services will be extended and pharmacists will be more involved in repeat dispensing without reference to the original prescriber. Prescriptions will be electronically transferred by 2004. This will make it possible to expand e-pharmacy - the remote dispensing and mail-order delivery of prescriptions.

Even in this first section, the inconsistencies of the document are clear. If there is to be a further shift of common medicines to OTC status, then the major beneficiaries are likely to be the supermarkets and large chains with their greater buying power and ability to operate on lower margins. The development of one-stop primary care centres will inevitably mean extensive closures of other outlets. More curiously, it is not clear how e-pharmacy can co-exist with greater opportunities for pharmacists

in health promotion. Where is the evidence of effectiveness for electronic promotion? What are the implications for medication concordance if the only contact with pharmaceutical care is electronic and remote? Given the evidence reported here and elsewhere, how are further extensions to pharmaceutical service hours to be achieved by anyone other than major chains without imposing even more unacceptable working conditions on community pharmacists? If there is to be electronic transfer of prescriptions, what are to be the safeguards against the occasional corrupt or collusive arrangement between GPs and pharmacists hinted at in this report?

The second section of the document deals with medicines management. This envisages the development of a nationwide network of medicines management services, possibly delivered through community pharmacies. A local trial of this package was promised for 2001. There are also to be investments in patient partnership in medicine taking. Again, it is not difficult to see the virtue of a medicines management service within a PCT as a service to its members. What is far more difficult is to see how this can be delivered unless there is more attention to the infrastructure of community pharmacy, ensuring that both corporate and small providers are able and willing to take this on. Similarly, it is hard to see how patient partnership is to be reconciled with e-pharmacy.

The third section discusses the service structures. Health authorities will be allowed to introduce new forms of contracting for pharmacy services. The national contract will be changed to make it easier to enforce quality standards rather than simply paying for volume. Control of entry rules will be relaxed, especially in major retail complexes. (There is, however, an interesting question about the Office of Fair Trading's current (2002) investigation of the control of entry rules. Although the Department of Health seem to think that they can stay in charge of these, the OFT's record suggests that the most likely outcome will be a requirement that the NHS contract with any provider who wants to contract with them, unless there is some defensible reason, such as previous malpractice, not to. The idea of a planned distribution of pharmacy services by PCTs may well prove to be something of a mirage.) Prescribing rights will be extended for at least some pharmacists. We might ask how the drastic reduction in the number of health authorities announced by the government in April 2001 will be reconciled with the greater development of locally sensitive contracting. What do the changes in the national contract imply for the regulatory overhead imposed on smaller contractors and smaller businesses? If, as implied, the Global Sum available for payment remains unchanged, there must be winners and losers. Most of the losers will be those enterprises that cannot spread the costs of compliance with government standards across a relatively high volume of business, particularly if the total volume is reduced by the development of mail-order e-pharmacy. Compare the overheads of a

dispensing mill in an industrial park with a low ratio of pharmacists to dispensing assistants and no walk-in facilities and of a retail outlet which has to provide private consultation space, a high ratio of pharmacists to assistants, accessible premises and the like. Relaxation of entry controls will further increase pressure on small providers from larger predators, who can sustain the costs of competition in a way that others cannot. A large chain can absorb the low margins and predatory pricing needed to break into a market across its whole business in a way that is not open to a small chain or solo provider.

Finally, the document addresses the employment conditions of pharmacists. Much of this is concerned with hospital pharmacy, where uncompetitive salaries have led to considerable shortages. However, there are also commitments to further expansion of CPD, clinical governance and professional regulation. The problems with CPD have already been identified in this report, as have questions about the ability of small pharmacies to carry the overhead of clinical governance. Others have already questioned the double jeopardy implicit in the government's proposal that the NHS should second-guess professional regulatory bodies by having an independent system to decide who can receive contracts to provide primary care services.

There is clearly a danger of concluding that nothing should change. Solo practitioners and small chain pharmacies do not have a right to stay in business, especially when receiving public funds, unless they are offering something of value. However, they might also reasonably expect that if they are going to be put out of business, that this reflects a conscious act of policy, as in the case of the decision to eliminate single-handed general practice. They might also expect that there will be a fair scheme of compensation to reflect the capital that they have invested in their businesses, being for many of them their *de facto* pension fund. What is surely unacceptable is that their livelihoods should be destroyed as a result of a well-meant but incompletely considered and, to some extent, incoherent package of reforms.

Part of the government's problem is that it has moved twenty years too late to bring pharmacy within the NHS in the way that general practice has with the creation of Primary Care Groups, and their development into Trusts, since 1997. The primary care reforms have been able to take advantage of the increasing desire of many doctors for a more bounded life, without the open-ended commitment and proprietorial responsibilities of the traditional ways of delivering primary care. They have been facilitated by the crisis of professional morale in the wake of the Harold Shipman affair and its evidence that the old ways of doing business really could not detect and control a maverick

practitioner. As the Conservatives discovered, the long-term recruitment of students to UK medical education and practice on the basis of their espousal of the fundamental values of the NHS had made many doctors reluctant to accept market processes of restructuring or to see competition as a positive force.

Community pharmacy is very different. It has already been massively restructured by market processes, which will be further reinforced by the end of resale price maintenance (RPM), which protected the margins of smaller outlets. One authoritative estimate suggests that about 600 independent pharmacies are likely to close by 2006 as a result (Verdict 2001). The abolition of RPM has given powerful backing to the thesis that medicines are no different from other consumer products and require no special environment for their sales. This is consistent with the government's plans to expand the OTC categorisation, freeing more medicines for general sale, to relax entry controls and increase competition and to encourage e-pharmacy as a means of reducing the overheads on prescribed medicines. One plausible future scenario would see the virtual disappearance of specialised pharmacy outlets. A wider range of OTC medicines would be bought more or less anywhere, while electronic prescriptions were assembled in regional preparation centres and delivered by courier. It is unlikely that pharmacy only medicine sales, or even some limited prescribing, would provide sufficient income to sustain a business. Electronic prescription monitoring would eliminate a lot of the medicines management function, since GPs who deviated from PCT or national formularies would be easily identified and investigated. Supermarkets could probably cope with this, although large chains would have difficulties. Within this scenario, community pharmacists would survive mainly as independent contractors for the supply of specialised advice and health promotion services. The result would almost certainly be a much smaller profession doing very different things from today. Indeed, the arguments for preserving the independent contract would be rather weak. Much of the community health function might be better done as a salaried employee of a PCT, where socially acceptable hours and conditions could be more actively managed and supported. Regional preparation centres might be contracted out to private management but would, again, tend to employ pharmacists rather than to be owned or managed by them.

The problem with such a scenario is precisely that medicines are different from other consumer products. Although no-one would claim that there is much personal connection between most pharmacists and their patients or customers at present, the opportunity for this to develop exists and its importance is recognised. The efficient and effective use of NHS resources requires the active engagement of patients with their medication consumption. This is a complex task. It involves the

appropriate use of self-treatment, which requires patients to recognise when this is relevant and when they should seek professional advice. Self-medication needs to be used in accordance with instructions, both to be effective in contributing to population health and to avoid unwanted effects. Similarly, the prescription or counter sale of the correct medication is only a small part of its correct use. The medication subsidised or paid for by public funds wastes those resources if it is not taken as directed, or if the patient does not stop at the right time because some adverse effect is emerging. Important advances have been made over recent years in improving the efficiency and effectiveness of supply. These need to be matched by parallel improvements in concordance, which may include knowing when to disregard instructions. There is a distinct lack of evidence that the scenario outlined above would contribute to this.

The one-stop primary care centres offer a possible alternative. The current chair of the Royal College of General Practitioners advocated something very like this when he described the pharmacy which his, dispensing, practice had created in 1997 (The Conference 1999). However, it is not clear how rapidly these centres will actually develop and how they will relate to the large corporate interests that now dominate pharmacy services. If they are focussed mainly on inner city areas, then the result may be to destroy the small outlets that currently service these neighbourhoods and to replace them with corporate franchises. This may be efficient for the NHS but compromise access in areas that will also be seeing the concentration of their GP services as small providers are relocated into these centres.

It is hard to see that the small pharmacy business, whether solo, as here or, by extension, the smaller chain, can have much future, unless they can develop a 'boutique' strategy that will establish some line which is sufficient to sustain them. Even here, the danger is that a successful strategy will simply be picked up by larger players. Organic food was once the exclusive province of relatively small, committed shops: now it is a mass consumer product that fills the stores of their mega-competitors. A more clinical relationship with customers might help, but the NHS contract would need substantial reworking to pay for this. Of course, this contract would have to be offered without discrimination, which opens the door to the larger players to derive greater benefits because of their ability to spread overheads.

Solo practice is already struggling. Like all small businesses, it has difficulty in carrying the regulatory overheads imposed by modern societies. Individually, VAT returns, health and safety requirements, employment protection legislation, access for people with disabilities and so on may all be eminently desirable. Cumulatively, they impose increasingly onerous burdens on small businesses, who have

less access to specialist expertise on compliance, less leverage in negotiating interpretations with regulators and less capital to make necessary investments. These problems are multiplied by the special requirements of a regulated profession. Re-certification based on CPD participation, for example, becomes yet another burden on an owner-manager, whose quality of life is already under pressure. The larger players can deal with this by internalising locum arrangements, establishing their own supply banks or extending their use of part-time or 'floating' staff to cover absences. The solo finds the pool shrinking as locums find that they have difficulty in complying with the re-certification requirements and see that this may not be a possible exit route into their own retirement.

It may be that we as a community feel that businesses which cannot both meet all our regulatory expectations and give their owners an acceptable quality of life, do not deserve to survive. However, we should be sure that we are not losing something else that might be valuable in the process and, to the extent that the changing business conditions result from deliberate NHS policy choices, we surely have an obligation to manage the transition in a more orderly way.

6. REFERENCES

- Aldridge A, Dingwall R and Watson P (1996) *Evaluation of two pharmaceutical care programmes for people with mental health problems living in the community*. Discussion paper 96/03. Sheffield, Trent Institute for Health Services Research.
- Anderson S (1995) 'Organizational status and performance: the case of Swedish pharmacies', *Public Administration* 73:287-301
- Anon (1993) 'Not enough progress after Nuffield, says Lord Peston', *Pharmaceutical Journal* (April 3): 475-6.
- Axon S (1996a) 'Applying for an NHS contract', *Pharmaceutical Journal* 257 (August 17) : 220-1.
- Axon S (1996b) 'How pharmacy contractors are paid', *Pharmaceutical Journal* 257 (August 17): 221-3.
- Barley S and Tolbert P (1991) 'At the intersection of organizations and occupations'. Pp.1-13 in Tolbert P and Barley S, eds. *Research in the Sociology of Occupations and Occupations*, Greenwood, CT., JAI Press.
- Becher T (1990) 'Professional education in a comparative context'. Pp 134-50 in Torstendahl R and Burrage M, eds. *The Formation of Professions: Knowledge, State and Society*, London, Sage.
- Becker HS, Geer B, Hughes EC and Strauss AL (1961) *Boys in White: Student Culture in Medical School*, Chicago, University of Chicago Press.
- Berger J and Mohr J (1967) *A Fortunate Man: The Story of a Country Doctor*, London, Allen Lane.
- Birenbaum A.(1982) 'Reprofessionalization in pharmacy', *Social Science and Medicine* 16: 871-8.
- Blenkinsopp A (1992) 'Evolution in community care: the role of the community pharmacist' pp. 89-100 in Loveridge R and Starkey K, eds., *Continuity and Crisis in the NHS*, Buckingham: Open University Press.
- Blenkinsopp A (1997) 'Community pharmacy services: the 1996 Royal Pharmaceutical Society Survey', *Pharmaceutical Journal* 258: 633-35.
- Blenkinsopp A, Boardman H, Jesson J and Wilson K (1999) 'A pharmacy workforce survey in the West Midlands: (1) current work profiles and patterns', *Pharmaceutical Journal* 263: 909-13.
- Boardman H, Blenkinsopp A, Jesson J and Wilson K (2001) 'A pharmacy workforce survey in the West Midlands: (4) morale and motivation', *Pharmaceutical Journal* 267: 685-90.

- Brown ME, Ellis S, Linley PA and Booth TG (1992) 'Professional values and pharmacy practice: implications of a predominantly female Register of Pharmaceutical Chemists', *International Journal of Pharmacy Practice* 178-83.
- Byrt S (1996) 'Pharmacists in the rural community: interpreting their own worlds'. Pp. 47-70 in Phillips S, Delamont S and Temple D, *Qualitative Research in Pharmacy Practice*, Aldershot, Ashgate,
- Carlin J (1994) *Lawyers on Their Own: The Solo Practitioner in an Urban Setting*, San Francisco, Austin and Winfield. (First published 1962).
- Cartwright A and Anderson R (1981) *General Practice Revisited: A Second Study of Patients and their Doctors*, London, Tavistock.
- Cole W (1997) *Trends in the Solicitors' Profession: Annual Statistical Report 1997*, London, The Law Society.
- Collin J (1995) *Changement d'ordonnance*, Montreal, Boréal.
- Cutchin MP (1997) 'Community and self: concepts of rural physician integration and retention', *Social Science and Medicine* 44: 1661-1674.
- Denzin NK with Mettlin CJ (1968) 'Incomplete professionalization: the case of pharmacy', *Social Forces* 46: 375-81.
- DH (2000) *Pharmacy in the Future - Implementing the NHS Plan*, London, Department of Health
- Dingwall R (1995) 'Le verouillage du marché: les pharmacies anglaises dans la course à la licence 1794-1868'. Pp. 15-22 in Lasselain J ed. *Profession Pharmacien: Le Regard des Sciences Sociales*, Paris, Edition Imhotep Médecine Sciences.
- Dingwall R (1997) 'Accounts, interviews and observations'. Pp. 51-65 in Miller G and Dingwall R, eds. *Context and Method in Qualitative Research*, London, Sage.
- Dingwall R and Wilson E (1995) 'Is pharmacy really an 'incomplete profession?' Pp 111-128 in Holstein JA and Miller G, eds., *Perspectives on Social Problems*, Greenwood, CT., JAI Press.
- Editorial (1993) 'The small contractor', *Pharmaceutical Journal* (February 13): 193.
- Forum (1999) 'Building the future through PDGs', *Pharmaceutical Journal* 263 (December 11): 960-1.
- Freidson E (1975) *Doctoring Together: A Study of Professional Social Control*, New York, Elsevier.
- Furber T (1993) 'Broad Spectrum: Access to pharmaceutical services', *Pharmaceutical Journal* (February 20): 231.
- Goffman E (1983) 'Felicity's Condition', *American Journal of Sociology* 83: 1-53

- Green J (1993) 'The views of single-handed general practitioners: a qualitative study', *British Medical Journal* 307: 607-10.
- Hassell K, Noyce P and Jesson J (1998) 'White and ethnic minority self-employment in retail pharmacy in Britain: an historical and comparative analysis', *Work, Employment and Society* 12: 245-71.
- Heinz JP and Laumann EO (1994) *Chicago Lawyers: The Social Structure of the Bar*, Evanston, IL, Northwestern University Press/Chicago: American Bar Foundation. (Revised Edition: first published 1982).
- Heinz JP, Hull KE and Harter AA (1999) 'Lawyers and their discontents: Findings from a survey of the Chicago Bar', *Indiana Law Journal* 74:735-58.
- Heinz JP, Nelson RL, Laumann EO and Michelson E (1998) 'The changing character of lawyer's work: Chicago in 1975 and 1995', *Law and Society Review* 32: 751-76.
- Holloway SWF, Jewson ND and Mason DJ (1986) "'Reprofessionalization" or "Occupational Imperialism"?: Some reflections on pharmacy in Britain', *Social Science and Medicine* 23: 323-32.
- Horobin GW and McIntosh J (1977) in Stacey, M., Reid, M., Heath, C. C. and Dingwall, R., eds., *Health and the Division of Labour*, London, Croom Helm.
- Hughes D, Griffiths L and McHale J (1997) 'Do quasi-markets evolve? Institutional analysis and the NHS', *Cambridge Journal of Economics* 21: 259-76.
- Hull KE and Nelson RL (1999)
- Kronus, CL (1976) 'Occupational versus organizational influences on reference group identification: the case of pharmacy', *Sociology of Work and Occupations* 3: 303-30.
- Law Society (2000) *Annual Statistical Report 2000: Summary*, www.lawsociety.org.uk
- Lewis PSC (2000) *Assumptions About Lawyers in Policy Statements: A Survey of Relevant Research*, Research Series No. 1/00, London, Lord Chancellor's Department.
- Lunt N, Atkin K and Hirst M (1997) 'Staying single in the 1990s: single-handed practitioners in the New National Health Service', *Social Science and Medicine* 45: 341-49.
- Magirr P and Ottewill R 'Measuring the employee/contractor balance', *Pharmaceutical Journal* 254 (June 24): 876-9.
- Marshall TH (1963) *Sociology at the crossroads and other essays*, London, Heinemann.
- McCormack TH (1956) 'The druggists' dilemma: problems of a marginal occupation', *American Journal of Sociology*, 61: 308-15.

- McIntosh J and Horobin GW (1978) 'General practice in remote areas: attractions, expectations and experiences', *Journal of the Royal College of General Practitioners*, 28: 227-32.
- Meetings (1993) 'Not enough progress after Nuffield, says Lord Peston', *Pharmaceutical Journal* (April 3): 475-6.
- National Audit Office (1992) *Report by the Comptroller and Auditor General: Community Pharmacies in England*, London: HMSO.
- News (1997) 'Non-standard pharmacies to be targeted for fraud investigations', *Pharmaceutical Journal* 258: 362.
- Nuffield Foundation (1986) *Pharmacy: A Report to the Nuffield Foundation*, London: Nuffield Foundation.
- Office for the Supervision of Solicitors (1999) *Annual Report 1997-1998*, Leamington Spa, Office for the Supervision of Solicitors.
- Patel J and Boorman G (1999) 'An open letter to the Secretary of State for Health', *Pharmaceutical Journal* 263: 361-2.
- PIANA (1995) 'Pharmacy in a New Age: Developing a strategy for the future of pharmacy: A discussion paper published by the Council of the Royal Pharmaceutical Society of Great Britain', October.
- PIANA (1996a) 'Pharmacy in a New Age: The shape of things to come: six papers on the factors affecting the future of pharmacy', February.
- PIANA (1996b) 'Pharmacy in a New Age: Summary of responses: a consultation on the future of the profession led by the Royal Pharmaceutical Society of Great Britain', September.
- PIANA (1996c) 'Pharmacy in a New Age: The new horizon: a consultation on the future of the profession led by the Royal Pharmaceutical Society of Great Britain', September.
- PIANA (1997) 'Pharmacy in a New Age: Building the future: a strategy for a 21st century pharmaceutical service', September.
- Pollock A (2001) 'Will Primary Care Trusts lead to US style health care?', *British Medical Journal* 322: 964-7.
- Psathas G (1968) 'The Fate of Idealism in Nursing School', *Journal of Health and Social Behavior*, 9: 52-64.
- Quinney ER (1963) 'Occupational structure and criminal behavior: prescription violation by retail pharmacists', *Social Problems* 11: 179-85.

- RPSGB (1999) *Achieving Excellence in Pharmacy through Clinical Governance*, London, Royal Pharmaceutical Society of Great Britain.
- Seron C (1996) *The Business of Practicing Law: The Work Lives of Solo and Small-Firm Attorneys*, Philadelphia, Temple University Press.
- Shuval J and Gilbert L (1976) 'Attempts at professionalization in pharmacy: an Israel case study', *Social Science and Medicine* 12: 19-25.
- Sidaway J and Cole B (1996) *The Panel: A Study of Private Practice 1994/95 RPPU Research Study No. 20*, London, Law Society.
- Silverman D (2001) *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction*, London, Sage.
- Sitkin SB and Sutcliffe KM (1991) 'Dispensing legitimacy: the influence of professional, organizational, and legal controls on pharmacist behavior'. Pp.269-95 in *Research in the Sociology of Organizations* 8, Greenwood, CT., JAI Press.
- Smith DJ (1980) *Overseas Doctors in the National Health Service*, London, Policy Studies Institute.
- Statutory Committee (2000) 'Ethnic monitoring needed to ensure equal treatment of pharmacists', *Pharmaceutical Journal* 264 (January 29): 179.
- Superdrug (1999) 'The way forward: the need for greater choice and competition in the pharmacy sector', inserted in *Pharmaceutical Journal* 263 (September 11).
- Supplement (1997), 'Rational Distribution of Pharmacies', *Pharmaceutical Journal* (December 13): PD1-16.
- The Conference (1999) "'Give up independence for influence," urges RCGP chairman', *Pharmaceutical Journal* 263 (September 25): 490-1.
- The Society (1999) 'Society publishes framework for clinical governance in pharmacy', *Pharmaceutical Journal* 263 (September 25) 479-80.
- Thompson M (1993) 'Current Affairs: Community places high value on a small pharmacy', *Pharmaceutical Journal* (March 13): 335.
- Thorner I (1942) 'Pharmacy: the functional significance of an institutional pattern', *Social Forces* 20: 321-8.
- Van Hoy J (1997) 'Review Essay: The practice dynamics of solo and small firm lawyers', *Law and Society Review* 31: 377-87.

Verdict (2001) 'Verdict - 600 pharmacies could close', *Pharmaceutical Journal* (15 September) 267:
339.

Walker G (1993) 'Broad Spectrum: Small is beautiful', *Pharmaceutical Journal* (February 27): 261.

Other papers published by the Trent Institute for Health Services Research are listed below:-

Guidance Notes for Purchasers

96/01	Working Group on Acute Purchasing: The Use of DNase in Cystic Fibrosis (1996) by JN Payne, S Dixon, NJ Cooper and CJ McCabe.	£6.00
96/02	Working Group on Acute Purchasing: Tertiary Cardiology (1996) by J Tomlinson, J Sutton and CJ McCabe.	£6.00
96/03	Working Group on Acute Purchasing: The Use of Cochlear Implantation (1996) by Q Summerfield and J Tomlinson.	£6.00
96/04	Working Group on Acute Purchasing: Statin Therapy / HMG Co-A Reductase Inhibitor Treatment in the Prevention of Coronary Heart Disease (1996) by MD Pickin, JN Payne, IU Haq, CJ McCabe, SE Ward, PR Jackson and WW Yeo.	£6.00
97/01	Working Group on Acute Purchasing: The Clinical and Cost-effectiveness of Computed Tomography in the Management of Transient Ischaemic Attack and Stroke (1997) by A Ferguson and CJ McCabe. Series Editor: Nick Payne	£10.00
97/02	Working Group on Acute Purchasing: Prostacyclin in the Treatment of Primary Pulmonary Hypertension (1997) by TW Higenbottam, SE Ward, A Brennan, CJ McCabe, RG Richards and MD Stevenson. Series Editor: Nick Payne.	£10.00
97/03	Working Group on Acute Purchasing: The Use of Riluzole in the Treatment of Amyotrophic Lateral Sclerosis (Motor Neurone Disease) (1997) by J Chilcott, P Golightly, D Jefferson, CJ McCabe and S Walters. Series Editor: Nick Payne.	£10.00
97/04	Working Group on Acute Purchasing: Recombinant Factor VIII Versus Plasma Derived Factor VIII in the Management of Haemophilia A: An Examination of the Costs and Consequences (1997) by C Green and RL Akehurst. Series Editor: Nick Payne.	£10.00
97/05	Working Group on Acute Purchasing: The Use of Cisplatin and Paclitaxel as a First Line Treatment in Ovarian Cancer (1997) by SM Beard, R Coleman, J Radford and J Tidy. Series Editor: Nick Payne.	£10.00
97/06	Working Group on Acute Purchasing: The Use of Alpha Interferon in the Management of Chronic Myeloid Leukaemia (1997) by RG Richards and CJ McCabe. Series Editor: Nick Payne.	£10.00
97/07	Working Group on Acute Purchasing: Spinal Cord Stimulation in the Management of Chronic Pain (1997) by J Tomlinson, CJ McCabe and B Collett. Series Editor: Nick Payne.	£10.00
97/08	Working Group on Acute Purchasing: The Use of Growth Hormone in Adults (1997) by JN Payne and RG Richards. Series Editor: Nick Payne.	£5.00
97/09	Working Group on Acute Purchasing: A Review of the Use of Donepezil in the Treatment of Alzheimer's Disease (1997) by FA Pitt, J Chilcott, P Golightly, J Sykes and M Whittingham. Series Editor: Nick Payne.	£10.00

97/10	Working Group on Acute Purchasing: The Use of Bone Anchored Hearing Aids (1997) by NJ Cooper, J Tomlinson and J Sutton. Series Editor: Nick Payne.	£10.00
98/01	Working Group on Acute Purchasing: A Review of the Use of Current Atypical Antipsychotics in the Treatment of Schizophrenia (1998) by S Beard, J Brewin, C Packham, P Rowlands and P Golightly. Series Editor: Nick Payne.	£10.00
98/02	Working Group on Acute Purchasing: Internal Fixation of Tibial Shaft and Distal Radius Fractures in Adults (1998) by N Calvert, P Triffit, S Johnstone and RG Richards. Series Editor: Nick Payne.	£10.00
98/04	Working Group on Acute Purchasing: The Effectiveness of High Dose Chemotherapy and Autologous Stem Cell Transplantation in the Treatment of Hodgkin's Disease and Non-Hodgkin's Lymphoma (1998) by S Beard, P Lorigan, A Simms and F Sampson. Series Editor: Nick Payne.	£10.00
98/05	Working Group on Acute Purchasing: Angiotensin-Converting Enzyme (ACE) Inhibitors in Heart Failure: Reducing Mortality and Costs to the NHS (1998) by N Calvert, J Cornell and C Singleton. Series Editor: Nick Payne.	£10.00
98/06	Working Group on Acute Purchasing The Use Of Ultrasound (Viability) Scans In Early Pregnancy Bleeding (1998) by N Calvert, C Singleton and P Tromans. Series Editor: Nick Payne.	£10.00
98/08	Working Group on Acute Purchasing: The Effectiveness of High Dose Chemotherapy with Autologous Stem Cell / Bone Marrow Transplantation in the Treatment of Multiple Myeloma (1998) by S Beard, F Sampson, E Vandenberghe and F Scott. Series Editor: Nick Payne.	£10.00
98/10	Working Group on Acute Purchasing: Supplementary Document: The Use of Paclitaxel in the First Line Treatment of Ovarian Cancer (1998) by S Beard, R Coleman, J Radford and J Tidy. Series Editor: Nick Payne.	£10.00
98/11	Working Group on Acute Purchasing: The Use of Fluoridated School Milk in the Prevention of Dental Caries (1998) by N Calvert and N Thomas. Series Editor: Nick Payne.	£10.00
99/01	Working Group on Acute Purchasing: The Role of Antileukotrienes in the Treatment of Chronic Asthma (1999) by M Stevenson, R Richards and S Beard. Series Editor: Nick Payne.	£15.00
99/02	Working Group on Acute Purchasing: Hepatic Resection as a Treatment for Liver Metastases in Colorectal Cancer (1999) by S Beard, M Holmes, A Majeed and C Price. Series Editor: Nick Payne.	£15.00
99/03	Working Group on Acute Purchasing: A Review of the Use of Propentofylline in the Treatment of Dementia (1999) by J Chilcott, K Perrett, P Golightly, J Sykes and M Whittingham. Series Editor: Nick Payne.	£15.00
99/04	Working Group on Acute Purchasing: The Use of Routine Antenatal Anti-D Prophylaxis for Rhesus Negative Women (1999) by M Allaby, K Forman, S Touch and J Chilcott. Series Editor: Nick Payne.	£15.00

99/05	Working Group on Acute Purchasing: Magnetic Resonance Imaging (MRI) in the Management of Knee Disorders (1999) by SM Beard, I Perez , S Touch and D Bickerstaff. Series Editor: Nick Payne.	£15.00
99/06	Working Group on Acute Purchasing: The Effectiveness of Surgery in the Management of Epilepsy (1999) by J Chilcott, S Howell, A Kemeny, C Rittey and Richards C. Series Editor: Nick Payne.	£15.00
99/07	Working Group on Acute Purchasing: Tacrolimus and Mycophenolate Mofetil as Maintenance Immunosuppressants following Renal Transplantation (1999) by J Chilcott, M Corcoran, KM Rigg and RP Burden. Series Editor: Nick Payne.	£15.00
99/08	Working Group on Acute Purchasing: The Use of Endovascular Stents for Abdominal Aortic Aneurysm (1999) by NW Calvert, M Lloyd Jones, S Thomas, RG Richards and JN Payne. Series Editor: Nick Payne.	£15.00
00/01	Working Group on Acute Purchasing: The Effectiveness of Intrathecal Baclofen in the Management of Patients with Severe Spasticity (2000) by FC Sampson, SH Touch, A Hayward, G Evans, R Morton, D Playford, M Vloeberghs, A Collett, and P Critchley. Series Editor: Nick Payne.	£15.00
00/02	Working Group on Acute Purchasing: Summary of the Current Evidence of Comparative Effectiveness for SSRIs and TCAs in the First Line Treatment of Depression in Primary Care (2000) by S Beard, C McGarrity and S Touch. Series Editor: Nick Payne.	£15.00
00/03	Working Group on Acute Purchasing: The Use of Hyperbaric Oxygen in the Management of Patients with Oral Cancer (2000) by S Ward, N Thomas, C Mander and I Brook. Series Editor: Nick Payne.	£15.00
00/04	Working Group on Acute Purchasing: Transmyocardial Laser Revascularisation for Angina not Controlled by Medication or Amenable to Surgery (2000) by RJ Wilson, R Slack, N Calvert, M Galinanes and AH Gershlick. Series Editor: Nick Payne.	£15.00
00/05	Working Group on Acute Purchasing: The Long-term Use of Oral Antiplatelet Therapy for the Prevention of Stroke and other Serious Vascular Events (2000) by J Sutton, J Tomlinson and N Calvert.	£15.00
00/06	Working Group on Acute Purchasing: Nasal Continuous Positive Airways Pressure in the Management of Sleep Apnoea (2000) by J Chilcott, E Clayton, N Chada, CD Hanning, W Kinnear, JC Waterhouse.	£15.00

Discussion Papers

No.1	Patients With Minor Injuries: A Literature Review of Options for their Treatment Outside Major Accident and Emergency Departments or Occupational Health Settings (1994) by S Read	£7.00
96/01	Working Group on Acute Purchasing: The Role of Beta Interferon in the Treatment of Multiple Sclerosis (1996) by RG Richards, CJ McCabe, NJ Cooper, SF Paisley, A Brennan and RL Akehurst	£7.50

96/02	The Mid-Level Practitioner: A Review of the Literature on Nurse Practitioner and Physician Assistant Programmes (1996) by P Watson, N Hendey, R Dingwall, E Spencer and P Wilson	£10.00
96/03	Evaluation of Two Pharmaceutical Care Programmes for People with Mental Health Problems Living in the Community (1996) by A Aldridge, R Dingwall and P Watson	£10.00
97/01	Working Group on Primary and Community Care Purchasing: Report of the Sub-Group on the Promotion of Quality in Primary Care - Effective Purchasing of Primary and Community Health Care: Promotion of Quality in the Provision of Primary Care (1997) by S Jennings and M Pringle	£10.00
97/02	Working Group on Primary and Community Care Purchasing: Report of the Sub-Group on Information for Health Needs Assessment and Resource Allocation (1997) by T Baxter, A Howe, C Kenny, D Meechan, M Pringle, P Redgrave, J Robinson and A Sims.	£10.00
98/01	Working Group on Primary and Community Care Purchasing: Hospital at Home - Lessons from Trent (1998) by I Perez, A Wilson, A Siu and R Harper	£10.00
00/01	Genetic Counselling: A Review of the Literature (2000) by A Pilnick, R Dingwall, E Spencer and R Finn	£15.00
00/02	Working Group on Primary and Community Care Purchasing: The Prevention of Osteoporotic Fracture in Women in a Primary Care Setting (2000) by C O'Neill, D Black, S Jennings, M Grainge, M Allaby, D Hosking, J Hippisley-Cox, A Wallace and CED Chilvers	£15.00

Copies of these documents are available from:-

Trent Institute Information Service @ SchARR
 Regent Court
 30 Regent Street
 SHEFFIELD S1 4DA

Tel 0114 222 0703
 Fax 0114 272 4095
 E-mail scharrlib@sheffield.ac.uk

Please make cheques payable to "The University of Sheffield".