

**Professional Engagement of
Locum Community Pharmacists**

by

Alison Margaret Astles

A thesis submitted in partial fulfilment for the requirements for the degree of
Doctor of Philosophy at the University of Central Lancashire

February 2017



STUDENT DECLARATION FORM

Concurrent registration for two or more academic awards

I declare that while registered as a candidate for the research degree, I have not been a registered candidate or enrolled student for another award of the University or other academic or professional institution

Material submitted for another award I declare that no material contained in the thesis has been used in any other submission for an academic award and is solely my own work

Collaboration

Where a candidate's research programme is part of a collaborative project, the thesis must indicate in addition clearly the candidate's individual contribution and the extent of the collaboration. Please state below:

None

Signature of Candidate: *Ahsan Aslam*

Type of Award: Doctor of Philosophy

School: Pharmacy and Biomedical Sciences

Abstract

Locum community pharmacists ('locums') constitute a significant proportion of the community pharmacy workforce in the UK, and have been identified as isolated practitioners who work outside existing quality assurance processes. This study examines professional engagement of locums in terms of their networking with pharmacist colleagues and their professional identity as pharmacists.

With a constructivist, inductive approach, the study consisted of a series of five focus groups with a total of 25 participants in 2013, which were thematically analysed to yield a series of themes around professional engagement. The focus groups confirmed the isolation felt by locums and the effort undertaken by them to develop and maintain networks with colleagues. Locums used their networks for obtaining information, benchmarking their practice, decreasing personal stress, problem solving, sharing opinion on moral and ethical issues and promoting professional growth

Next, the LocumVoice online forum for locum pharmacists was observed for a two month period in 2014, with the data being examined using an adaptation of Bales' interaction process analysis, integrated with thematic analysis of the content. The interactions and content of the forum support it being considered a pharmacy community of practice, with locums' interactions developing professional identity concepts via storytelling, sharing opinions and information. In particular, views on the nature of the role of the pharmacist were prominent in the discussions.

The study contributes to knowledge of UK locum community pharmacists in that it describes the purpose and value of networking as perceived by locums and examines in detail the interactions occurring on an online community of practice that contribute to locum professional engagement and identity development.

Contents

List of Tables	7
Acknowledgements.....	8
Glossary and abbreviations.....	9
Introduction	10
Phase 1: Locum focus groups.....	14
1 Literature: Professions and professionalism.....	14
1.1 Process of literature review	15
1.2 The nature of profession.....	17
1.3 Professional regulation	18
1.4 Professional knowledge	19
1.5 Professional autonomy and values	20
1.6 Professional identity	23
1.6.1 About social identity	23
1.6.2 Professional or occupational identity	25
1.7 Shifting concepts of profession.....	27
1.8 Social media and pharmacy	29
1.9 Conclusion.....	32
1.10 Thesis structure.....	33
2 Study design and methodology	34
2.1 Introduction	34
2.2 Methodological approach to the focus group study	34
2.3 The researcher as a research instrument	36
2.4 Ethical approval.....	38
2.5 Sample and recruitment	38
2.6 Topic guide.....	40
2.7 Transcription	41
2.8 Analysis	43
2.8.1 Analysis process	44
2.9 Summary	45
3 Analysis of the focus groups	46
3.1 Introduction	46
3.2 Constitution of the groups.....	46

3.3	Learning.....	47
3.3.1	Undertaking CPD.....	48
3.3.2	Access to learning.....	49
3.3.3	Feedback on performance.....	54
3.4	Networking with other pharmacists.....	59
3.5	Autonomy.....	63
3.6	Experiences with pharmacy staff colleagues.....	70
3.7	Quality issues for the focus groups.....	73
3.8	Summary.....	75
	Phase 2: Locums' interactions online.....	76
4	LocumVoice: locums' interactions online.....	76
4.1	Introduction.....	76
4.2	How the forum was selected.....	76
4.3	About LocumVoice.....	77
4.3.1	Who were the posters to LocumVoice?.....	77
4.3.2	Sampling areas within the site.....	77
4.4	Ethics and online research.....	79
4.5	Data collection.....	82
4.5.1	Data cleaning.....	82
4.6	Analysis of the online forum.....	82
4.6.1	Approach to the analysis.....	82
4.6.2	An integrated thematic and interaction process analysis.....	83
4.6.3	Interaction process analysis.....	83
4.6.4	Limitations and adaptation of interaction process analysis.....	85
4.6.5	Analysis process.....	85
4.7	Summary.....	87
5	Results of the online analysis.....	88
5.1	Does the forum consist of small groups?.....	88
5.2	How the results are presented.....	89
5.3	Sharing suggestions, opinion and information.....	90
5.3.1	Suggestions.....	90
5.3.2	Opinions.....	92
5.3.3	Information.....	95
5.4	Solidarity/antagonism, tension and agreement.....	99

5.5	General quality issues for the research	102
5.6	Quality issues for the analysis of the online forum	105
5.7	Summary	106
6	Conclusions: locums and professional engagement.....	108
6.1	Introduction	108
6.2	Closure of LocumVoice.....	108
6.3	Discussion and implications of the research.....	109
6.3.1	Locums and networking with other pharmacists	109
6.3.2	Locums and professional identity	112
6.4	Conclusion.....	115
7	Appendices.....	118
7.1	Appendix: Reflexive statement.....	118
7.2	Appendix: Focus group ethical approval.....	122
7.3	Appendix: Illegal activities protocol.....	124
7.4	Appendix: Focus group information sheet and consent form	127
7.5	Appendix: Focus group topic guide.....	132
7.6	Appendix: Example of post-focus group discussion	135
7.7	Appendix: List of focus group transcription conventions	137
7.8	Appendix: Professional engagement node list and description	138
7.9	Appendix: Decision factors for choice of discussion forum.....	142
7.10	Appendix: Text for online weblink	145
7.11	Appendix: Online data cleaning protocol	146
7.12	Appendix: Memos for online analysis – interactions.....	148
7.13	Appendix: Example of coding of online analysis.....	153
7.14	Appendix: The existence of small groups on the online forum	154
7.15	Appendix: COREQ checklist.....	156
8	References	159

List of Tables

Table 1: Databases used for literature search	15
Table 2: Composition of the focus groups	46
Table 3: The posting areas within the LocumVoice forum	78
Table 4: Posts per month on the LocumVoice forum	78
Table 5: Bales' framework used for the analysis.	84
Table 6: Bales' task areas	90
Table 7: Bales' social emotional areas	100
Table 8: Number of posts in each thread.....	154
Table 9: Number of posters present on each thread	154

Acknowledgements

Many thanks to my supervisory team of Dr Sarah Wilson, Professor Gordon Becket, Dr Cath Sullivan and Dr Nicola Gray for their continued support and advice. Thanks to Michael Hartley for technical help and to George Hartley for useful distraction.

I am grateful for the significant support of Pharmacy Research UK, in providing financial support via the Sir Hugh Linstead Award in 2011.

Particular thanks are owed to Lindsey Gilpin, the owner of the LocumVoice website who sadly died in 2014. Her enthusiasm for this research greatly facilitated the data collection process and her passion for locum community pharmacy will be remembered.

Glossary and abbreviations

Blog	A website or online journal, where current topics and news are discussed. Bloggers engage in discussion with their readers and generate a lot of social interaction thought to be useful in knowledge creation.
Discussion forum	An online site where people can post messages and respond to hold conversations. Synonyms: Chat room, online forum, internet forum.
Emoji	Image to display emotion or message. Synonym: Emoticon.
Facebook	Social networking site that connect one to friends and others in your network. It is used by over one billion people worldwide up upload photos, share links and videos and to communicate.
GPhC	General Pharmaceutical Council.
Listserv	Members share information and engage in conversation using moderated email lists.
Locum	Locum community pharmacist.
Locuming	Undertaking work as a locum community pharmacist.
Moderation	The process whereby a website administrator screens and edits posts, removing unsuitable contributions.
MUR	Medicines Use Review.
Post (verb and noun)	The act of typing a contribution into a site conversation (verb), or the entry so created (noun).
Poster	A person who posts to a site.
RPS	Royal Pharmaceutical Society.
Social media	The use of digital media, including internet and mobile, to engage with other users and form self-organised networks. Typical elements of social media include the ability to: create a profile, friend or follow others to see their activity streams, create content such as text, photos, audio or video and share, tag, rate, comment on or vote on content created by others. Blogs, Facebook, wikis, Twitter, social voting sites and virtual worlds are all examples of social media.
Sticky	A fixed message that stays visible at the top of a webpage.
Thread	A series of posts about a topic. There is usually a thread title that reflects the topic.
Traffic	The number of posts on a discussion forum.
Twitter	A micro blogging service where users send and receive messages less than 140 characters called tweets.

Introduction

This thesis describes research undertaken to investigate professional engagement among locum community pharmacists in England and this first chapter contextualises the research in relation to the literature.

A locum community pharmacist is a self-employed practitioner who undertakes work as the pharmacist responsible for the operation of the pharmacy whilst they are in charge, usually when the regular pharmacist manager is not present. To set the scene for the project rationale, a description of community pharmacy is provided, followed by consideration of the professional context for locum community pharmacists (abbreviated to 'locums' in this thesis). Following this section, the chapter continues with a review of literature considering the nature of professionalism.

There are approximately 50,000 pharmacists registered with the General Pharmaceutical Council (GPhC), the regulatory body for pharmacy in Great Britain (NHS England 2013). Pharmacists undertake a four-year MPharm degree, following by a year's pre-registration training and a final exam before registration as pharmacist with the GPhC. Approximately 70% of practising pharmacists work in community pharmacies (high street pharmacies) and locum pharmacists account for around a quarter (23%) of community pharmacy posts (Seston, Hassell 2009), which makes locum community pharmacists a significant part of the pharmacy workforce. Other sectors of the pharmacy workforce include hospital pharmacists, primary care pharmacists working with general practitioners, academics and pharmacists working in the pharmaceutical industry.

Community pharmacies are contracted to the National Health Service (NHS) to provide pharmaceutical services (dispensing and other clinical services) and as such operate as private businesses. In brief, within the community pharmacy contractual framework, in addition to the core pharmacy role (essential services) there are advanced and locally commissioned services that pharmacies may provide under certain circumstances (Pharmaceutical Services Negotiating Committee 2015). Advanced services, such as the medicines use review (MUR) and new medicines service (NMS), are contracted nationally and require some accreditation of the pharmacist (Pharmaceutical Services Negotiating Committee 2015). Locally commissioned services, as the name suggests, are commissioned by local NHS organisations and local authorities in response to local need. Examples are provision of emergency hormonal contraception and smoking cessation services.

Pharmacies may be owned by individuals (known as independent pharmacies) but are increasingly part of large corporate organisations (known as 'multiples'). One trend over the last ten years has been the growth of multiple pharmacy organisations (Health and Social Care Information Centre 2015). This creates a picture of an increasingly corporatised community pharmacy environment, with large companies owning multiple pharmacies dominating the

market. The new community pharmacy contractual framework established in 2005 opened pathways for additional pharmacy services, many of which require practitioner accreditation to undertake. These shifts in pharmacy ownership, contract and opening hours may have had an impact on the nature of locum working, as it provides greater opportunities for locum working but also potentially create different working pressures (Shann, Hassell 2006).

Some further aspects of locum community pharmacy are now considered. Locums are self-employed practitioners and there are Inland Revenue criteria for defining self-employment (HMRC 2009), which centre on being paid for providing a service and the principle of being able to decide how to do the work. Locums are paid for providing a pharmaceutical service and operate outside the usual employment processes of appraisal (Jee, Jacobs et al. 2013). Locum working patterns may vary greatly, from a one-off few hours' work to working regularly and full time for one pharmacy (Seston, Hassell 2009). Most locums (around two thirds) worked solely as a locum pharmacist, with the remaining third being also employed in other sectors of pharmacy (community, hospital, industry, academia) (Seston, Hassell 2009).

Locums have a variety of motivations for their choice to work in a locum capacity, including the flexibility of the job role, the financial contribution of the work, variety, keeping up to date professionally and to accommodate family commitments and other social interests (Shann, Hassell 2004). Older locum pharmacists reported enjoying the social contact of locum work (Shann, Hassell 2004). Some of the motivations of locum community pharmacists for working as a locum include the desire to be able to practise as a pharmacist, without being encumbered by the trappings of management and business targets (Shann, Hassell 2006).

The next section describes literature relating to locums and their learning. Learning here includes issues such as informal learning in the working environment, continuing professional development (CPD), continuing education and obtaining feedback on performance. Since 2009, pharmacists have been required to record a minimum of nine CPD entries, which must be submitted to the regulator for assessment upon request (General Pharmaceutical Council 2015). This time point is significant when examining literature on this subject, as it marks a point when maintaining a learning record ceased to be voluntary, which may have affected pharmacists' attitudes and behaviours on this subject. A series of interviews with community pharmacists during 2002-4 aimed to find out their views on barriers to engagement with continuing professional development activities (Laaksonen, Duggan et al. 2009). As part of this work, motivational factors influencing the pharmacists' decisions to undertake CPD were identified. These included the purpose of CPD in terms of personal development and keeping up date, benefits in terms of being able to provide services and feeling compelled by professional obligation to undertake CPD. Barriers included the costs associated with CPD and some lack of access to resources.

A 2011 review of Scottish community pharmacists' attitudes to CPD revealed that community pharmacists required more support to undertake and complete CPD than primary care or hospital pharmacists (Power, Grammatiki et al. 2011). It was suggested that this was related to the relative isolation of the community role, which has been previously reported in a series of telephone interviews with locum pharmacists (Shann, Hassell 2006). This study also noted that locums felt they had to be proactive about their own learning and development. In 2013, the

Wilson review of community pharmaceutical services in Scotland identified community pharmacists as isolated and recommended facilitation of networking with colleagues (Wilson, Barber 2013). This provides support for the relevance of this research study, addressing professional engagement of locums in terms of the impact of their isolation.

There is some dated evidence that locums may be less likely to undertake CPD than employed pharmacists (Hull, Rutter 2003), but the position may be different following introduction of mandatory CPD recording and recall. In a review of literature addressing pharmacists' attitudes to CPD, it was noted that locums felt they missed out on employer support for CPD activities when compared to employee pharmacists (Donyai, Herbert et al. 2011). Similarly, in a series of interviews with female community pharmacists, locum pharmacists again felt the lack of employer support for supporting CPD (Gidman, Hassell et al. 2007b). In another small study in 2004, one focus group with locum community pharmacists noted that locums felt that resources for CPD were targeted towards pharmacists working in one place, rather than locums who often did not return to the same workplace (Miller, Jones 2004).

Anecdote suggests that locum pharmacists have traditionally been considered less professionally committed practitioners than other pharmacists (Badwal 2008). Locums themselves have been reported as recognising this attitude from others towards locums, citing negative attitudes to being a locum from pharmacy staff and patients (Shann, Hassell 2006). There is little concrete evidence to support the view that locums are less professionally committed, however the difficulties that arise in judging locum performance have been researched to some extent. The issue of identifying poorly performing pharmacists was explored in an a series of interviews with pharmacy senior managers to determine the mechanisms by which performance concerns could be identified and managed (Jacobs, Schafheutle et al. 2013). Locum pharmacists were considered a 'particular challenge' for pharmacy managers, due to the transient nature of the workforce. In particular, lines of responsibility for performance management and routes for feedback were not clear and not shared between different employing organisations. Feedback was often informal and reactive, for example in response to complaints or errors. The action taken by employers when faced with a poorly performing locum was usually limited to not re-employing them. This lack of routes for feedback for locums, such as appraisal systems used by employees, was highlighted in another study, which also noted the lack of appraisal processes by locum agencies (Jee, Jacobs et al. 2013). The study also noted that informal feedback mechanisms were possible from the staff that locums worked with, and again that avoidance of future employment within that organisation was usually the sanction for poor performance.

The other side of the performance coin occurs when locums meet practice within pharmacies that they consider unprofessional. GPhC guidance on poor working practices that may compromise patient safety states that pharmacists should raise concerns and not ignore the issue (General Pharmaceutical Council 2012). A study from 2004 noted that locums chose not to return to a pharmacy where they experienced poor practice, rather than raise the issue as a performance concern. This was reflected in a more recent article which noted that locums felt that their future employment would be jeopardised by raising concerns (Weinbren 2012).

One area that does reveal some performance differences between locum and employed pharmacists is provision of advanced pharmacy services. Latif and Boardman found that locum pharmacists were less likely to undertake medicines use reviews, but the authors stated that the reasons for this were not clear and might be unrelated to professional commitment (Latif, Boardman 2008). Similarly, John and Turner suggested in an opinion article that locums were less likely to engage with additional services within community pharmacies (John, Turner 2010). It has been reported that many pharmacists experience pressures from employers to undertake additional services (Yuen 2009), (MacDonald, Cheraghi-Sohi et al. 2010). Debate within the pharmacy profession has highlighted opinion that locums should be free to judge whether to undertake a medicines use review consultation without pressure from employing organisations (Schofield 2009). This position may have changed in recent years with reports of locums also being pressured to meet corporate targets for clinical services such as MURs, the threat being refusal of further work booking for locums who do not meet the targets (Weinbren 2012). This is interesting in the light of some locums' stated motivations for working as a locum being to avoid corporate targets (Shann, Hassell 2006).

Perceived levels of clinical autonomy of locum pharmacists were explored as part of a study looking at how practice setting might affect autonomy of community pharmacists (Magirr, Grimsley et al. 2004). A hierarchy of employment was found, in that independent contractors scored most highly for clinical autonomy, followed by employees, followed by locums. The authors speculated that despite self-employment apparently giving locums a freedom to practise as they wish, locums may in fact be in a weak position to demonstrate professional autonomy due to perceived threats to their employment prospects from decisions unpopular with the employer. This was summarised in general terms by Wilensky, as long ago as 1964: 'both salaried and self-employed professionals are vulnerable to loss of autonomy when demand for service is low and dependence on powerful clients or bosses unreceptive to independent professional judgement is high' (Wilensky 1964).

In summary, locum community pharmacists in the UK constitute a significant proportion of the community pharmacy workforce. Locums comprise a disparate group, with few defining features other than being self-employed for their locum work. One of the motivations for locum working was given as the ability to avoid corporate targets imposed on employee pharmacists, but this position may have shifted in recent years due to threats to future employment. Locums also reported lack of access to learning resources, isolation of the locum role, lack of feedback on performance and no appraisal processes. Locums have had some poor 'press', in that their reputation as professional workers was not seen in a good light. Locums' ability to work in a professional, autonomous fashion may also be compromised when unpopular decisions create threats to their continued employment. Given the evidence that locums had concerns about isolation, lack of access to information resources, and reputational issues, these elements from the literature support the research aims of the project, which are to investigate locum professional engagement in terms of their:

- Networking with other pharmacists and professional colleagues
- Professional identity as a pharmacist

This research project aimed to discover locums' perspectives on professional engagement via a series of focus groups. A further study was then undertaken examining an online discussion forum for locum pharmacists to determine the relevance of their online interactions to professional engagement.

The structure of the thesis as a whole will now be described. The next section provides a literature review on professions, professionalism and professional identity. This also considers how these concepts have impacted on professionalism issues within pharmacy. It includes a review of online activities of pharmacists, to inform the observation of the online discussion forum.

Following this, chapter two reviews the methodological approach to the study and the process of undertaking a series of focus groups. The results and discussion of the focus groups are provided in an integrated manner in chapter three.

The method for the observation of the online locum pharmacist forum is provided in chapter four, followed by a second integrated results and discussion in chapter five. Chapter six brings together and concludes the two phases of the study.

Phase 1: Locum focus groups

1 Literature: Professions and professionalism

The introduction above has provided some basic information on pharmacy and locum community working, and established the research aim. This chapter now reviews literature exploring concepts of profession and professionalism that have informed this study. Exploring professional engagement requires consideration of what it means to be professional and indeed what a profession actually is. Hence it was felt important by the researcher to create a background understanding of profession and professionalism, and to identify aspects that would be relevant to this research. It is not intended to be a definitive description, but instead, considers profession as a sociological concept, examining possible traits of profession. This is expanded to consider two different models of profession in society and considers professionalism and professional identity at the individual level. Online interactions of pharmacists are then described, providing a background for the second phase of this study.

The next section describes how the process of literature searching and analysis was undertaken and maintained throughout the period of the study. The nature of the review is first considered, describing the approach that was taken. Different approaches to literature review were considered when planning how to undertake the review. An integrative review is a broad consideration of the literature around a topic which accommodates different methodological approaches and can consider theoretical literature as well as research studies (Whittemore, Knafl 2005). Whittemore and Knafl also put forward strategies for undertaking an integrative review, which provide a structure and enhanced rigour to the process. This was felt to be unsuitable for this research study as the review aimed to develop an understanding

of the topic area to set a context for the study. A narrative literature review was considered a more appropriate approach to deliver this aim. The narrative review has been defined as allowing the researcher ‘to arrive at an overview of a field of study through a reasonably comprehensive assessment and critical reading of the literature’ (Bryman 2012page 102). This meant that the scope of the review could vary – starting with a broad overview and narrowing down to issues of relevance. It also meant that grey literature and opinion could be considered where necessary and that the review could be undertaken within an inductive methodological framework as described further in section 2.2. In summary, the review was influenced by elements of an integrative literature review, but did not adhere strictly to this methodology, being in essence a narrative review. The literature review also reflects the overall inductive methodological approach to this research, which is discussed in section 2.2, which includes the personal development of the researcher, described below. The process of undertaking and maintaining the literature review is now described.

1.1 Process of literature review

The literature search and acquisition process was undertaken during the whole of the research period. Initially, however, a search was undertaken to inform and direct the research approach. A search strategy was developed at that point to guide the search, which is described here. Whilst this is not a systematic review, guidance on searching in health research was taken from McNally and Alborz (2004), which emphasised that a rigid strategy may not be suitable for more ‘diffuse’ topics and that a flexible approach is required.

Firstly, the subject area was defined. This involved identifying the words and ideas that surround the topic to ‘create the conceptual framework within which the literature review [is] located’ (McNally, Alborz 2004 page 184). The ideas framing the search included what a locum community pharmacist is, what it means to be a professional worker in today’s society and what engaging with professionalism might involve. Words associated with these ideas were locum community pharmacist, bank, relief, engagement, participation, professional, professionalism, attitude and conduct.

A range of databases was used to identify likely relevant literature, as shown in Table 1. When considering professionalism, the researcher wished to identify progressive changes in the concepts over time as well as current thinking, so date ranges used were as expansive as possible. Searches were undertaken around professionalism and locum community pharmacy. Synonyms of keywords were used where possible (for example, bank, relief for locum), and wildcard characters used where appropriate, for example, ‘profession*’.

Table 1: Databases used for literature search

Database
Cinahl Complete
Embase
Ethos
Psychinfo
Scopus

SocIndex
Social Sciences Abstracts
Web of Science

Bibliographies from useful papers were reviewed for further relevant papers. Colleagues were also a source of references. The Ethos website (a database of UK theses maintained by the British Library <http://ethos.bl.uk/>) was searched for relevant research work published within the last 15 years. The Pharmacy Research UK website <http://www.pharmacyresearchuk.org/> was similarly examined. The reference lists of relevant theses and reports were then searched for papers which also appeared relevant to this review. The websites of organisations such as the GPhC and HM Revenue and Customs were also searched for useful information sources. 'Grey' literature such as pharmacy magazines (for example, Chemist and Druggist) were individually searched as these were unlikely to be represented in the search databases.

The initial literature search was undertaken in summer 2011, but the process continued throughout the research period until the end of 2015, when the review was finally completed. Following the initial review, future searches were commonly date-limited to only include sources post-2011. The researcher signed up to email 'auto-alerts' for a number of databases to receive updates when selected papers were further cited or when saved search criteria obtained further hits. The research and literature processes were integrated and iterative, which meant that whilst the literature informed the research objectives, subsequent research findings prompted further searching of the literature to illuminate the findings.

Titles and abstracts were reviewed for relevance to the research objectives. Strict inclusion and exclusion criteria were not applied, but the researcher gave consideration to the country of origin of the paper, the date published and apparent relevance to the research objectives. The context of the papers was also considered – non-UK papers were not necessarily excluded, but international papers were less likely to be relevant to this research and were viewed critically in that context.

In addition, the personal development of the researcher during the course of the literature review process should be considered as this did influence the literature review. As the researcher became absorbed in the literature, her thinking was developed which changed the perspective of the literature review. As an example, learning about the development of professionalism concepts over time stimulated new thoughts about current pharmacy professionalism, which meant previously discarded papers were revisited in the light of new understanding. In this way, the literature review is not systematic, but iterative based on the researcher's growing understanding of the issues (but rigour was informed by consideration of 'diffuse' search strategies as described by McNally and Alborz (2004). Again, this fits with the inductive approach taken to the research described in section 2.2.

The literature review was initiated to consider the nature of professions and professionalism in society and to explore how these had changed over time. Development of professionalism within pharmacy was also explored, and this was integrated with wider societal developments. A flexible approach was taken to literature analysis, given the wide range of studies examined and the historical context of some. Appraisal was considered in broader terms than study

quality (McNally, Alborz 2004), in that, with older studies, the passage of time and societal changes enabled criticism of relevance to the situation today. So whilst some studies may be methodologically sound, the context could be subject to criticism from a present-day perspective. However, even if not directly relevant to present-day circumstances, the concept journey was often of relevance to illustrate development of ideas through time, which has influenced the present-day situation. As described in the previous subsection, the process was iterative, in that the researcher's ideas, developed by reading, influenced the synthesis process, in line with the research objectives.

This section has described the approach and process of the literature view. The review itself now follows, starting with a broad overview of profession.

1.2 The nature of profession

In order to consider professional engagement of locum community pharmacists in this research, it was necessary to explore just what a profession is, and what it means to be 'professional'. This section discusses the place and development of professions within society, and how that development relates to professional behaviour. Professions have traditionally been defined as distinct occupational groups within society that are afforded particular social status to provide societal benefits, but attempts to clarify the definition have proved difficult (Evetts 2011). The concept of profession has varied over time and changes in differing contexts (Caldwell 2007). For example, international comparisons of profession can be fraught with difficulties and assumptions, as demonstrated by Neal and Morgan's (2000) consideration of the varied role and influence of different nation states in development of professional groups. In this example, the roles of the UK and German governments in development of professional groups in those societies were considered. In the UK, professions developed largely from the 'bottom up', in that the professional groups themselves initiated structures to establish a position in society. Whereas in Germany, the government took a more active and directive role in creating similar structures, utilising a more 'top down' approach. This emphasises that just because there was a certain historical pattern to profession development in the UK, that is not necessarily replicated elsewhere. Indeed, Evetts noted that the concept of profession is rare outside Anglo-American literature, so it is not necessarily a global concept (Evetts 2005). Neal and Morgan (2000) note that the word 'profession' is often not directly translatable to other languages, so the very concept of profession is situated in a particular kind of society and is not an absolute or universal term. In this review, it is the Anglo-American model which is considered.

It is important to acknowledge again that the meaning of profession is context specific and there is no attempt here to create an absolute definition. As an example, Dingwall discusses the conservative, McCarthyite environment of 1950s America and how this influenced thought on the role of professions in society, showing how the political climate of a state will influence how profession is perceived (Dingwall 2008). Dingwall's review does attempt to review some of the ways in which professions and professionalism have been discussed. The next few paragraphs describe some professional characteristics that have been put forward as defining

professions. The discussion then moves forward to consider more recent viewpoints on professions in society.

In addition to geographical and political differences, views on the nature of the professions have changed over the course of the twentieth and twenty first centuries (Traulsen, Bissell 2004). One approach that has been put forward is that there are 'traits' or characteristics of members of a profession that can be defined – such as altruism, rationality, authority and competence (Parsons 1939). Though Parsons' contribution to the traits approach has been contested (Dingwall 2008), it provides an early historical acknowledgement of a profession as a distinct occupational group. Later in the twentieth century, Hickson and Thomas (1969) synthesised a measurement system of various traits to determine if an occupational group could be considered a profession, reinforcing the idea that a profession was different in its attributes from other occupational groups. Hickson and Thomas reported a series of traits that may signify a profession: a knowledge base that was unavailable to others, a defined education process, a code of conduct required of members, altruistic service, a licensing process that creates a defined group, and a professional and fiduciary client relationship (Hickson, Thomas 1969). This traits approach reinforced work by Wilensky who considered attributes such as the existence of structural elements such as professional associations, codes of ethics and regulation law for a number of occupational groups to determine professional status (Wilensky 1964).

To summarise so far, professions have been recognised as distinct occupational groups within society but as the concept is so influenced by context, there can be no absolute definition. Traits or characteristics have been put forward as representative of professions. Whilst the language used to describe the traits has varied, certain key concepts of regulation, an exclusive knowledge base, independent practice, shared values and identity have remained constant. These key concepts are now discussed in general terms and in also relation to pharmacy.

1.3 Professional regulation

Historically, professions were self-regulating organisations that were enabled by society to control entry to the professional group, to define their own standards of performance and to establish systems for monitoring performance of individuals against those standards (Wilensky 1964), (Hickson, Thomas 1969). Relating this to the development of the pharmacy profession, Crellin provided a perspective of nineteenth century pharmacy professionalism that described a unique body of pharmaceutical knowledge, training processes for professional advancement, development of trade bodies and societal recognition of pharmacy as a distinct group of practitioners (Crellin 1967). This self-regulation model was exemplified by the establishment of new organisations for management of professional groups such as doctors and pharmacists. The Medicines Act 1858 in Great Britain established the General Medical Council in 1858 for doctors. The Pharmacy Acts of 1852 and 1868 allowed the Pharmaceutical Society of Great Britain to regulate, examine and prosecute pharmacists (Royal Pharmaceutical Society, 2013). British state regulation therefore enabled these bodies to establish a register of members and hence control entry into the professional groups. As mentioned in the previous section, in Britain this process was largely driven by the professional bodies themselves, a mechanism not

necessarily replicated in other countries where the state may have played a more directive role (Neal, Morgan 2000).

Powers of standard-setting and monitoring performance against those standards were delegated by the state to these organisations. This model of self-regulation was to be the dominant model for professional groups in Great Britain for the next 150 years. According to Parsons' early twentieth century view, benefits for the professional groups included protected occupational status – entry requirements to the profession could be set, leading to a closed shop arrangement for providing professional services, so protecting income and providing social prestige; benefits for the public included some greater measure of protection from poor service delivery by having a register of accredited professionals deemed to have met certain standards (Parsons 1939).

Within the British pharmacy profession, the regulatory system has shifted in recent years. The most significant development was the removal of the regulatory function from the Royal Pharmaceutical Society of Great Britain in 2010, a function it had held since its establishment a century and a half before. The regulatory function was passed to a new organisation, the General Pharmaceutical Council; the Royal Pharmaceutical Society maintaining its role as a professional leadership body for pharmacy. In summary, a defined system of regulation created a societal structure for establishing standards of professional performance and behaviour, within pharmacy as well as other professional groups.

Consideration of regulatory procedures has relevance for locum community pharmacists in that there is evidence locums may have some difficulties meeting the continuing fitness to practise requirements of the GPhC. At present, there is a requirement for CPD activity to be undertaken to maintain registration as a pharmacist (General Pharmaceutical Council 2015) and locums themselves have identified lack of support with learning compared to employed pharmacists (Donyai, Herbert et al. 2011). The introduction to this thesis highlighted that locums may have difficulties accessing resources for CPD and often feel they practise in isolation from pharmacy colleagues. The situation is also compounded by lack of appraisal processes (Jee, Jacobs et al. 2013). The GPhC is developing additional continuing fitness to practise procedures that include CPD, peer to peer discussion and collection of evidence of competency (General Pharmaceutical Council 2015) and it is possible that locums' abilities to meet these requirements may be compromised by their isolated working situation.

1.4 Professional knowledge

The existence of a body of exclusive knowledge or expertise held by members of the professional group has long been held to be a significant defining factor of profession (Parsons 1939). Parsons (1939) refers to 'superior technical competence' providing authority for the professional person. A specific competence provided a professional group with exclusivity of service delivery, effectively creating a monopoly. Structures were created such as educational processes and credentialing that protected and limited access to that particular competency (Wilensky 1964), (Muzio, Hodgson et al. 2013). Hence professions carved out a service provision niche and effectively protected the status of group members.

Growth in information technology including the use of the internet has resulted in greater 'democracy in information access' (Royal College of Physicians, 2005 page 1). Knowledge is now not restricted to particular professional groups, but is widely available to anyone who wishes to access it. This conflicts with Edmunds and Calnan's (2001) proposition of professionals controlling knowledge. In the modern context, a different way of expressing this might be the application of expert knowledge (MacDonald, Cheraghi-Sohi et al. 2010), rather than control of it. This is not a new debate – Denzin discussed the dissociation of pharmacy practice from the traditional roles of medicines supply to provision of information about medicines use (Denzin 1962) and also the distancing of the pharmacist from the physical dispensing role, which is performed by other staff. Denzin provided a USA perspective on pharmacy professionalism, and given the previous emphasis on the importance of context, his discussion should be viewed with consideration of the societal and health system differences from the UK. Denzin makes the point that pharmacy as a professional group does not have exclusive claim to medicines knowledge, as doctors maintain control via prescribing activity. The pharmacy profession responded to these challenges via promotion of clinical pharmacy cognitive services (Birenbaum 1982), mirroring the move to knowledge application rather than merely knowledge possession. However, the professional knowledge and skill base is still an ongoing debate, as anecdotal reports discussing accredited checking technicians replacing pharmacists reveals (PDA Union Locum Membership Group 2012).

To summarise this section on professional knowledge, a protected knowledge base was a key trait for a profession, protected via organisational structures and credentialing procedures. Greater information availability has challenged this trait, creating a response of expert knowledge application being the professional criterion. The nature of the professional expertise of the pharmacist – what they should be doing as part of their job - is an ongoing debate. Locums have reported difficulties with access to information resources compared to employee pharmacists (Donyai, Herbert et al. 2011), (Gidman, Hassell et al. 2007a), but in terms of the application of knowledge and job roles, the relative isolation of the locum from pharmacy colleagues may also have implications for professional engagement.

1.5 Professional autonomy and values

From early discussion of professions, the idea of a set of common values that govern the behaviours of group members has also been a core element of profession. Parsons described it as 'disinterestedness', having the interests of clients above personal profit (Parsons 1939) and he discussed the differences between 'egoistic' and 'altruistic' motivations for work, referencing back to medieval guilds which protected the quality of services and products. This idea of selfless consideration for the wellbeing of the client has been integrated into the institutionalised structures created around professions, creating codes of conduct and shared internalised values amongst group members. This formed part of the basis of Parson's 'contractual relationship' between a profession and society – in return for protected status, the professions acted in the best interests of their clients (Parsons 1939). Values and autonomy are both considered in this section as they are interlinked – freedom or autonomy is necessary in order to exercise professional values.

Autonomy has been a cornerstone of professionalism, being a fundamental part of the trust relationship between the practitioner and client (Wilensky 1964), (Dingwall 2008) and different facets of autonomy may be considered. Political autonomy relates to the impact that a profession can have on its surrounding policy environment. This policy impact can help a professional group maintain control of the labour market via regulation and credentialing (Edmunds, M 2001), which can consequently maintain the economic power of the group by limiting access to the profession's roles. Clinical autonomy may be said to reflect the degree to which a health professional is able to make a clinical decision in the best interests of the patient, a relationship which has traditionally been based in trust. The difference between trust and confidence encourages some consideration of the value of clinical autonomy for professionals today (Tonkiss, Passey 1999). Tonkiss and Passey (1999) discuss trust and confidence in the context of the voluntary sector, commenting that the traditional model of trust is increasingly being replaced with confidence-building governance structures, which erodes the concept of individual practitioner autonomy. However, this is not necessarily a new phenomenon, as Wilensky discusses in 1964 how 'an increasing percentage of professionals work in complex organisations. These organisations develop their own controls... the salaried professional often has neither exclusive nor final responsibility for his (sic) work; he must accept the ultimate authority of non-professionals in the assessment of both process and product' (Wilensky 1964 page 146). Thus autonomy may have been put forward as a significant professional trait for a long period of time, but has probably been under attack from corporate influences for equally as long.

Societal changes may also influence the expression of autonomy. Increasing consumerism, led by increasing access to online information and changes in the perceptions of the patient-health professional relationship, have led to challenges to the fundamentals of clinical autonomy (Hibbert, Bissell et al. 2002). Old concepts such as 'compliance' with professional advice are predicated upon an imbalanced power relationship between the patient and healthcare professional, the patient being required take the advice of the professional. Newer concepts such as 'concordance' reflect a more joint agreement and decision-making approach towards health outcomes, with patients taking a more active role (Cushing, Metcalfe 2007). This shift in the client-professional balance of power, combined with the move from trust to confidence and the influence of corporations on professional behaviours have impacted to create a different picture of professionalism in the twenty-first century from its nineteenth and twentieth century roots.

The pharmacy profession has not been immune from these societal changes. Harding and Taylor (1997) describe how the increasing number of large multiple pharmacy organisations may be reducing opportunities for individual pharmacists to act with autonomy as work processes are increasingly structured and dictated by the employers. Since 1997, the situation has developed further, with increasing numbers of pharmacies now being owned by large multiple companies (Health and Social Care Information Centre 2015). Andrews (2010) describes his and others' experiences of pressure to behave in certain ways to meet corporate targets. He states, "in a dispensary operating for a large multiple, today's focus appears to be on corporate financial benefit rather than the benefit of others" (Andrews 2010 page 604). In a Canadian community pharmacy study on how ownership of the organisation influenced professional autonomy, ownership (multiple, franchise or independent) did not appear to

influence professional decisions, as stated by the pharmacists themselves (Perepelkin, Dobson 2008). Whilst a Canadian study might not be directly applicable to the British situation, it was significant that the tension between corporate goals and individual professionalism was reported in the study to cause 'role strain' and to be associated with higher levels of burnout and stress (Perepelkin, Dobson 2008 page 97).

Benson et al loosely use the term 'values' as 'those things which practitioners see as making pharmacy valuable or worthwhile' (Benson, Cribb et al. 2009 page 2223) and describe practice dilemmas as situations which cause conflict between values for an individual. In an interview study with pharmacists from a range of sectors of the profession in Britain, the researchers described two core values amongst the pharmacists studied: the patient's best interests and respect for medicines. Whilst these are not surprising findings for a pharmacy study, dilemmas that prompted consideration of these values related to rule breaking activities, resource allocation (including time), patient communication issues and teamwork. One example of a rule breaking dilemma arose when employer obligations such as business targets conflicted with personal professional values (Benson, Cribb et al. 2009).

Within community pharmacy, Rapport et al (2010) described eleven themes of patient centred professionalism based on work with a small number of UK pharmacists and patients, listing safety, professional characteristics (workload, restrictions, job role), relationships with patients, confidentiality and privacy, accessibility, training, professional pressures, services, environment, changing professional roles and patient characteristics. The study also explored the professional tensions and anxieties created by 'patient demands and overarching company policies' which sometimes conflicted with the themes. These themes and tensions provide some reflection of Benson et al's (2009) professional values.

More recently, Maguire (2013) reflected on how a 'target culture' in the NHS resulted in abnegation of professional responsibilities by staff. He theorised, 'stress resulting from poorly managed change forces professionals towards self-preservation as they are robbed of autonomy in their work' (Maguire 2013 page 669). In this instance, it was political imperatives driving the targets, rather than commercial ones, with the same outcome. This idea of role conflict arising from commercial versus professional drivers was emphasised in a report on reducing workplace stressors from the Royal Pharmaceutical Society (2011a), highlighting that 'this tension between commercialism, on one hand, and humanism and altruism, on the other, is a central part of the professionalism challenge pharmacists face today'.

The role of corporate targets on pharmacist behaviour has often focused around delivery of medicines use reviews (MURs). Bush et al (2009) reported corporate disciplinary threats to pharmacists for not achieving target levels of MURs almost as soon as the service started, citing this as reflecting the low levels of professional autonomy of employees. This is reinforced by later research by MacDonald et al (2010), again highlighting that company targets for activities such as MURs meant that 'pharmacists' ability to exercise discretion and control over their work is under threat' (MacDonald, Cheraghi-Sohi et al. 2010 page 456). This paper however, also reveals the same pressures from pharmacists working as employees for independent pharmacies, the key element being the hierarchical arrangement creating tensions between business owners and employee pharmacists. This reflects a conflict between

commercial and patient interests inherent in any professional operation. This dichotomy has always existed however, and Holloway (1986) expressed views that a direct conflict between professionalism and commercialism may be too simplistic. Professional behaviour was viewed as beneficial to the financial success of the business, good service leading to reputational benefits.

In summary, the existence of a set of common values for group members, which promotes a selfless approach to clients, has been put forward as a key trait of professionalism. Similarly, a knowledge and competency base that is exclusive to the group is also important. These two factors are supported by institutionalised structures for education, indoctrination and credentialing that create protected status for the group. The role autonomy has played in the interactions between professional and client, particularly in health fields, has shifted significantly during this century. Corporate and patient pressures may create conflict with values and autonomy. As described in the introduction, part of the motivation for working as a locum may be to maintain autonomy and avoid the pressures of corporate targets (Shann, Hassell 2006), but the realities of locum working may mean that these are not achievable aims (Magirr, Grimsley et al. 2004), which may create conflicts for locums. Consideration of values, knowledge and autonomy lead into discussion of professional identity – what it means to be a pharmacist – and this is considered next.

1.6 Professional identity

The above sections provided an overview of some of the traits of professions and professionalism and related these to the pharmacy profession and how these developments may impact on pharmacy and on locum workers. To a large extent, this gave an overview from a societal point of view, of the role professions play in society and how professionalism concepts have developed with societal changes. However, this research is concerned with individuals and their interactions with others, involved both as research participants and as active members of a British pharmacy culture. The sections that follow explore concepts of professionalism as they relate to the individual. An individual's sense of identity within a group is explored, moving on to consider development of professional identity. In addition, learning as a social activity is also considered, and how informal groups may develop to support professional issues.

1.6.1 About social identity

This section considers what identity is to an individual and how it is formed and develops. Consideration is then given to professional, or occupational, identity and how that is influenced.

An individual's perception of themselves in relation to others can be described as their social identity. A person's identity is a socially constructed concept, and occupational identity is just one facet of wider social identity theory and of one's identity. Social identity theory puts

forward that people classify themselves according to social categories or groupings, such as gender, religion, occupation and so on (Ashforth, Mael 1989). Multiple identifications are clearly possible. Ashforth and Mael also describe two fundamental functions of social identity – to order the social system (enabling individuals to define other people according to their identity) and also to allow the individual to define themselves.

Ashforth and Mael go on to explore a number of principles of social identification. Firstly, behaviour and affect of the individual (what they do and how they feel) do not need to be congruent with the group – the individual just needs to *perceive* themselves as part of the group. This suggests that the identifying individual may not necessarily put effort in to meet the goals of the group (may lack commitment) and may not feel loyalty to the group. Secondly, identity with a group can differ from internalisation of attitudes and beliefs ('I am' versus 'I believe'). In other words, an individual can feel part of a group without necessarily accepting the values of that group. The only necessity for identification with a group is therefore to think you are part of the group – neither loyalty, commitment or shared values are necessary (Ashforth, Mael 1989).

However, Ashforth and Mael note that socialisation processes within a group can contribute to development of shared values and beliefs. Socialisation processes are 'verbal and non-verbal interactions of individuals' (Ashforth, Mael 1989 page 27), in other words, communication between individuals shares attitudes. Attitudes of individuals to an issue or situation are formed by interactions with others, group and individual attitudes being interdependent and not having any external validity : 'an attitude is correct, valid and proper to the extent that it is anchored in a group of people with similar beliefs, opinions and attitudes' (Festinger 1957 page 272).

Another way of considering societal 'meaning' is the term 'culture'. The idea that there is a culture or way of thinking that members of a group share originally arose in the early twentieth century with the concept of a 'group mind' (Hogg, Abrams 1999 chapter 1), being an idea of a 'collective consciousness' that was not capable of being understood by examining the individual minds involved. These terms were replaced by ideas of socially shared cognitions (Hogg, Tindale 2003), or shared meanings across a group of individuals. Meanings may be derived from sharing experiences or from social comparison (Festinger 1957), where uncertainty is reduced for an individual by comparing their issue with those of others in their social group. Learning is a process of being part of a social community, described as 'developing an identity of a member of a community and becoming knowledgeably skilful are part of the same process, with the former motivating, shaping and giving meaning to the latter' (Resnick, Levine et al. 2004 chapter 4 page 65). Effectively, culture or meaning is socially negotiated. One definition of culture is that there is a 'set of thoughts that are shared among group members', which guide group members actions and provide a common interpretative framework for their experiences' (Resnick, Levine et al. 2004 page 258). In addition to thoughts, culture may encompass social customs. Types of cultural customs found in groups described in Resnick et al (2004 page 263-4) are:

- Routines/habits/traditions – defined by what is a norm to the group
- Accounts/storytelling and explanations

- Jargon – that has a lot of meaning to the group and little to outsiders
- Rituals and ceremonies, for example, initiations and status changes which build solidarity and trust in the group
- Symbols – for example, insignia which have special meaning for group members

Development and reinforcement of social culture is effectively the socialisation process and the socialisation process then facilitates the transmission of cultural knowledge (Resnick, Levine et al. 2004 page 266).

To summarise so far, social identity, or the self in relation to others, may or may not involve shared attitudes and beliefs, but social interactions between individuals can help to meld attitudes, beliefs and cultural knowledge in a way that is meaningful for that group. This has relevance for this research study which will address networking between locum colleagues.

1.6.2 Professional or occupational identity

One facet of social identity can be occupational status – ‘I am a [job title]’. A profession may be called a community (Goode 1957) and Goode described a number of characteristics of a ‘community of profession’, namely a sense of identity amongst its’ members, stability of the group in that few members leave, shared values amongst members, a defined professional role for members, a common language and a socialisation process whereby new members can come to feel part of the group.

When considering what might constitute occupational identity, early work by Becker and Carper (1956b) proposed four main elements: occupational title and ideology, commitment to task, commitment to institutions and the significance of the occupation in wider society. Dating from the 1950s, some of these elements appear to fail to transfer to the modern vision of professionalism, being based on what now seem out-dated views of the place of deference and professions in society. In addition, ideas of commitment are at odds with Ashforth and Mael’s later review that considers commitment and loyalty are not necessary components of identification. However, their paper considering *development* of identification with an occupational group (Becker, Carper 1956a) may still have relevance. Becker and Carper examined how occupational identity was acquired in a number of professional groups and noted a number of mechanisms. Becker and Carper use the phrase ‘acquisition of ideology’ to describe the process of being inculcated into a group culture via interaction with other group members: ‘*Acquisition of ideology operates to produce commitment to occupational title, appears to be closely related to participation in informal groups*’ (Becker, Carper 1956a page 297). This idea of the significance of interaction with others for professional identity is also raised by Beauchamp and Thomas more recently who note ‘the power of stories and discourse’ in identity formation within the teaching profession and also the influence of self reflection (Beauchamp, Thomas 2009 page 176). Within the pharmacy profession, interaction with colleagues has also been seen as key to professional identity (Noble, Coombes et al. 2014). A study by Elvey et al (2013) examined pharmacists’ perception of their pharmacist identity and highlighted a range of ‘identities’, including concepts such as the social carer,

manager, clinical practitioner. These identities may be helpful to define what it means to be a pharmacist, but this research study is more concerned with how identity is generated within an individual, rather than the content of that identity.

It is important to note that professional identity is also dynamic – for any individual it changes over time, being influenced by emotions, factors internal to the individual and also external influences such as job issues and life experiences (Beauchamp, Thomas 2009). Beauchamp and Thomas expand these external factors by considering them as a contextual influence on professional identity – the context of practice, or things that exist or happen at work, provides confrontations which may promote shifts in identity.

This creates a picture of interactions with colleagues being important to develop and maintain identity. One concept that may help illustrate this is the community of practice, which were described by Wenger as ‘groups of people who share a concern for something they do and learn how to do it better as they interact’ (Wenger 2011). This definition can relate to any group, not just those labelled professions as they ‘develop around things that matter to people’ (Wenger 1998). So a community of practice is a group of individuals who come together informally around some issue which is of joint interest, in contrast to formalised activities such as work teams or training events. The existence of the issue of interest is key, according to Wenger, which differentiates a community of practice from an informal network or set of relationships. Participation in communities of practice has been linked to professional identity (Andrew, Ferguson et al. 2009), in that communities of practice are more than simple exchanges of information, but utilise storytelling and personal histories to ‘weave a narrative to contextualise professional and practice development’ (Andrew, Ferguson et al. 2009 page 608). Wenger’s original approach to communities of practice as described here has evolved to be considered more of a managerial tool for knowledge management within organisations (Li, Grimshaw et al. 2009) and limitations of this latter approach have been discussed (Roberts 2006). However, its original basis as a way of describing informal interactions between individuals to share knowledge and identity has relevance to this research study, which examines an online locum forum, an area where people come together to interact on locum issues.

With the growth of internet communications, online communities offer the potential for coming together of individuals with a particular interest to discuss issues of relevance to them. Group learning is a fundamental part of these interactions as Desanctis et al (2003) reference a structure of group learning that defines three types of learning processes: declarative and procedural learning, transactive learning and sense-making.

- Declarative and procedural learning is swapping information (for example, what is the address for x company, or how do I do y).
- Transactive learning relies on individuals becoming invested in the community and sharing information on who has the expertise within the group (for example, x has some good contacts for that project).
- Sense-making is the process of group members creating new mental models based on their interactions. This relies on individuals giving opinions, storytelling and reflecting on reported actions.

Sense-making is a fundamental part of Wenger's community of practice concept (Wenger 1998). A community of practice is in essence a learning network, a group of individuals who come together to develop or share knowledge in some way, and in doing that, shape their group identity.

To summarise this section, identity is a dynamic concept that is a perception of self in relation to others. It is negotiated by reflection and experience with factors both internal and external to the individual playing a role. A professional group may provide an identity, but this does not necessarily imply shared loyalties, commitment or attitudes amongst members. Socialisation processes are a means of acquiring or reinforcing shared attitudes and behaviours and the basis of socialisation is interaction with others in the group. Stories and narratives within those interactions form the basis of moulding identity. Communities of practice are informal groups of individuals who coalesce around an issue of interest, sharing knowledge and stories. This is of relevance to locum community pharmacists as they have been identified as an isolated group of practitioners and anecdotally, they have a poorer reputation for professional commitment than employee pharmacists (Badwal 2008). This research study therefore aims to examine interactions on an online forum to determine the impact of those interactions on professional identity.

The next and final section on professionalism puts forward a different theoretical model. It discusses if shifts in the way that (western) society now operates have created a different model for professions that may have implications for individual behaviours.

1.7 Shifting concepts of profession

The 'trait' theory of profession was considered previously in this review, exploring the idea that there are some defining characteristics that all professions share. This section now considers how the ideas of profession and professionalism may be shifting. Dingwall puts forward that a profession is not a collection of fixed, or even moving, attributes, but is what its members say it is, being a 'concept invoked by members of particular collectivities' (Dingwall 2008 page 11). The outcome of this train of thought is that a profession 'is nothing more or less than what some sociologist says it is' (Dingwall 2008 page 12). Dingwall mentions 'folk concept' and 'tribe' as terms to express how members of a group will identify with each other. He also cites Becker (Becker, Carper 1956b) as highlighting that the word 'profession' has tried to do two jobs: being used in a lay capacity to describe approaches to occupations and by sociologists to describe a defined occupational group.

Thus ideas about what a profession means have adapted from ideas of fixed traits or attributes of a particular group of workers and towards the idea that the nature of what a profession is may be created by the members of an occupational group, as described in section 1.6 above considering development of professional identity.

One way that concepts have been taken forward is by consideration of 'organisational' and 'occupational' professionalism (Evetts 2010), (Faulconbridge, Muzio 2008). Professionalism differs from profession in that the latter may describe a distinct work category whereas the former describes behaviours associated with performing in a professional way, which shifts

and broadens the focus of analysis (Evetts 2005). Organisational professionalism is reflected in the common use of the word 'professional' to describe behaviours (doing a good job) in many different occupational groups, linking to Dingwall's thoughts on profession being invoked by members' beliefs. Evetts (2010) puts forward that this is an organisational tool to manipulate worker behaviour to deliver organisational goals. It manifests itself within organisations as hierarchical authority structures, standard operating procedures, work targets, performance management and accountability.

Occupational professionalism on the other hand reflects more the nineteenth and early twentieth century's ideas of professionalism being a series of traits or attributes as previously described. It is much more derived from the activities of the practitioners themselves, involves trust between the practitioner, the employer and the service user, and is based on an occupational identity that comes about via a professional socialisation process. In essence, it is professionally-led, via institutes and associations that create the structures for professionalism to exist.

However, the modern, multinational business world is a very different environment to nationally-based professional institutes and associations that arose in the nineteenth century, and professionalism as a concept has had to adapt to this new corporate, trans-national world (Evetts 2011). Evetts (2011) describes the modern workplace organisation as the 'fifth player' in the professionalism debate, adding to the traditional picture of professionalism stakeholders being practitioners, users, states and universities. With the growth of large, multi-national corporations that transcend national and cultural boundaries, these powerful organisations will inevitably have an influence on the professionals working within them, and maybe also on the professional and political organisations within the countries associated with the businesses.

As an example, these ideas were explored by Faulconbridge and Muzio (2008) with a case study of globalised law firm professionals and also examining management consultancy professionals. These highlighted the issues that arise when a profession crosses national and cultural boundaries and how localised, nationally-based professional institutes or regulatory organisations can start to lose their meaning. The political and economic power exerted by such large organisations can start to threaten professional autonomy and the political and economic power of national professional bodies. Large organisations can start to dictate and also support professional values. As stated at the beginning of this review, professionalism as a concept exists only in a particular context of time and culture, and the modern business world represents a new culture to which professionalism adapts.

Another element of organisational professionalism is the integration of professionals into the management structures of the organisations (Faulconbridge, Muzio 2008). A more traditional occupational model would see differential career paths for managers and professionals, with resulting conflicts as discussed above. A model of integrating professionals into the management/target setting structures may possibly be paralleled with changes in the UK NHS structures, with service commissioning devolved further to healthcare professionals (Evetts 2011). Taking a more historical view, these same ideas of managerial and organisational

control of professionals and professional services were discussed by Wilensky (1964), indicating that the concept of profession has a long and complex background.

The impact of multinational organisations on professionalism concepts has relevance to this research study as the corporate environment in which UK community pharmacy operates has changed. Community pharmacy in the UK has not been immune to these societal changes, including the increased influence of large corporations on pharmacy provision which Bush et al demonstrated had an impact on pharmacy service provision, but which he also suggested provided different opportunities for service development (Bush, Langley et al. 2009). As mentioned above, UK community pharmacy has seen a trend of reduced numbers of 'independent' pharmacies and growth in 'multiple' pharmacies in recent years, which has implications for the meaning of profession and professional behaviour.

The previous sections have described how professions are situated in a particular context, and have adapted as that context has shifted. Traits associated with professions have been explored, including knowledge base, trust, the role of institutions and autonomy. A shift to organisational and client-centred professionalism in the context of societal changes was described. This has reflected a change in discussion from 'the professions' to 'professionalism' – which more considers the behaviours and attributes of individuals than societal structures. How individuals themselves develop and maintain a sense of professional identity was considered, including social interaction and grouping together around an issue of joint interest.

This creates a complex picture of what being a professional might mean. This has to be considered alongside the picture of the locum community pharmacist described earlier, as a potentially isolated practitioner, who may be struggling to maintain pharmacy cultural norms due to lack of interaction and poor access to resources. This review has attempted to integrate this individual picture into the broad and fluid context of professionalism.

The literature presented here has emphasised the importance of social interaction to development of professional identity, and the second phase of this study examines an online forum where interaction occurs. To support that work, the use of social media and online interaction by pharmacists is now considered.

1.8 Social media and pharmacy

The section above demonstrated the key importance of social interaction to developing professional identity. Use of the internet to communicate via social media provides new opportunities for interaction, and literature considering the use pharmacists make of social media is now discussed. Much literature in this area relates to use of social media in pharmacy undergraduate education – only literature that considers pharmacist use of social media is reviewed here. Difficulties in reviewing this literature include the fact that this is a rapidly-moving field and information is quickly out of date. Given the fast-paced nature of terminology of the online world, a glossary has been adapted from a paper on social media use in pharmacy, provided on page 8.

In terms of the pharmacy profession, social media may be defined as blogs, web forums, Twitter, Facebook and virtual networks (Royal Pharmaceutical Society, 2011b), which is probably an adequate definition for the purposes of this thesis. A US study of pharmacist use of social media in 2010 highlighted YouTube, Wikipedia, Facebook and blog use – used primarily for personal social purposes (Alkhateeb, Clauson et al. 2011). Another survey of US community pharmacists also revealed Facebook use primarily for personal purposes (Shcherbakova, Shepherd 2014). However, Alkhateeb et al suggested that ‘it is probable that pharmacists will also increasingly utilize [social media] for professional and educational purposes’ (Alkhateeb, Clauson et al. 2011 page 141).

In a news article that is effectively an advert for an American pharmacy social media site, its author describes sharing ‘war stories’ with colleagues and valuing the opportunity to ‘swap ideas and stories’ (Cohen 2009), selling the benefits of the site as ‘spirited and sometimes confrontational, combination of humorous and serious discussions about our profession’. Sharing professional tales and stories is seen as a key selling point, but this is a promotional message for the site.

Grindrod et al conducted an international scoping review of social media use within the pharmacy profession in 2014 which highlighted that the majority of the growth in online interaction was within pharmacist-specific social networks, that is, peer to peer closed groups such as provided by listservs, rather than in forums where pharmacist-patient interactions could occur (Grindrod, Forgione et al. 2014). The review noted that online methods of interaction helped pharmacists to keep up to date, could reduce professional isolation and helped shared learning. The review noted that future research should consider the contribution of online interaction to professional satisfaction. This starts to create a picture of pharmacist participation in more ‘open’ social media such as Facebook and Twitter in a personal, non-pharmacy capacity, and participation in more closed networks in a professional capacity.

An older study of an online mailing list for UK pharmacists identified benefits of participation as increased professional confidence, gaining knowledge and overcoming professional isolation (Whitaker, Cox et al. 2003). Participants also valued seeing the perspectives of others and described influences on career decisions, professional development and their attitudes and behaviours. Members of the forum were surveyed for their views on participation, which was found to be valued as a rapid information source, as emotional support and a way of knowing the views of other pharmacists. Locum pharmacists were identified within the paper as a separate group of participants, but it is not clear whether these were community locums or from another branch of the profession, or a mix. The locums on this forum constituted 15% of list members and subject areas identified as posted by locums included clinical problems, non pharmacy chat, legal issues and pharmacy politics. Again, this supports pharmacist professional interaction on the more closed, listserv format that was available at that time and that pharmacists find value in online interaction with colleagues.

Benefits of interacting on online forums may not be restricted to the members of the group who post. Lurkers, or passive members who read but do not post, may be a significant group of people who benefit from the interactions on the forum (Whitaker, Cox et al. 2003). Lurkers

may, by regularly reading posts, pick up 'the genre of the community' (Davies 2000), which may be seen as part of the socialisation process for professional identity. Lurking may also be seen as an 'apprenticeship' for group membership, absorbing group culture before finding the courage to post (Whitaker, Cox et al. 2003).

The professional dangers of use of internet social media have been highlighted, in terms of risks to privacy and personal reputation (Rutter, Duncan 2011), (Mattingly, Cain et al. 2010b), (Cain, Romanelli 2009). The Royal Pharmaceutical Society has issued guidance on social media use for pharmacists, noting that the individual's professional image may be at risk from inappropriate posts, as well as the image of the profession (Royal Pharmaceutical Society, 2011b). The potential benefits of social media use for learning, professional development and for business development has been recognised within the pharmacy profession (Mattingly, Cain et al. 2010a). It may also be the case that social media use has changed the nature of the socialisation process whereby professional mores are inculcated amongst the group members (Mattingly, Cain et al. 2010b). Traditionally, the older, more experienced members of the profession mentored younger members and passed on professional expectations. Mattingly et al suggest that new social norms and limits of behavioural acceptability may be developing online, which changes the norms of professional acceptability also. This is supported by Cain and Romanelli's definition of e-professionalism as 'the attitudes and behaviours reflecting traditional professionalism paradigms that are manifested through digital media' and that 'culture will more readily accept online personas as separate from the real life individual' (Cain, Romanelli 2009). So whilst we at present have issues with online behaviour potentially compromising professionalism, this may or may not be the case in the future as real life versus online or Secondlife personas become differentiated. In effect, one's online persona may become clearly distinct and separate from real life activities.

In summary, this section has explored use of social media by pharmacists, drawing on international experiences and a variety of media types. Open forums such as Facebook seem to be used primarily for personal social purposes, more closed listserv forums are more likely at present to be used for professional interactions. Posting online has some risks attached, in terms of professional reputation, but interacting online is a growing phenomenon. Pharmacists perceive value from their online interactions and it appears to promote both professional working practices (through sharing information) and professional identity (through sharing stories).

This review is limited in that it attempts to be restricted to online interactions of pharmacists with each other. This was purposeful as the aim was to examine networking between colleagues and how that contributed to professional identity. Literature that was not within the scope of this review related to use of social media within pharmacy undergraduate education and also in online interactions with patients. Both these areas are significant ideas which relate to pharmacy online professionalism but are outside the scope of this review. To conclude, the internet creates a fast-moving world where societal norms may be shifting, which creates new opportunities: 'the interactions between online media and the pharmacy profession could be harnessed to benefit individuals and organisations and is worthy of examination' (Mattingly, Cain et al. 2010b page 425).

1.9 Conclusion

The thesis introduction on page 10 set the scene for community pharmacy and locum community pharmacists in Great Britain. The literature review contained in this chapter has discussed professionalism in general terms and in relation to the pharmacy profession in Great Britain. An occupational model of profession derived from nineteenth century societal norms may lend itself to a definition based on characteristics or traits. A twenty first century model utilising multinational organisations as powerful stakeholders in the professionalism concept is less clearly defined and applying either of these models to an individual's behaviour becomes extremely difficult. Concepts of professionalism adapt and change, as a consequence of a changing world. This has led to fundamental changes in the regulatory and support structures for professional groups. Individual professionals have lived and worked through these changes, which may have impacted on their practice to varying extents. Professionalism may mean very different things to each individual, depending upon their working environment, the extent to which they interact with other colleagues, how much they engage with current professional developments and how much they engage with standards of professionalism from their professional bodies. A locum pharmacist practising today may have been inculcated into professional mores thirty years ago by practitioners who qualified thirty years before that. They will be practising in a modern regulatory and support environment that is adapting to new professional approaches, whilst attempting to do the same themselves as self-employed workers. This implies professional tensions for locums who are also practising in an isolating environment without effective performance management structures.

Modern community pharmacy employment, usually as part of a global company, bound by standard operating procedures, management targets, appraisal processes and the like, looks very much like an organisational professionalism model. It may be that different models are operating simultaneously, varying with the perspective of the individual, the organisation and wider society.

This creates a picture of a locum potentially struggling to access learning resources, feeling isolated from professional colleagues, resisting or accepting pressure to undertake services and working in an unfamiliar environment where professional values may not match their own.

The aim of this study is to investigate professional engagement among locum community pharmacists in terms of their networking with others and how aspects of their activities construct their professional identity as a pharmacist. These elements give a practical, focused approach to discussing professionalism with locums. By considering these elements with locums, the study aims to explore elements of professional engagement from the locums' point of view. The research may also uncover different elements that locums consider important.

The introduction and literature review have provided a frame through which to view the professional situation of locums. It has been shown that locums may have difficulty accessing

learning opportunities, lack appraisal, face professional tensions in work environments and feel isolated. Also shared competencies, values and knowledge base are key concepts for profession and professionalism. Putting these two elements together identifies the purpose of this research: to investigate professional engagement among locum community pharmacists in terms of their:

- Networking with other pharmacists and professional colleagues
- Professional identity as a pharmacist

To clarify this investigation, the following research questions were proposed:

- How do locum community pharmacists network with pharmacist colleagues?

As locums are an isolated group, the research aims to illustrate how locums approach meeting pharmacist colleagues.

- What is the value of networking to locum community pharmacists?

The locum situation may present particular working difficulties that networking could address.

- Do the networking interactions on the LocumVoice forum contribute to development of professional pharmacist identity?

The LocumVoice forum was a site where locums are able to interact with each other. The research will examine the types of interactions undertaken on the site and determine their value in terms of development of professional identity as a pharmacist.

1.10 Thesis structure

The study will be delivered by two phases of research – a series of focus groups with locum pharmacists to explore their perceptions and experiences of these objectives, and an observational study of an online forum for locum pharmacists to determine the types of interactions and content that occur on the site. The focus group study aims to respond to the first two research questions, relating to networking with colleagues and the online study will examine development of professional identity through online interactions.

The structure of the remainder of the thesis is as follows:

- Chapter 2: Study design and methodology for the focus group phase
- Chapter 3: Results and discussion for the focus group phase
- Chapter 4: Study design and methodology for the online analysis phase
- Chapter 5: Results and discussion for the online analysis phase
- Chapter 6: Conclusions

2 Study design and methodology

2.1 Introduction

This chapter presents the rationale for the first phase of the study design: a series of focus groups with locum pharmacists. Firstly, the overall research position of the study is discussed (section 2.2), followed by detail of the method used.

2.2 Methodological approach to the focus group study

This study is concerned with professional engagement of locum community pharmacists. As such, it was about people and their thoughts and behaviours, and constituted a piece of social research (Cassell, Symon 2004 page 4). Some of the considerations that have informed the research process are now explored.

Research may be deductive in nature – an existing theory driving the research process – or inductive, where the research develops a theory (Bryman 2012). When considering these concepts to position this study, this can create something of a false dichotomy, as it is likely that very little is ever purely inductive. Theory always exists somewhere in some form. Bryman (2012 page 21) discusses ‘grand theory’ and ‘middle theory’ to accommodate this, grand theories being more abstract and general concepts and middle theories being more based in the practical, observed world. This study is essentially inductive in nature – the conclusions are derived from the research process in the absence of a grand theory and there is no underlying hypothesis to be tested. However, there is undoubtedly a middle theory base to the research aims and objectives, as explored in the literature discussion in chapter 1. Whilst literature is not theory, theory may be ‘latent or implicit in the literature’ (Bryman 2012 page 22). In consequence, whilst an inductive approach is put forward for this research, latent theory in terms of the literature considered has undoubtedly influenced the process. As an illustration, an inductive approach was also taken to the literature review presented in chapter 1, where consideration of the research objectives influenced the focus of the review – and vice versa.

Having established a broadly inductive approach to this study (accepting the blurred nature of that choice), epistemological considerations are now discussed.

Epistemology is the theory of knowledge, what knowledge is and how it is acquired. This can be considered in terms of a positivist stance – that research should test some theory and help develop some basic laws that will apply in other situations – or as a constructivist model, resting on the premise that people will create their own version of reality depending upon their perspective, and the research process aims to uncover that version (Rooney 2005). This research study follows this constructivist model, putting forward that there is no objective truth about professional engagement of locum community pharmacists to be discovered, or rather that any truth cannot be accessed in an objective way. Professional issues concerning

locum community pharmacists are social constructs – the issues have no objective existence outside the interaction of people, and are created and changed by those interactions. This is summarised well by Bryman who notes that constructivism ‘invites the researcher to consider the ways in which social reality is an ongoing accomplishment of social actors rather than something external to them’ (Bryman 2012 page 34). Hence, the aim is that in this study, the combination of the researcher and research process will create a robust and meaningful interpretation of the situations examined.

The above section has established a largely inductive, constructivist stance for this study. Given this stance, the research methods proposed in this study will now be considered. The role of the researcher in the research process will also be discussed.

Fitting with the inductive approach, the study is essentially exploratory in nature and the research data should yield ideas and theories about the research topic. A number of qualitative approaches may be relevant to this objective, including observation, interviews and focus groups. Observation was not considered an appropriate method for this study, as the research is concerned with locum’s views on their working environment, which may or may not be observable (Cassell, Symon 2004). In addition, observational methods may prove logistically difficult with a transient locum workforce and also with obtaining consent from employing organisations.

Individual interviews would have enabled locums to express their views and for the researcher to influence the data collection to meet the research objectives. Interviews may be structured, semi-structured or depth (Britten 1995). Structured interviews require a pre-existing awareness of the issues to be considered and provide a fixed framework for the questions and responses. Semi-structured interviews use a looser framework of topic areas for discussion but allow flexibility for the interview to follow the interests of the participant. Depth interviews have less structure, but allow consideration of one or two issues in detail (Britten 1995). Individual semi-structured interviews could have provided an option for the research methodology for this study, being flexible enough to give an exploratory approach to the data collection, but directive enough to achieve the research objectives.

Focus groups provide a further approach, enabling, as with individual interviews, exploration of issues by participants, but with the added advantage of the group interaction contributing to the data generation process. Debate and interaction between participants can develop and contribute to the richness of the data obtained (Smith 1998). Interviews may be said to provide greater depth of data, but focus groups enable a broader approach to data collection due to participant interaction (Morgan 1995). The interaction possible in a focus group between the participants and with the researcher aids construction of ideas and themes that an individual interview may not achieve to the same extent. Participant interaction can also have negative effects – the presence of others may induce censorship or conformity in the process, which can limit the breadth of data (Carey, Smith 1994). Locum community pharmacists also do not constitute an established ‘group’ so there may be practical issues in bringing people together. More positively, the interactions between participants can stimulate the development of ideas, help compare and contrast ideas and a sense of community can help participants express ideas more willingly (Huston, Hobson 2008). In addition, focus groups

can help explore the reasons for participants' views, as challenge and discussion can reveal assumptions and attitudes (Huston, Hobson 2008). The role of the researcher as facilitator of the group can also influence the data richness by guiding the interactions (Morgan 1995).

Focus groups were chosen as the research method for this study. It was felt that communication within groups of locum community pharmacists would provide a stimulating and rich data source, an advantage over individual interviews. The creation of a semi-structured topic guide would provide a structure to achieve the research aims but allow sufficient flexibility to accommodate the views of participants. The impact of the researcher on the focus group process was also a consideration, which is discussed further in the next section.

The above section describes the methodological approach for this phase of the research study and the research strategy. The role of the researcher as facilitator of the focus group is mentioned briefly above. To consider this idea further, the importance of the influence and impact of the researcher on the research process is now considered in more detail.

2.3 The researcher as a research instrument

This section continues with consideration of the research methodology in terms of the impact of the researcher on the research. A constructivist approach indicates that the researcher and research participants will create their own version of reality according to their own perspective. It is pertinent therefore to examine the perspective of the researcher, as this will impact on the particular version of reality being created. This discussion brings in issues of research quality.

The researcher in this study was a locum community pharmacist (amongst other roles) and as such may be considered part of the population under study. An 'insider' is someone who has a direct connection with the research issues and a researcher can be an insider in a number of ways (Rooney 2005). These ways include being a worker in the work setting being researched, becoming an accepted part of the community being researched or where the researcher is affiliated in some way (politically, emotionally) with the research topic. On this basis, the researcher can be considered an 'insider' by working in the environment, being emotionally affiliated and being an accepted part of the community.

This has consequences for the research process and relates to issues of validity. In a positivist approach to research, where the aim is to determine some objective truth about reality, validity reflects the degree to which the research reflects that truth. With a constructivist research approach, there is acknowledgement that reality is constructed by the individual, and with each individual's perspective comes a new reality. As an insider, the researcher brings a particular perspective to the work different from an 'outsider'. The concept of validity as one absolute truth about a situation then ceases to be meaningful. Rooney (2005) summarises a variety of terms to better reflect a robust research approach in this situation, for example, authenticity, credibility, understanding, dependability. The purpose of this section of the thesis is therefore not to remove any influence of the researcher on the process, but to acknowledge its' existence and accommodate it within the research process.

To appreciate the impact of the researcher on the research, a more detailed consideration of the researcher is required. The term often used for this process is reflexivity. Dowling (2006) notes two approaches to reflexivity – personal and epistemological – recognising the need for reflection by the individual and also for consideration of how the research approach may have put boundaries on the results that have been ‘found’. For example, the perspective of the researcher may have provided a focus or direction for the research. The methodological approach and assumptions are described earlier in this chapter.

The person undertaking this piece of work is a pharmacist, a woman, a wife, a mother and many other things. She has her own set of experiences, prejudices, knowledge, attitudes, biases and values. These are influencing this research at every step. This section attempts to describe how these influences are acknowledged, managed and utilised by the research. To explore this, a first-person reflexive statement is included by the research in appendix 7.1.

This statement explores the researcher as a key research instrument in this study. The researcher describes her own presuppositions and values in relation to pharmacy and locum work. The impact of being an ‘insider’ on the process is considered, both at a broad and specific level. The broad impact relates to the researcher’s decision to study this topic at all. Watt (1997) explored issues arising from being an ‘insider’ researcher and suggested exploration of motives for conducting the research, ‘researchers need to be aware of their personal reasons for carrying out a study – their subjective motives’ (Watt 1997 page 85). The reflexive statement reflects awareness that the researcher’s own drive to initiate this research gives a particular perspective.

The more specific influences of the researcher relate to her own emotional needs in conducting the research, a desire to uncover the ‘new’, challenged by conscious efforts to recognise these needs. Throughout the research, the researcher attempted to be aware of her influence on the process. This was aided by writing a reflection immediately after each focus group had taken place, that included thoughts about the data and also her place in the interactions. The researcher also discussed the progress of the groups with supervisor colleagues, including her own performance. On transcription of the data, the researcher looked in the text for evidence of collusion and any assumed joint understanding with participants on her part – where her insider role may have led to unjustified data assumptions – which enabled critical analysis of these situations.

During the data analysis, the researcher attempted systematically to determine cases which went contrary to emerging themes – deviant cases. The researcher’s experience also had a positive contribution to the focus group process. In some of the later focus groups, the researcher was able to ‘think on the hoof’, making mental links between the ongoing conversation and previous themes and making enquiries that pushed the issue further. The researcher’s detailed insider experiences of community pharmacy enabled group moderation to operate at a complex level with participants.

This section of the thesis has recognised that the researcher has played a role in the research process and described the attempts to be as transparent as possible about this influence. The

detail of the operation of the focus groups study is provided in the following sections, covering ethical approval, sampling, the topic guide, transcription of the data and how the analysis was undertaken.

2.4 Ethical approval

Ethical approval was obtained from the University of Central Lancashire Research Ethics Committee reference STEM062, which is provided in appendix 7.2. Written, informed consent was obtained from each research participant, with an information sheet being distributed via email beforehand and a consent form collected at the event. Consideration was given in the ethical application to actions that would be taken if illegal activities were reported. Discussions with the supervisory team explored the potential tensions between the researcher's role as a researcher and also as a pharmacist, which may have arisen if patient harm was identified during the focus groups. As a pharmacist, the researcher would have needed to ensure that a patient harm situation was resolved, which is not the researcher remit. In this case, the most likely illegal activity to be revealed would be a dispensing error and a protocol was devised to assure the protection and wellbeing of the researcher, participants and any patients involved. The protocol is provided in appendix 7.3 .

Participants gave consent to audio recording of the groups and were also asked for consent at the start of each session. In terms of confidentiality, participants were assured that identifiers would be removed from the transcript of the session, including geographical identifiers such as motorways, towns and company names.

Consideration was also given to the physical safety and wellbeing of the participants and the researcher. Venues were chosen to be accessible and neutral (community halls or education rooms), refreshments were provided and the researcher was accompanied by an assistant at all events.

2.5 Sample and recruitment

The unit of analysis for this research is the locum community pharmacist. For the purposes of the research, this is defined as a UK registered pharmacist who has undertaken self-employed locum community pharmacy work since 2005. This date was selected as the introduction of the new community pharmacy contractual framework, which has imposed different working conditions and services upon community pharmacists. Pharmacists who have not worked as community locums since 2005 were deemed to be sufficiently distanced from current working practices to be excluded from this research. The population was therefore defined as pharmacists who defined themselves as community pharmacy locums, and have worked as such at some point since 2005.

The concept of sampling implies a total population from which a sample may be taken. Locum community pharmacists are undeniably a group, but are a constantly changing population as pharmacists enter and leave the locum workforce. It is also not possible to identify everyone who has ever worked as a locum community pharmacist, short of asking each pharmacist

individually. Prior to the establishment of the General Pharmaceutical Council in 2010, the registration body at the time, the Royal Pharmaceutical Society, enquired about the sectors of pharmacy that each registrant worked in at the time of annual registration. This provided a database of pharmacists who stated they had worked as a community locum, which was accessible to researchers. The GPhC no longer collects these data, so this sampling source is no longer available. The approach was therefore taken to advertise in the locality of the focus groups for community pharmacists defining themselves as locum workers.

The localities for recruitment were selected pragmatically as being within one and half hours' drive from the researcher's home, meaning that evening focus groups could be conducted without requiring the research team to stay overnight in the area. Areas near to major areas of population, near motorway links and not within major city centres were selected to facilitate transport for potential participants.

A purposive approach to sampling was taken. This involves identifying characteristics of research participants that are likely to provide variety in certain characteristics that will achieve the research goals (Bryman 2012 page 419). Three sampling criteria were considered for recruitment: to recruit locums both under and over 40 years old, a mix of male and female and to recruit locums who worked in one pharmacy regularly and who worked in a range of different pharmacies. These broad criteria were selected with an assumption that younger locums, being at a different life stage, may have different issues and concerns to older locums and that working in one pharmacy regularly may give a different perspective to working in a new pharmacy every day, supported by evidence that locums have various motivations for undertaking locum work that includes life stages and significant life events (Shann, Hassell 2006). Forty years old was chosen as being roughly half way through an average working career. Gender was considered relevant as the locum role may appeal in different ways to men and women (Platts, Tann 1999), (Shann, Hassell 2006).

Locums were recruited via a variety of routes. Key contacts were identified to locate likely candidates to approach. Key contacts included chairs of local pharmaceutical committees, leads for local pharmacy forums, local tutors from the Centre for Pharmacy Postgraduate Education (CPPE), locum agency facilitators, pharmacy company locum co-ordinators and primary care organisation medicines management teams who may hold lists of local locums. In addition, an advertisement was posted in online community pharmacy networks to invite participation. The online networks used were local pharmacy forums (LPFs), CPPE Facebook and Twitter lists, pharmacy company mailing lists and local pharmaceutical committee (LPC) mailing lists in the relevant geographical areas for the focus groups. Possible participants were asked to contact the researcher by email or phone, and provided with further information and a consent form (provided in appendix 7.4). Following agreement to participate, they were provided with the venue details. Participants received a payment of £30 each for participation in the focus group, which was provided on the night. This sum was decided upon as being approximately one and half hour's locum fee, this being the planned duration of the focus group.

Participants were provided with the venue details by email or telephone. Venues were chosen to be neutral, non-health venues such as school, community or church halls and refreshments

were provided. Participants signed a consent form if this had not already been returned by post. The researcher was accompanied by a second person for security and practical assistance, and the assistant, whilst not involved in the interactions, also assisted with note-taking during the group sessions.

The focus groups were audio-recorded with consent of the participants and notes were taken during the session by the assistant and by the researcher and assistant after the session. These notes provided information on significant dynamics noted in the group and also aided in identifying speakers in the recording. The groups lasted for an hour and a half and kept to time.

The first focus group acted as a pilot for the subsequent groups (the data was used in the analysis). The assistant for this session was experienced in focus group methodology (Dr Nicola Gray) and was able to provide support and feedback to the researcher on the process of undertaking the groups. Some practical and timing issues were amended in subsequent groups as a result of the pilot, for example, the researcher being slightly more directive at the start of the session and also making sure that the recording process started prior to the group introductions.

2.6 Topic guide

A topic guide was developed to provide some structure to the focus group discussion and is provided in appendix 7.5. The topic guide covered areas relating to the research objectives, namely participation in continuing professional development, engagement in pharmacy services, networking with colleagues and involvement with pharmacy organisations. These areas were felt to be able to deliver data to accomplish the research objectives whilst still being practical and ‘real world’ enough for participants to be able to engage readily with the process. The researcher aimed to cover these areas within the first hour of the session, leaving time for an ‘anything else’ discussion to conclude.

The topic guide started with introductions and invited participants to create some ground rules around the session, with some prompts and ideas for ground rules to be suggested. The warm-up process consisted of participants introducing themselves and describing their locum activity briefly in whatever way they wished. The researcher then introduced the objectives for the research, starting with CPD as a topic that participants would be familiar with and comfortable discussing. The prompts from the topic guide for participation in service developments are provided below as an example:

Participation in service developments
<i>Pharmacy has changed a lot since the new contract. We’ve advanced and enhanced services. Taking the NMS as an example, do you have any thoughts on locum participation in services?</i>
Prompts:
<i>Do locums engage? Why? Why not?</i>
<i>Does it matter? Why? Why not?</i>
<i>Are there any barriers? What helps?</i>

The degree of direction of the researcher over the focus group, or how much she guided the conversation, was considered as part of the research process during the post-focus group reflection. In simple terms, the researcher was relatively non-directive, in that she introduced the main topics and allowed conversation to flow without intervention unless the discussion stalled. Bryman indicates there is no 'best way' of structuring a group discussion, and that the style should depend upon factors such as the nature of the research question, the knowledge and interest of participants and the researcher and the sensitivity of the topic (Bryman 2012 page 512). Given the significant subject knowledge of both the participants and the researcher, and the lack of sensitivity of the topic, it was felt that a non-directive questioning approach was suitable.

The topic guide was also subject to change as the research progressed. After each focus group, the researcher completed a reflective document, based on questions suggested by Kidd and Parshall (2000 page 297). An example is provided in appendix 7.6, which describes an example of the researcher considering issues of power and assertiveness in future focus groups. Similarly, as the analysis aimed to progress alongside the data collection, the researcher was able to identify and focus on new and innovative statements from participants that may not have been covered by the topic guide, but were still of relevance to the research objectives. Again, this was recorded in the reflective statements after each focus group.

2.7 Transcription

The sessions were audio-recorded and immediately backed up via the University network. The sessions were then transcribed before analysis, and the decisions involved in the transcription are now discussed. Transcription could be viewed as a mechanical process undertaken as a prelude to analysis, but as Oliver et al (2006) note, reflection on the transcription process should be an important part of the overall analysis process. This section describes that reflection on this data transformation process.

Transcription of voice data may be considered as a continuum, with poles of naturalism and denaturalism (Oliver, Serovich et al. 2006). Naturalism aims to describe the voice data in as much detail as possible, with all non-verbal elements and involuntary vocal noises included. Denaturalism will remove elements such as pauses, stutters, laughs and dialect.

Oliver et al continue to describe how the point on this continuum that is chosen should be dictated by the research objectives. In simple terms, naturalism may be the preferred approach where it is important to identify *how* the ideas within speech are constructed. This is often the approach taken in conversation analysis methods. A denaturalism approach will be preferred where the meanings and perceptions of the data are of greater priority than how they have been generated.

In a similar vein, Kvale (1996 page 166) puts forward the question, "What is a useful transcription for my research purposes?", highlighting again that the transcription method should reflect the needs of the research objectives. Kvale also highlights the importance of

researchers undertaking at least some of the transcription themselves (P169), describing how this facilitates asking clear questions and receiving clear answers during an interview, and also understanding the many decisions involved in transcribing speech to text, and how this may affect the subsequent analysis.

The objectives for this research are to identify meanings and perceptions from focus groups with locum pharmacists on their experiences of being a locum. Bearing this in mind, an approach to transcription was taken that is nearer the 'denaturalism' end of the continuum described by Oliver et al. However, the transcription does take into account some of the interactions between participants that described agreement or dissent. Thus the transcription does include some vocalisations and non-verbal signals (for example, laugh, mmm, oh, pause) that contribute to exploring levels of agreement and understanding between participants. These elements lend a 'tone' to the transcript which can aid understanding of meaning, for example, "I feel isolated, erm, you know..." (focus group 3 line 30).

Focus group recordings were initially backed up to a separate computer file to secure the data and then listened to by the researcher. The recordings were imported into Nvivo 10® software, and transcribed directly into Nvivo by the researcher. There are advantages to the researcher undertaking transcription of the data, in that it enables the researcher to begin to become close to and familiar with the data, and to start to develop ideas about themes (Bryman 2012 page 486). Practically, it also allows the researcher to take full control of the transcription, matching the transcription style to the nature of the research.

A list of conventions used was established during transcription of the first two focus groups. For example, emphasis of words or parts of words was indicated by use of capitals and colloquialisms such as 'wanna' and 'coulda' were written in full as 'want to' and 'could have'. The list of conventions is shown in appendix 7.7. Due to time constraints, transcription of further groups was outsourced to a transcription company, who were provided with the first two samples, and the conventions list. This enabled the company to produce a very close style match to the first two transcriptions undertaken by the researcher.

All transcripts were proof read against the recordings by the researcher. At this point, the researcher also anonymised the transcripts. This comprised giving each file a code name, giving participants a code name, removing any references to company names and removing any geographical information from the transcripts.

As mentioned, the transcripts were either transcribed directly into Nvivo (the first two) or imported into Nvivo. It was decided to allocate each person's section of speech as a numbered 'row' in Nvivo. As the data was being coded, having a speech section available for each coded statement provided a lot of context to maintain understanding of the idea being expressed. Another option would have been to have a row for each line break, which would have resulted in much shorter sections which would probably have lost context.

Having each person's section of speech as a row also facilitated 'range coding' in Nvivo, where several rows could be coded against one node or idea. This clearly provided information on the interaction between several people – each row clearly being part of the to and fro of the conversation.

2.8 Analysis

This section describes the approach to the analysis and gives details of the analysis process itself. The method used this project was a thematic analysis, which will now be described.

This approach was chosen for this study as the research is essentially exploratory – the study aims to uncover aspects of locum working which are currently unknown. As explained in section 2.2, an inductive approach was taken to this research, but influenced by literature and the experience of the researcher. The consequence of this is that the research results may differ from the initial stated research objectives, as the data analysis will dictate the findings, rather than any priori objectives or framework. Indeed, it is probably desirable that the results differ from the research questions that informed the topic guide, otherwise there is a circularity to the process. Hence there is a balance between a purely inductive approach, and the bounds set by the literature and researcher experience that shaped the initial research questions.

This balance is evident in what themes are reported in the results chapter 3, where the entire thematic data set is not reported (as would be the case in a purely inductive approach) – only themes relevant to the research objectives are presented. Braun and Clarke (2006) highlight the importance of making clear what is presented and what is omitted and why this is so.

The search for themes may be found within many qualitative approaches and there are arguments that thematic analysis is not a method in its own right, but a tool used in other methods (Bryman 2012 page 578), and counter-arguments that it should in fact be considered a research method (Braun, Clarke 2006). Braun and Clarke note the flexibility of the method, its adaptability to different research approaches and the necessity to describe the epistemological background within which it is being used.

Thematic analysis was used as the research method in this study due to its flexibility and adaptability to different research approaches, and also its accessibility in that it is a recognised approach to analysis of focus group data (Braun, Clarke 2006). It was also possible to use thematic analysis to provide a descriptive (or semantic) level of data analysis (in terms of what is being talked about) and also an interpretive approach to the data, attempting to consider underlying ideas and assumptions that are creating the semantic content (in other words, why they are talking about the content). Both descriptive content and interpretation are provided in the results section.

The terms 'theme' and 'code' are used within this thesis, and the meaning of these terms is now examined. A theme may be defined as 'a category identified by the analyst through her data' (Bryman 2012 page 580) but it also has to relate to the research objectives and to contribute to providing a theoretical understanding of the data under study. Themes are derived from data being coded – a descriptive process of the researcher considering the content of each section of data and allocating a descriptive name. In crude terms, codes may be said to provide the description and themes the interpretation.

In summary, this section has described that thematic analysis was used as the research method to analyse the data and, given the flexibility of this method, the detail of the assumptions, decisions and processes undertaken are now described in detail in the next section.

2.8.1 Analysis process

After transcription of the first interview into Nvivo software, an initial broad descriptive coding was performed. This involved consideration of what a phrase or comment was about, and creation of a code within the software labelled with a simple description of that topic.

This coding process was continued for each of the focus groups, new codes being added where they appeared. A code book system was developed within Nvivo, as part of the report facility of the software. A report was established that highlighted the name of the code, the number of references to that code, a description of the code and how that code differed from and linked to other codes. A field could also be added (and removed) that provided the text sections related to that code – this was added in where clarity on the code definition was required. The degree of context maintained by the text sections here supported the decision described above to have each person’s section of speech defined as a row in Nvivo.

After the second focus group and each subsequent one, a review of the existing codes was undertaken by the researcher. This aimed to consider the meaning of each code, to review if there were any duplicates that could be merged and to clarify the definitions. This was facilitated by having an overview of the codes and descriptions in the code book report.

After five focus groups were undertaken, a decision was taken by the researcher and supervision team to halt the data collection, and complete the data analysis. This would then clarify if further data collection was required.

Following the initial rough coding of the five focus group data, the code book was reviewed again for changes, links and major themes. The researcher then selected a theme, created a source document containing all the text references relating to that theme and imported this into Nvivo. A second round of coding on the themes then took place. This phase of coding aimed to derive meaning from the text, in addition to the purely descriptive. Some useful prompt questions for this interpretative stage of the analysis were derived from Pope and Mays (2006 page 76) and Braun and Clarke (2006), which are listed below:

- what lies behind this pattern?
- what does this theme mean?
- why does this relationship occur?
- what are the assumptions underpinning this theme?
- what are the implications of this theme?
- what conditions are likely to have given rise to this theme?
- what do these themes reveal about this topic?

This second, more detailed, coding phase was conducted by reviewing each of the transcripts again, identifying any reference to the identified theme (for example, CPD). This phase aimed to identify the meaning and interpretation behind the text, and resulted in the development of a theme hierarchy (for example, a series of further nodes under the node heading 'CPD'). An example of the coding process is shown in appendix **Error! Reference source not found.** At this stage, links between themes were also identified and highlighted within Nvivo. Thus the themes developed from a broad range of separate themes, to a narrower but deeper network of linked themes.

The inductive approach to the research enabled a revision of the research objectives in the light of the findings. Initially, the research objectives reflected in the topic guide (appendix 7.5) considered locum involvement with pharmacy organisations. Reflection on the results, using an inductive, data-led approach, meant this was better expressed as professional identity, and the research objectives were amended accordingly.

2.9 Summary

This chapter has described the methodology for this phase of the study and given practical details of the method and analysis process. The inductive, constructivist research approach has been described and the influences of the researcher considered. Issues of research quality and the strengths and weaknesses of the process are considered in the conclusion to the thesis. Next, the results of the focus group investigation are provided in the following chapter.

3 Analysis of the focus groups

3.1 Introduction

This chapter presents and discusses the analysis of the data from focus groups conducted with locum community pharmacists in England in 2012. The analysis yielded a number of themes, and these are presented here supported by quotes from the data.

This chapter is structured around the major themes developed from the data. The aim of this research was to explore professional engagement with locum community pharmacists, in terms of their networking with colleagues and their professional identity. Whilst the topic guide, shown in appendix 7.5, has clearly guided the outcome of the discussion with locums around these objectives, an inductive approach was taken to the analysis in that the data were allowed to lead the development of themes and to influence the research objectives. The results presented here are the researcher's interpretation of the participant interactions in the focus groups and are structured in a way that makes analytical sense rather than the order in which issues arose in the groups.

The main themes described in this chapter relate to learning, networking with other pharmacists, autonomy and experiences with pharmacy staff. Firstly, details of the participants of the groups are provided in the next section.

3.2 Constitution of the groups

The composition of the focus groups is described below. As stated, five focus groups were conducted with a total of 25 participants and their gender, age range and pattern of locum working are described in Table 2: Composition of the focus groups. The participants were allocated pseudonyms (given in the table below).

Table 2: Composition of the focus groups

	Gender	Age	Locum pattern
Focus group 1			
North West England			
Andrew	M	Over 40	Different pharmacies
Barbara	F	Under 40	Different pharmacies
Christine	F	Over 40	Different pharmacies
David	M	Over 40	Different pharmacies
Focus group 2			
North West			
Edward	M	Under 40	Different pharmacies
Fran	F	Under 40	Same regular pharmacy
George	M	Over 40	Different pharmacies

Helen	F	Under 40	Different pharmacies
Focus group 3			
West Yorkshire			
Isabel	F	Under 40	Different pharmacies
Jack	M	Over 40	Different pharmacies
Kate	F	Under 40	Different pharmacies
Leon	M	Over 40	Different pharmacies
Mike	M	Under 40	Different pharmacies
Norman	M	Over 40	Different pharmacies
Focus group 4			
West Midlands			
Peter	M	Under 40	Same regular pharmacy
Quinn	F	Under 40	Different pharmacies
Raj	M	Under 40	Different pharmacies
Steven	M	Over 40	Different pharmacies
Focus group 5			
North West			
Tim	M	Over 40	Different pharmacies
Vincent	M	Over 40	Same regular pharmacy
Ursula	F	Under 40	Same regular pharmacy
Wendy	F	Over 40	Same regular pharmacy
Yan	M	Over 40	Different pharmacies
Xavier	M	Over 40	Same regular pharmacy
Zac	M	Over 40	Different pharmacies

In line with the sampling strategy, each group aimed to have a range of ages, gender and working pattern. In practice all respondents were accepted for participation as the total number recruited fell below the maximum for each focus group, which was eight to twelve participants. Fortunately, each group did consist of a reasonable mix.

In total, of the twenty five participants, sixteen were male, eleven under forty and six worked in the same pharmacy regularly rather than varied sites.

The initial descriptive phase yielded a total of 64 codes. This initial large number of themes was then grouped into four main theme areas, which are presented here. The relevance of themes to the research objectives was identified from the researcher's knowledge of the literature on locum community pharmacy and consideration of the overall research objectives, in discussion with supervisors. The following sections now provide detail of the analysis under the main theme headings of learning, networking, autonomy and experiences with colleagues.

3.3 Learning

This section covers the focus group analysis in relation to a number of aspects of locums' professional learning, including CPD and access to information resources. Participants provided

descriptions of their general learning activities and approach, CPD and locating and using information resources.

3.3.1 Undertaking CPD

In all focus groups, CPD was the first topic to be discussed after initial introductions. This was deliberate, as it was felt to be a familiar topic to participants, that they would be comfortable discussing and hence provide a relaxed start to the conversation. The topic was raised by the facilitator as a starting point, and as such was obviously mentioned in all focus groups.

Motivations for undertaking CPD were described by locums. Several described how they had been trained as pharmacy students and pre-registration pharmacists to undertake CPD, so it was just now part of the job – an accepted routine:

“because I had decent training at (company) and stuff, we were always, it was kind of ingrained in us to always do it? To always do the CPD and we had extra training and...erm, at University it was always kind of there, to do CPD” FG2 (Fran, female, under 40)

Participants also reported that obtaining accreditation for advanced and enhanced pharmacy services was a driver for them undertaking CPD. This was related to enhancing employability for the locum by being able to provide services:

“as a locum, you do have to prepare yourself to be able to do MURs, local emergency hormonal contraception, services, drug services, you know, drug, methadone supervision, Subutex™, whatever. So do you have to focus on those to make sure you've done them, so then you can prevent, present yourself as a job” FG2 (George, male, over 40)

Defensive practice was also described, recording CPD activities as a defence against future mistakes or adverse outcomes for patients. This related to having some evidence of competency, and being able to demonstrate this when challenged:

“then if later on some employer or somebody accuses me of you know well you've past it now, you know or you can then turn to other people, other employers and they start to think ‘well that's, you know that's not to standard’, at least the General Pharmaceutical Council can say well 2 years ago he put this CPD in and it was very good” FG3 (Jack, male, over 40)

One participant disagreed with CPD being a validation of competency, expressing instead that she felt the process of undertaking CPD was a fundamental part of her professionalism:

“for me I don't see it [CPD] as validation. I see it as an essential part of my role of a healthcare professional so I don't see it that it's to prove that I'm good at what I do, it's part of what makes me a healthcare professional... I think it's something that forms part of the term professionalism for me” FG3 (Isabel, female, under 40)

The following quote reinforces this view, describing learning as a route to doing a better job and providing better care for patients:

“it is learning for a purpose because it's learning to do your job effectively” FG2 (Edward, male, under 40)

As mentioned previously, the subject of CPD was part of the topic guide and was therefore raised within all focus groups. Throughout the conversations, it seemed that the concepts of learning, CPD and continuing education were largely used interchangeably and without discrimination by most participants, mirroring previous earlier findings in one focus group that reflection and the CPD cycle were not part of the locums' vocabulary when discussing CPD (Miller, Jones 2004). There was, however, some expression of CPD as a reflective exercise and being an integral part of one's professionalism. Participants gave a variety of reasons for undertaking CPD, which included:

- enhanced employability through demonstration of being accredited for pharmacy services
- to provide better care for patients
- as defence if an error should occur
- as part of the professional role and activity of the pharmacist.

Again, these findings reflect previous work by Laaksonen, Duggan and Bates (2009), Power et al (2011) and Shann and Hassell (2006) in terms of motivations for CPD. Power et al note that the isolation of community pharmacists (locums not identified separately) could mean that they need more support for CPD activities than pharmacists in other sectors of the profession, an issue that may be even more relevant for locums.

There was a strong impression that ongoing learning was an accepted part of the pharmacist's role, a finding which is in contrast to earlier reports summarised in a review by Donyai et al (2011), which highlighted less wholehearted acceptance of CPD at that time. The advent of mandatory CPD may have contributed to attitudinal shifts amongst pharmacists on this issue. This impression may also be related to the self-selected nature of the participants – locums who were willing to attend a research focus group may have been more accepting of CPD and ongoing learning.

To summarise, locums in this analysis showed an acceptance of CPD as part of their job role, but little expression of reflection as part of CPD or differentiation from continuing education, though this was recognised by some. Perhaps as a consequence of this, motivations for undertaking CPD related mostly to practical issues such as employment opportunities and competency defence. However, some locums did consider CPD to be part of their professional approach to their role and to consider wider benefits of their learning.

3.3.2 Access to learning

The broad nature of participants' discussions around CPD encompassed learning that occurs within the workplace, and also more formal learning resources such as courses and bulletins. Whilst participants said that their job role exposed them to a variety of workplace learning, some problematic issues were discussed around accessing more formal learning resources. It was felt that employed pharmacists had easier access to learning resources than locum

pharmacists, as participants often felt 'out of the loop', meaning they did not receive the same access as employees:

"we're out of the loop with CPD unless you're on the emailing list from CPPE or C&D then you don't get to hear about these courses and you don't get...so you're out of the loop" (FG5 Vincent, male, over 40)

Locums recognised that employee pharmacists were supported by their employers' provision of learning resources and that locum pharmacists missed out on this support, a point that mirrors findings from another earlier focus group study (Miller, Jones 2004):

"CPD training materials sometimes are provided by employers for the employee pharmacists so you may not always have access or if the companies have sent things out to...it's like for the resident pharmacists rather than yourself, you've almost been missed out of that, erm, sequence" FG4 (Raj, male, under 40)

Some locums gave a different view, that there was sufficient access to learning resources within their professional environment:

"I don't think it [locuming] impacts that much because there's so much CPD that you can do" FG4 (Quinn, female, under 40)

In terms of this variety of working situations and experiences, focus group 1 introduced the concept of a population of '2000 patients' that constitutes the average patient population of a pharmacy. Locums suggested the idea that an employed pharmacist working regularly in the same place will have a relatively stable population of patients that he/she becomes accustomed to, and as such, is not exposed to new ideas as much as a locum pharmacist. This section of conversation described the issue:

"Because if you've worked in one store wh... one store all the time or even one company, but one store particularly, you just know that, that, or new things..". (David)

"You've got your 2000 patients" (Andrew)

"That's it!" (Christine)

"That two thousand and first patient never walks through the door!" (Andrew)

"No!" (Christine)

However, as a locum, there is not a stable patient population, so learning opportunities arise more often. The varied nature of the locum role does provide a range of learning experiences, as described by Andrew later in the conversation:

"no one person knows it all, so you go to a different pharmacy you've got a different set of problems. (Barbara:yeh) You might, it might be routine to them, it might be their 2000 patients, as opposed to my two, but 400 of those are different, I've never seen before. (Barbara:yeh, Christine:mmm!)" FG1 (Andrew, male, over 40)

This point below from Quinn in focus group 4 described a rather more subtle point that locums have less opportunity to discuss learning activities with colleagues than employed pharmacists. This links to the isolation described by locums described in a later section:

“it’s [CPD] much more flexible but at the same time it can be much more difficult to do [as a locum] because then you don’t have quite a lot of people around you doing a similar type of CPD for you to be able to discuss it” FG4 (Quinn, female, under 40)

There was comment from one pharmacist that working as a locum was a choice, and that responsibilities for CPD provision went along with that choice:

“Dare I say I think we’re almost self select (sic), if you become a locum you almost choose to step outside of the support mechanism as a previous, you know, manager and you have to take on that responsibility and that burden, do you not?” FG3 (Leon, male, over 40)

Participants did provide some detail of information resources that they used, and national organisations that provided information were highlighted. This research was not designed to be a survey of information resources used by locums, but participants reported that they used a variety of sources. Most resources highlighted were online, but phone calls to national resources such as the National Pharmacy Association and Drug Tariff resources were also described:

“There are like C&D websites, MHRA website, well maybe if you’re not part of the Royal Pharmaceutical Society then you don’t get that all in one place” FG1 (Barbara, female, under 40)

“The Drug Tariff they’ve got a number at the back where you can ring them if you’re stuck on something and they’ll help” FG1 (Barbara, female, under 40)

“I’ve found the NPA really good” FG1 (Christine, female, over 40)

Being networked with others (individuals and organisations) was significant as a method of keeping in touch with information resources. Some participants had examples of information they would have missed without specific online information resources, for example, the Royal Pharmaceutical Society site:

“I, erm, when the Society split and they formed the two separate bodies I made a conscious decision not to join, erm, the RPS and, erm, I’ve decided to rejoin for a variety of different reasons and since I’ve rejoined that’s actually helped my CPD in terms of what’s filtering through now from the RPS, erm, especially the daily bulletins and that signposted me to new things that are happening, you know the MHRA Guidance about them developing simvastatin, I might have missed that if it wasn’t for the RPS alerts actually so that’s actually helped focus my CPD more” FG4 (Quinn, female, under 40)

Internet access to facilitate finding information was repeatedly mentioned by participants. There was some discomfort that the internet was not always accessible in the work environment, either because access was limited by companies or because computer terminals were constantly occupied by staff labelling prescriptions:

“Another thing that bothers me is... everything’s on the internet and the internet is very useful but many companies don’t have it and for me it helps me. Sometimes, I’m newly qualified, sometimes it helps maybe if I look some things up, it’s two minutes job and some pharmacies don’t have the internet and I feel that’s well making us go behind a little bit. (Christine: because we’ve got the tools) Because we’ve got the technology why not use it? Such as, finding another

pharmacy that's close to you, or erm, health centre, anything. Maybe they do have their own websites, for example, big companies they've got their own search engine, but we don't know how to use that, even if we do you need a password, so that's the main thing actually that bothers me." FG1 (Barbara, female, under 40)

Participants also described bringing their own internet access to work via their phones:

"I've got internet on my phone as well I tend t... sometimes I need to use it. That's why I would have found it useful if there was internet in the shop as a locum. I think it would help me more." FG1 (Barbara, female, under 40)

Local rather than national information resources were also described, such as the Local Pharmaceutical Committees (LPC) and former Primary Care Trusts (PCT):

"The LPC send out, well, send out the shop, four or five emails a day, so they can see what's gone on" FG1 (Andrew, male, over 40)

"Well I contacted, just, it was just because I felt I was a bit on my own, I contacted the PCT and said, this is who I am and I spoke to, I forget what his name was, and he started sending me emails basically of things that was going on, so it's good, you can do that with PCTs and they'll send you" FG2 (Helen, female, under 40)

Pharmacist friends were repeatedly cited as useful information sources, highlighting the importance of local personal networking:

"I ring a friend or, and they help me" FG1 (Barbara, female, under 40)

"The only way I knew about the training that was going on was because I had people, I had friends telling me I'm going to such a training you know, would you mind coming. Otherwise I would never have known about it" FG2 (Edward, male, under 40)

Sources of information were also considered in the context of daily work – the type of practical information that was necessary to do the job in a strange pharmacy. It was acknowledged that finding this type of very local information could be problematic:

"when you land in a given shop, a lot of what you need to know is only in the minds of other people" FG1 (David, male, over 40)

It was recognised that this sort of immediate information requirement to solve day to day issues was different from background, ongoing learning:

"I try to differentiate between what I need instantly in the shop rather than what I can browse when I get home." FG1 (David, male, over 40)

"Me too, I'm like that" (Andrew, male, over 40)

"Yeh, yeh." (Barbara, female, under 40)

Obtaining information was often described as serendipitous, rather than in any way planned:

"The way I describe it quite simply is you pick things up by osmosis rather than ANY formal

route.” FG1 (David, male, over 40)

Focus group participants also expressed views about accessibility of CPD opportunities as a locum. A number of participants expressed the view that the variety of working situations as a locum meant that CPD opportunities presented themselves frequently, because of the different experiences available to the locum:

“I think there is some more variety maybe because you’ve got you know every different patient groups so I think that does give you perhaps some opportunities or different opportunities for CPD” FG4 (Steven, male, over 40)

In terms of access to learning opportunities participants had conflicting views, which may reflect the disparity between the use of the terms CPD, learning and continuing education. Some may have been considering that only continuing education activities such as attending courses constituted CPD, whereas others may appear to have taken a more holistic view of CPD and learning that integrates reflection on role needs and work situations to inform learning. One limitation of this study is that this was not explored further in the focus groups, and the researcher’s view on what constitutes CPD (the more holistic view) may have been imposed upon participants (the impact of the researcher on the research process is discussed in section 2.3). Despite this, the differing perspectives of the participants on the meanings of CPD, continuing education and learning have still been identified during the analysis.

Some participants expressed dissatisfaction with the level of support that they received compared to employed pharmacists and spoke of being ‘out of the loop’ and isolated from resources that may be available to other pharmacists. This is reflected in previous literature including Miller and Jones (2004), Gidman et al (2007a), Shann and Hassell (2006) and Donyai et al (2011). However, some participants felt that the variety of the locum role presented a lot of opportunities for learning. The novel concept of a ‘practice’ population of 2000 patients was raised in this analysis, describing differences in learning opportunities between pharmacists who work in one place with a regular patient population versus locums who experience more variety (two thousand patients also approximately represents an average general practitioner list size). Participants appeared to value the contribution made by variety to their learning, most recognising that their experiences provided many learning opportunities.

Some participants may have held a view that their access to training courses was limited, whilst others take a wider view of the learning within their practice and recognise the value of reflecting on their varied role. Greater exploration of pharmacists’ (not only locums) understanding of reflection and CPD is worthy of further research.

There was some differentiation between immediate knowledge required to solve day to day problems and ongoing, background learning and competency. Participants described the importance of networking for both sorts of knowledge – being ‘in the loop’ with local organisations and national bodies for ongoing learning, and also have local personal contacts for more pressing professional issues. Networking is discussed further in section 3.4, but these findings emphasise its importance for learning and problem solving for locums. Pharmacist friends were identified as a useful information resource, highlighting the importance of

personal networks, which also contrasts with locums' reported lack of opportunities to discuss learning with colleagues. This again perhaps reflects differences between immediate problem-solving activities and ongoing learning. There was acknowledgement that isolation was an inevitable part of the locum role, a role that locums had voluntarily chosen. This is an unsurprising finding that is reflected in previous research (Shann, Hassell 2006). Participants reported using information from a variety of national and local organisations, and electronic resources were particularly referred to. Difficulties accessing electronic resources in a busy pharmacy were raised, solved by some locums by using their own phones for internet access. Overall, participants felt that they had to be proactive and put effort into locating information resources and networks, and required multiple sites to meet their information needs. This research highlights the importance of different types of networks for locums to support both their day to day practice and their ongoing development needs.

3.3.3 Feedback on performance

Reflecting on feedback on performance clearly integrates with consideration of learning and CPD, as feedback should prompt and respond to learning. This section covers the variety of ways in which locums considered they obtained feedback on their own performance and any difficulties with that provision. Participants described how the temporary nature of working as a locum affected access to feedback opportunities. This was described as being due to the lack of feedback from others on activities (whether from staff, managers or patients), because the locum was not present in the workplace long enough to receive that feedback:

"as a locum as well you've got no one to really tell you look you're not doing this right, you know, your approach to the staff isn't right because you're only there for a day or two, so it's harder to identify your needs for CPD" FG2 (Edward, male, under 40)

Some of this lack of feedback was put down to difficulties establishing relationships with patients in the short amount of time the locum was present:

"It is a bit harder because if you're at the same place every day, you notice, erm, different customers coming in and if they have sig... problems then you're more likely to pick them up? Than if you're a locum, erm, they're a bit hesitant to talk to you as well? Because you're just the... odd pharmacist who comes every now and then. So it's hard to identify certain issues" FG2 (Fran, female, under 40)

Lack of feedback on the clinical situation was also mentioned, relating to the fact that a temporary locum will often not get any information on the outcome of a consultation or situation, because they do not see the patient again:

"with the follow up NMS, you identify something and you do the initial, erm, but the follow ups you don't get to do, you don't get to see, erm, the outcomes so in terms of writing that up and being able to put it towards your CPD especially if you have to research it you don't get to see the outcome" FG 4 (Quinn, female, under 40)

Participants also discussed how isolation led to lack of feedback on their CPD activities and recording, which meant they lacked confidence in how they were performing in comparison to peers:

"I feel this, I feel isolated, erm, you know, is my stuff any good?" (FG3, Leon, male, over 40)

Participants reported a lack of feedback on their performance whilst at work. They identified potential sources of feedback as from staff, from patients and from errors, but had criticisms of feedback routes from these sources. It was acknowledged that staff could provide feedback to locums, but that relationships would get in the way of satisfactory feedback as staff may not wish to criticise a person they are having to work with:

"You've got anecdotally what staff say about you but they're probably not going to say anything bad in front of you" FG1 (David, male, over 40)

Some informal mechanisms of feedback were described, such as comments from staff. Perfunctory feedback from staff was mentioned by a number of participants as a positive indicator of their working performance:

"I just go by the basic, when you finish at the end of the day if they say thank you very much it would be nice to see you again that's enough for me, that's actually more than enough for me in terms of feedback." FG4 (Quinn, female, under 40)

Feedback from staff was also described as being problematical in a number of ways. These ways centred around being uncertain about the motivations of staff and how that could influence their feedback. In this quote, Peter highlighted how unrelated behaviours might influence feedback, rather than his actual performance as a pharmacist:

"you don't know whether the staff are asking about just because you bought them some chocolates or you bought them or, erm, or because they fancy you, I don't know, they might, no, you don't know" FG4 (Peter, male, under 40)

Participants commented that professional relationships with staff could compromise the feedback that staff provided. It was described how locums making professional decisions that conflicted with staff could result in staff feeling disgruntled, and consequently providing poor feedback on the locum's performance. Hence personal feelings could potentially act as a significant barrier to assessment of performance:

"I've been in stores where sometimes staff, erm, have undermined you as a pharmacist which is not a good feeling at the end of the day and when you've stood your ground, erm, you've actually been penalised" FG3 (Mike, male, under 40)

It was apparent that participants sometimes felt threatened by staff's influence because of the possibly false negative feedback that might be forthcoming if the locum had to criticise staff and impose their authority:

"the situation where they haven't had a manager for quite a while and they've been having different locums each day sort of thing, erm, and they've got used to their own sort of ways sort of going early on a Friday and stuff like that and they don't want any sort of kind of authority sort of thing so any locum that comes there they're not going to give them positive feedback, 'Oh he was like this, he was like that, he came half an hour late' even though he

didn't come half an hour late they will just, you know, this sort... kind of thing does happen"
FG4 (Peter, male, under 40)

Mike described a scenario demonstrating the balance between making professional decisions which brought him into conflict with a staff member. His handling of a situation with a controlled drug resulted in a complaint against him from the staff member:

"I'd had enough. So professionally I said to her, 'Look my name is on that register, its under my authority, I'm responsible you know my neck is on the chopping board so if you don't mind just let me deal with it like I need to and after that if you don't like it or if you're going to provide feedback, by all means provide it to the company'. She actually burst out in tea...she obviously complained to the area manager, the area manager didn't really want to know my version of events, kind of brushed it under the carpet and left it but I ended up not going back to the shop again" FG3 (Mike, male, under 40)

One participant described how lack of feedback from staff directly to him hinted at negative feedback that threatened future employment at that pharmacy:

"if you're not getting the best out of your staff you know if you're upsetting them, none of them tell you what you're doing wrong, all they do.. you're just not going to get booked any more. And... end of." FG2 (Edward, male, under 40)

The ability of pharmacy staff members to judge the quality of a pharmacist was also discussed. The fact that staff members cannot assess all the work the pharmacist does was noted:

"They [staff] can't follow you, they can't follow you around for 9 hours and listen to every conversation and every phone call to see how good you are, you know, they only actually said, they only assess you for how many mistakes you've made not the positive things you've done."
FG5 (Tim, male, over 40)

There was also discussion about what constitutes a 'good' pharmacist, and the fact that opinion on this may vary between the staff member, the pharmacist and also the patient. This difference in viewpoint may influence the feedback that the pharmacist receives from the staff member:

"It depends what is a good pharmacist, is it...sorry, is it somebody who gets their head down and clears the deck or is it somebody who'll give the patient a bit of time because that depends how they judge you then." FG5 (Wendy, female, over 40)

Two participants did describe feedback from patients, Steven highlighting difficulties where patients' wishes conflicted with their needs:

"generally it [feedback] comes from the patients, rather than from the staff" FG2 (George, male, over 40)

"I upset one of their patients there but that's by the by because I wouldn't give them an emergency supply but that's by the by but you know you've met their needs" FG4 Steven, male, over 40)

Participants described some feedback from pharmacy companies when the locum had made a dispensing error. This feedback did not seem sufficient however to allow locums to learn from

their mistake:

"I couldn't get a copy of the script however anonymised they wanted to make it, erm... or any other information that would help me to, er, well how did I come to make that error? So although the company told me I'd made an error, I couldn't gain any further information to learn from" FG1 (David, male, over 40)

"I received one as well yeh, saying, just the error but no other information, because they have to, erm, report it and maybe change a few things but I don't receive that. They just said there was, it wasn't really that harmful so..." FG1 (Barbara, female, under 40)

Participants expressed the view that they would appreciate more feedback on errors that had occurred, to enable them to learn:

"it says you don't need to take any action (Barbara:yeh! that's what they said yeh) it's all been resolved in branch, that's all well and good, you need to get better at the job, and how did we come to make this error?" FG1 (David, male, over 40)

Participants did discuss some strategies that they used to obtain feedback, but again, success seemed limited. One described inviting feedback at the bottom of his invoice, others described leaving questionnaires:

"I put actually at the bottom of my form, my invoice form, feedback please, er, but I've never done, never..." FG2 (Helen, female, under 40)

"I work for three organisations and all of them have internal locum feedback forms..." FG3 (Norman, male, over 40)

"Used by?"(Facilitator)

"...used by staff to feed back to you know head offices" FG3 (Norman, male, over 40)

In addition, one participant described a locum agency arranging feedback mechanisms, both about the locum and the pharmacy:

"an agency, and they've proactively started to collect a database of feedback about, erm, each of the different places so they have the feedback from the stores about the locum and they have your feedback about what you thought about various things of the stores, I don't have as much time as I would like to be able to do that but I think if they were able to gather that and start to analyse that, that would be useful to see" FG4 (Quinn, female, under 40)

There was comment that positive feedback was rarely obtained:

"You'd get the bad feedback you'd never get the good feedback" FG2 (Helen, female, under 40)

Participants reported a dearth of effective routes of feedback on their performance and had criticisms of the routes that were available. Isolation was again a key factor. When feedback was available, it tended to be related to negative events, for example, errors. The main route of feedback for locums seems to be via staff members, but this route appears fraught with factors which may make any feedback subject to bias. The role of the pharmacist as the person responsible for the quality of the pharmaceutical service in the pharmacy means that locums may occasionally make professional decisions that cause them to be unpopular with staff

members. When these staff members may control feedback mechanisms that influence the future employment of the locum, this creates a conflict of interests and an uncomfortable dynamic for the locum. In addition, opportunities to obtain feedback from colleagues were limited, giving few opportunities to benchmark performance against peers. Some locums did report mechanisms of their own devising for initiating feedback from staff, with limited success. The short duration of most locum working meant that locums reported not being able to establish relationships with staff or patients necessary for feedback, and that often they did not see the clinical outcomes of their actions so lacked that feedback also.

This study supports work by Jee et al (2013) in that locum isolation meant a lack of appraisal processes, staff were reported to provide some feedback and feedback on errors tended to be reactive and limited. Similarly, research into managing performance concerns amongst community pharmacists by Jacobs et al (2013) highlighted that isolation meant little peer comparison or opportunities to benchmark practice.

This research provides some further insight into the difficulties of obtaining feedback by locum community pharmacists. Participants reported a desire for more feedback on performance that they currently obtained. Particularly, they wished for more positive feedback, as well as negative. Staff appeared to provide the most frequent feedback route for locums, but the relationship difficulties with this were clear. Despite the transient working environment, locums also relied on patients for feedback, which is an interesting finding when considered in the context of the General Pharmaceutical Council's continuing fitness to practise developments (General Pharmaceutical Council 2016). These developments, which will be clarified and implemented over the next few years, include elements of peer review and performance indicator data, in addition to CPD. The Royal College of General Practitioners' appraisal process specifically includes reference to patient feedback on GP performance and it may be that patient feedback would be a useful performance indicator within the pharmacy profession (Royal College of General Practitioners 2015). The difficulties of using pharmacy staff to provide feedback are explored in detail by the locums in this research. The fact that locums use patients to obtain feedback suggests this could be a feasible option for a continuing fitness to practise process.

Within this research, participants clearly expressed that they chose to deal with poor performance at the pharmacies they attended by not returning to those branches – 'voting with their feet'. This was despite acknowledging a professional responsibility to report poor practice. Routes to do so appeared very unclear. This is recognised in existing literature (Weinbren 2012) and is reinforced here. Whilst there are clearly factors in the financial relationship between a locum and their employing organisation that influence reporting of poor practice, locums would benefit from support in being able to discuss and report practice they consider substandard.

3.4 Networking with other pharmacists

Isolation was raised independently by participants in the focus groups, and is clearly still a significant issue for them. That locum workers experience professional isolation is an obvious finding, but the finding is explored here as it sets the context for other discussion of continuing professional development, use of information resources and networking as a professional development mechanism:

"It's the first time in 20 years I've met locums tonight" FG5 (Tim, male, over 40)

"As locums, the fact that we don't interact with one another (Barbara: yeh) means that we're often isolated". FG1 (David, male, over 40)

"I feel this, I feel isolated" FG3 (Leon, male, over 40)

The overall importance of networking with colleagues was frequently mentioned, specifically as an information resource:

"Yeh, that's what it's like, you don't... sometimes you're quite isolated from like your network and stuff like that and you know if there's a problem you don't, the, you know shop's NPA number and stuff like that, you know you don't know whether... or the numbers you can ring up in case of any problems, that can happen, you feel isolated" FG4 (Peter, male, under 40)

Participants described their attempts at networking and communicating with colleagues. This seemed to serve a number of purposes. One purpose was to communicate practical issues in relation to the working environment and to supplement learning and problem resolution between colleagues. Practical day to day communication between colleagues was often highlighted and the unreliability of communication methods in pharmacies was also described:

"Well, (pause) I put notes in the diary. I'm not absolutely certain that anybody reads them on the next or subsequent days" FG1 (David, male, over 40)

Participants identified that sharing experiences was a valuable part of networking with colleagues which was recognised as a mechanism for reducing stress on the individual:

"I think as I said there's also another part of any social gathering is, "Oh did that happen to you?" you know there is that, there is that chance on, on one level to de-stress perhaps" FG3 (Leon, male, over 40)

Part of this social support was locums being able to recognise that other locum pharmacists experienced similar difficulties and issues to themselves:

"It is nice talking to other people because you realise you do feel, y... sometimes... sometimes you feel you've dropped down a black hole and the world's gone mad around you, don't you and then when you talk to other locums you think oh actually there's other people (Barbara:yeh, yeh) in the same boat as me" FG1 (Christine, female, over 40)

Benchmarking practice against other pharmacists was another key benefit from meeting with colleagues. In the quote below, Isabel also explores using colleagues to help develop new working practices:

“But it also underestimates the value that pharmacists get from talking to other pharmacists and actually for a lot of locums I wonder if that is one of their main points of, erm, of checking out where their practice is compared to other people and looking at innovation and looking at different ways of working” FG3 (Isabel, female, under 40)

This benchmarking, or peer comparison activity, was identified as a useful feedback mechanism on a locum’s performance:

“I find it [talking to other pharmacists] inordinately useful and I don’t see that there’s any other feedback mechanism available to you at the moment as a locum” FG3 (Norman, male, over 40)

There was recognition that all pharmacists probably benefit professionally from talking to other pharmacists and this is not just a locum issue. This quote from Leon below describes professional growth, or progression, from interaction with colleagues:

“I think all professions learn from individual members, I think that’s how you progress isn’t it, you know whatever profession you’re in” FG3 (Leon, male, over 40)

Participants discussed liaising with other colleagues over work issues, which was in all cases viewed positively. Sometimes this related to a request for practical information, but more commonly to a desire to discuss the issue with another colleague to test out an approach to resolving an issue:

“Sometimes if you just speak to another pharmacist without them giving you any advice, the speaking out loud helps I find. Erm, any situation. Sometimes you’re trying to think what shall I do in this situation and maybe if you just discuss it with, you probably don’t need an answer you can work it out yourself, but it’s nice to have someone to maybe discuss it with” FG1 (Barbara, female, under 40)

Participants described using colleagues to help think through dilemmas that arise in the working environment. This was commonly in the sense of sharing possible courses of action about a situation:

“You deal with a certain number of erm patients with a certain number of queries there will always be one that’s different that somehow you think oh my goodness how do I deal with this? It may well be there on the locum space. Or the moral issues or what do you do when you’ve got emergency supplies that you don’t want to do what do you do in this instance what do you do in that instance.” FG1 (Christine, female, over 40)

The lack of overlap of working time was described as a barrier to meeting other colleagues – the fact that community pharmacists very rarely work together and a locum, by the nature of the role, is there when the regular pharmacist is not:

“the staff who work in the shop say, “Oh yes so and so is absolutely brilliant isn’t he?” I don’t know I’ve no idea I’ve never met him because when I come here I’m here to cover him so I have

no idea what he looks... he could walk into this room and I would have no idea who he is, because that's the nature of what we do, we go in to cover for somebody else" FG3 (Isabel, female, under 40)

Participants described how meeting other pharmacists was difficult in the working environment:

"It was very rare that you'd be double covered with anyone, erm, so it's pretty much impossible, erm, to meet new pharmacists I've found, it was very difficult." FG2 (Edward, male, under 40)

Training events were frequently highlighted as one source of informal meeting with other pharmacists. This quote from Andrew also describes how the lack of locum involvement in company work meetings limits interactions:

"The only networking I've ever had because I've only worked within a small shop, is CPPE. There is no other networking. (David:no). I don't have managers meetings, I don't have monthly area meetings, it was CPPE or nothing. So yes I did phone a friend and I phoned a friend quite a lot" FG1 (Andrew, male, over 40)

Networking at training events does appear to have limitations, in terms of time available at the event to have informal conversations and the requirement to meet the formal objectives of the event, rather than spend time getting to know others:

"I don't think the training events are frequent enough to get to know people (G:no, exactly). Because when you go you kind of drag someone you know, so then you're just together and you, smile at people you kind of recognise but you wouldn't, wouldn't go and have a chat to them as you would on a social kind of, erm, gathering, like the branch I suppose (G:yeh).

In contrast to this, another participant felt that there was sufficient social space within a training event to communicate with others:

"That's another thing going back to CPPE that their events are very good for because you are in a room with 30 or 60 other pharmacists and there is peer group role play so it is an opportunity I suppose to not necessarily network but to, to have a chat with other colleagues you know in a sort of fairly safe environment because you're all learning so there's no sort of, erm..." FG3 (Isabel, female, under 40)

This emphasis on the benefit of social interaction at training events is repeated in the following exchange between Leon and Norman in focus group 3, which reiterates the benefits of exploring possible courses of action and the stress reduction aspects of professional social contact:

"I think as I said there's also another part of any social gathering is, 'Oh did that happen to you?' You know there is that, there is that chance on, on one level to de-stress perhaps" FG3 (Leon, male, over 40).

"I think you learn more from the peripheral events than you do from the central theme quite often, yeh." FG3 (Norman, male, over 40)

The value of having friends who were pharmacists was described as being a source of help and advice:

"I've quite a lot of friends who are locums (F:yeh) so I'm quite lucky in that way I think, erm, and even people I got quite close to being a manager, like, regular locums, so I'd still, if I ever had an issue or a concern or whatever, I would ring them for advice" FG2 (Helen, female, under 40)

Participants described the effort they put into locating these kinds of pharmacist-friend contacts:

"It's very difficult to meet other colleagues I find, erm, unless you're going to training events you know, you might meet people there but then you're training so you don't really have the chance to get to know each other. Erm, for me, when I first qualified I used to meet pre-regs and we'd always take contact details because I knew they would be future pharmacists, so that was my way of networking." FG2 (Edward, male, under 40)

Social get-togethers were mentioned, but largely in a historical context. The demise of the old Royal Pharmaceutical Society branch system was discussed as reducing opportunities for social contact:

"Well do you know what I was Chairman of my local Royal Pharmaceutical, you know the local branch and actually I think, erm, when I first started 24 years ago we used to have very good branch meetings and then over the years the rise of, erm, and it was obviously from the rise of different forms of education as well actually killed the branch and people migrated and drifted away into their own silos" FG 3 (Leon, male, over 40)

In focus group three, there was some discussion about moves away from face to face training towards use of online resources such as webinars. Isabel raised the following issue, which describes the value of meeting colleagues, including peer comparison and innovating practice:

"But it [webinars] also underestimates the value that pharmacists get from talking to other pharmacists and actually for a lot of locums I wonder if that is one of their main points of, erm, of checking out where their practice is compared to other people and looking at innovation and looking at different ways of working." FG3 (Isabel, female, under 40).

Participants did sometimes discuss the use of technology to network with colleagues. This was overall seen as a positive development, providing more opportunities to interact with colleagues:

"I mean in contrast to 10, 15 years ago there are more opportunities I think to interact with your peer group... Yeh, largely IT driven, yeh." FG3 (Norman, male, over 40)

Ursula describes below use of a locum social networking site that appeared to be a negative experience for her:

"There was, erm, I joined the locum voice and then that just turned into a big...like you tried to have a serious debate and then it just...whatever comment you put up just gets into a big slanging match so I don't go on there anymore" FG5 (Ursula, female, under 40)

Participants consistently reported feeling professionally isolated and recognised the importance of networking with colleagues. Locums used personal networks to resolve practical work issues, to reduce personal stress, for enhancing learning, to develop practice, to obtain feedback and to benchmark performance. Networking provided an opportunity to share experiences and problem-solve, both in a practical and a moral sense.

The practical issue of being a lone pharmacist worker in community pharmacy was noted as a factor in professional isolation. Participants said they appreciated the value of face to face meetings at educational events and of having friends who were pharmacists. Using technology to network was described positively, but some negative experiences online were also recalled.

To summarise, in the focus groups, locums described their networks being used for:

- Obtaining information
- Benchmarking
- Decreasing stress (listening ear)
- Problem solving
- Sharing opinion on moral and ethical issues
- Promoting professional growth

As mentioned above, isolation of locum pharmacists is consistently reported in the literature (Shann, Hassell 2006). Locums in this study put effort into developing their pharmacy colleague networks and used them in a practical and emotionally supportive way. The importance of using colleagues to problem-solve, compare practice, share work experiences and discuss dilemmas highlights the significance of networking activity to professional behaviours. The second phase of this study, involving examination of an online forum, progresses this idea to explore the interactions undertaken on the site by locums. Focus group participants also described using colleagues to support their own professional assertiveness, which is discussed in the next section.

3.5 Autonomy

Autonomy was both directly and indirectly referred to by locums in a number of ways. It was discussed in the context of decision-making around clinical and legal issues, employment issues and making decisions about poor practice of others.

Autonomy around clinical and legal issues related to issues that locums met during their professional work. The example below describes a professional competency confidence 'shell' that enables the locum to assert a clinical decision for a patient:

"I think part... maybe part of the thing that as... you know... part of your professional need to get that shell around you which says, I know what I think I'm competent to do and I know what I think is appropriate for the patient and have the, the, sort of the guts to say no this is not reasonable for the patient." FG2 (George, male, over 40)

Participants also reported being assertive with working and employment conditions in pharmacies:

"I've had arguments with them because they...some companies will let you have a 20 minute break which is unpaid but you must stay signed in as RP and I've had arguments and I've signed out as RP and I said, "If I stay signed in you'll pay me" and they don't...they can't argue with you, they don't like you." FG5 (Ursula, female, under 40)

One participant reported a threat to clinical decision-making when the decision may be unpopular with staff and potentially threaten future employment prospects:

"the fact that the locums are not empowered to make the clinical decision, they're scared of making those clinical decisions simply from my point of view because they're scared of not getting a job again, they have to be very careful not to upset the staff." FG5 (Xavier, male, over 40)

Disagreements about employment conditions interacted with clinical issues when locums felt that patient safety was compromised by the working conditions of the pharmacy:

"I remember once having an argument with the store manager at one of the multiples, there was only one girl to help me so I, I said, "Surely there's always two when I've been here in the past" he says, "I can't afford, erm, an extra member into the pharmacy" well I said, "In that case do you want me to close the pharmacy because it's not going to be run properly" and I had one hell of a row with him and eventually he sent somebody in, once again off the counter, off, erm, one of the shelves...filling the shelves up." FG5 (Yan, male, over 40)

Participants described a powerlessness as individuals when addressing working conditions with employers, with again, the threat to future employment overhanging any complaints they might make:

"Do you think you have any clout?" FG5 (Facilitator) "No, too isolated." (Wendy, female, over 40) "Well I've joined the PDA but if you complain you get none, you don't get any work." (Tim, male, over 40) "You don't." (Ursula, female, under 40)

There was some discussion about group power of locums, in terms of negotiating strength with employers. Participants described feeling relatively powerless as individuals with multiple companies, and in the scenario below, Wendy contrasted a group situation with her current work to the lack of co-ordination as part of the locum workforce:

"That's...well that, that's funny you should say that because when I got my letter...I got a letter from a multiple today telling me that they have told me some months ago that the rate's been reduced by a few pound an hour. Erm, I was about to write back saying, "Well actually your letter didn't say that, your letter said somebody would be in touch to talk to me about it" and I just thought I can't be bothered because I'm on my own fighting I just thought I can't be bothered, do what you like. Whereas within my own work at the moment there's a lot about changing pay and changing conditions but there's 19 of us so we formed a group and we're working through the Union and I just felt, I bet there's a load of other locums out there thinking..." FG5 (Wendy, female, over 40)

In contrast, in another example a participant described a group of locum pharmacists working together to implement change at a pharmacy that operated without a regular manager. The locums had jointly identified a required change to practice and worked together to promote implementation of the change:

“But then, erm, the locums as a cohort had to say, ‘Well actually that’s true’ (Quinn). So the locums got together as a group? (Facilitator) Between ourselves because even though it runs on locums they’re quite regular locums and, erm, I would say quite high quality locums, erm, and I think because of being that calibre of locums we were able to say, ‘Well actually yes this is indicated and it should be implemented’” FG4 (Quinn, female, under 40)

Participants described on a number of occasions how working conditions in the pharmacy meant they chose not to return to that workplace in future. This choice was usually accompanied by a lack of feedback to the pharmacy on why the locum would not return:

“I think... I just wouldn't go back”. FG2 (Fran, female, under 40). “I've done that.” (Helen, female, under 40)

“Yeh, I tend to not complain and just don't go back.” FG5 (Ursula, female, under 40) “Yeh that’s what I'd do.” (Wendy, female, over 40)

Sometimes these working condition issues related to volume of work. The following story by David reflects how locum pharmacists have to accommodate working situations that they have not created, and how attempts to rationalise workload can be thwarted. David recognises how this experience affects his satisfaction of the work experience, and influences his choice not work in this way again:

“Yeh, just general pressure of work. Erm, there's one pharmacy I went into, they've got a pile of scripts that came over yesterday morning, another pile which came over yesterday afternoon, another pile which came over first thing this morning. Customers appearing, demanding scripts, I, I couldn't even persuade the staff to put those three piles into alphabetical order. So it made it easier to find a given patient. Erm, and they were quite content to work that far behind and I really, by lunchtime, had no incentive to try and reduce these piles at all. It was, erm, firefighting (Andrew: yeh, Christine: yes, yes), doing the script as the patient appeared. And... there was no job satisfaction in it but I was there for one day, and make a mental note don't take another booking” FG1 (David, male, over 40)

The stress related to volume of work was also noted, as described in this conversation in focus group one, where poor management of the workload created angry patients, which stressed the locum:

“You do get that in some stores and you think, oh god, I'm not coming here, because you get fed up of being shouted at! (David:yes!) It's not funny!” (Barbara:laugh) FG1 (Christine, female, over 40)

“Shouted at by...?” FG1 (Facilitator)

“The customers! And you can understand them shouting, why is it not ready?!” FG1 (Christine, female, over 40)

Whilst participants recognised that feedback to companies on poor pharmacies was probably the correct thing to do, there appeared to be a sense of resignation about some of the participants’ conversation about this issue. Quinn describes this issue below, where she recognises that feedback could probably make improvements, but it appears easier to simply not return than tackle the issues:

“Sometimes you can only be there for that one day so even if it’s been a difficult place and you know there is this inclination that you could build on this and give feedback and take feedback and so on and so forth, sometimes you just think, “I’ve done my day I’m not going there again” and that’s fine so I have been to one or two like that. (laugh) FG4 (Quinn, female, under 40). “I’ve done a place like that where, ‘This will be the first and last time I come here’” (Peter, male, under 40)

She goes on to describe a sense of powerlessness and survival as a locum in the face of difficult working circumstances:

Its... you’re not going to change it overnight so then sometimes you just make sure you’ve got through the day and all the boxes are ticked in terms of what you needed to do as a pharmacist and just leave it there, you don’t have to go back if you don’t want to and you have that choice as a pharmacist, as a locum pharmacist. FG4 (Quinn, female under 40)

This sense of being a ‘visitor’ to the pharmacy, and not having the power or authority to implement change, is put across quite strongly by Quinn in the next comment. Her reference to the ‘coward’s way out’ indicates she does acknowledge that a more proactive approach to the quality of the situation may have been preferable to her avoiding tactics:

“I mean there was this one branch that I decided I’m not going to come back after today, erm, and, erm, I didn’t feed it back but I was asked to go back there and actually I don’t know whether it was the coward’s way out I did say, “Oh no I’m busy on that day” and, erm, because what needed feedback was managerial, it wasn’t locum pharmacist orientated, it wasn’t pharmacy orientated it was managerial so... and then you have to sometimes think that you are just there as a visitor and, erm, you’re not part of their set up and you don’t know what the day to day working practices are there, erm, and sometimes you have to just leave it as a visitor: It’s like going to somebody’s house and saying, ‘Well you know what it’s really dirty here’ and, erm, then just leaving, you’ve got to be able to work out what to say and what not to say”. FG4 (Quinn, female, under 40)

Following her discussion of difficult working environments, Quinn described her strategy of sampling the work environment of a new pharmacy before taking on more bookings to work there again. Her experiences of unpleasant working environments seem to have prompted this behaviour:

“Previously in the past I would have taken a block booking for, erm, a chain of pharmacies or, erm, a number of bookings at the same pharmacy but over the years I’ve, erm, taken to just taking one booking at a time and then take more bookings on if I like it there. And I’ve had to

make a conscious effort to do that, to actually have a taster and, erm, then go back if need... if I wanted to. I've been able to be quite selective about that but that, that's... over the years become apparent that it's important to do that." FG4 (Quinn, female, under 40)

In contrast to issues over volume and management of workload, Steven describes below a pleasant working situation despite high workload:

"And yet one, the one shop I thought was going to be really challenging was one where they're doing, they're seeing 200 and odd substance misuse clients a week and actually that was one of the NICEST places to work except for the smell occasionally. But that, that's... just total expectations isn't it, you know you get this expectation about what it's going to be like and actually it can be completely the opposite." FG4 (Steven, male, over 40)

Whilst the majority of participants in the focus groups indicated that they would not return to a pharmacy where they had had an unpleasant working experience, there was usually some acknowledgement that feedback to workplaces, either directly, through management or locum agencies, would be a positive thing. Participants described feeling like there was no clear route to provide this feedback. Helen describes a pharmacy with no manager where she discussed the situation with staff:

"Erm, (pause) it would just like that, I wouldn't go back, it was short-staffing that's what it was. Erm, yeh, yeh. So I didn't go back. But again, there was no, there was no management it was locums, erm, and it was all locums it was locums, there was no manager there at that time, so there was really nobody to feedback to, so I just fed back to the staff." FG2 (Helen, female, under 40)

Mike commented that he provided some feedback to his locum agency, when requesting that he was not sent bookings for that pharmacy again. The effectiveness of this was not clear:

"I usually just give feedback to the agency...I usually just give feedback to the agency and just say, "I don't want to work there again" that's what I...I've done on a couple of instances where then she'll just ask me, "Well what was wrong with it, you know what happened?" and I'll just tell her my side of the story so that's it really, erm, I don't know if she usually feeds it back to the co-ordinator or I don't know what happens after that but I mean I think that's one good thing as a locum you can choose if you want to go back to a place or not, if you don't like it you don't have to go". FG3 (Mike, male, under 40)

Vincent described making a report to the local primary care trust over poor pharmacy procedures, but did not receive any feedback himself so never got to find out if the situation improved:

"I've just reported slack procedures and, erm, my concerns as a pharmacist to the safety working of that pharmacy and I never went back but I don't know whether the PCT responsible officer phoned up but he said he would look into it, whether or not that's his responsibility to do that I'm not sure". FG5 (Vincent, male, over 40)

In contrast to this, Jack described a successful feedback intervention he made via the superintendent pharmacist, where he did find out that the situation had improved:

I'd get on the blower to the Superintendent, that's what I've done on a couple of occasions. FG3 (Jack, male, over 40)

Did it help? (Facilitator)

Yes, done things about it. (Jack)

The most frequently mentioned consequence of providing adverse feedback on a pharmacy was the threat to future employment with that organisation. The lack of power of locums to initiate change in working practices, referred to by Quinn above in her view of the locum as a 'visitor' was mentioned in the exchange below. Ursula describes the negative consequences for her partner of taking action in an unsafe pharmacy environment:

"If I do a locum I always insist that there's competent staff present and if there's not then I say, if it's not, if they're not competent I'll walk out and this is something..." FG5 (Yan, male, over 40)

"Have you ever done it, have you ever done it?" (Tim, male, over 40)

"...very nearly once (laugh)." (Yan)

"Try it and you won't, you won't get invited back again. My partner shut a (company) shop and the Area Manager cancelled all his future bookings with that store. (all talk at once)" (Ursula, female, under 40)

This concept of not wishing to raise negative issues for fear of not getting future bookings was mentioned repeatedly:

"I think one thing you feel as a locum is that, erm, there's one being assertive but the second thing is that if you want more locum work and you want to continue there then you have to almost balance what you say and what you don't say, you have to pick actually, you pick your battles don't you in terms of what to focus on, erm, because then they can just, 'All your bookings are cancelled', and to a certain degree that's what's happened isn't it?" FG4 (Quinn, female, under 40)

"If you start kicking up too much of a fuss then you get labelled as a troublemaker and then that can affect your bookings with these companies." FG2 (Edward, male, under 40)

In contrast to the majority of reports indicating reluctance to give negative feedback on pharmacies, Jack describes a situation where supplies of a controlled drug methadone were not adequately accounted for. On reporting this to the superintendent pharmacist, the following positive situation arose:

"[The] Superintendent came over and stood in...he found out where I was on the Monday, came over and stood in for three hours whilst he sent me back to the other place to sort things out, that was 18 months ago and I still got bookings after it from that." FG3 (Jack, male, over 40)

Participants discussed assertiveness both indirectly and directly, in the context of clinical and legal decision-making, negotiation of workplace terms and conditions and dealing with poor practice of others.

Participants identified that individual bargaining power and professional strength was often weak, but did describe a number of situations where groups of locums had come together locally to initiate change, both in employment and clinical terms.

Participants clearly described how they made decisions not to return to work in pharmacies where they encountered difficulties. These difficulties included working conditions that may have been stressful or unsafe, including insufficient or difficult staff. Locums recognised that best professional practice would be to acknowledge and report these working difficulties, but many strongly felt that raising issues with employers would compromise their future employment prospects. There was some evidence to the contrary of employers responding positively to locums' criticisms.

Assertiveness links strongly to autonomy, which is a key trait of professional behaviours. Without assertiveness, the ability to act in an autonomous fashion for the benefit of the client or patient is severely compromised. It may be considered that locums, as they are not bound by company working frameworks, have greater freedom to work autonomously than employees. It has been noted that some locums undertake locum work in order to extricate themselves from employment targets (Schofield 2009) and hence that locums exercise greater clinical autonomy. This is confounded by research which indicates that threats to employment may reduce locum autonomy (Magirr, Grimsley et al. 2004).

Within this study, participants identified that acting assertively to justify a professional decision could make them unpopular, which could threaten future employment, particularly via negative feedback from staff. Participants also identified a lack of power to influence and change practice in a pharmacy, which led to locums not returning to pharmacies whose practices they did not agree with. Locums also reported using colleagues to help support their own assertiveness and influence change. Networks appeared to be significant in reinforcing assertive behaviour by sharing ideas and practice, and creating a volume of opinion to promote change.

Taking a view broader than that of the individual pharmacist, an increasing number of pharmacies are now owned by large, multinational corporations, albeit with professional head office functions devolved to local UK level. Corporatisation has been seen as a threat to clinical autonomy (and possibly political and economic autonomy as well, with the power exerted by organisations at national level), but it may be the case that the concept of professionalism is merely evolving in the light of global changes. The traditional, trust-based occupational model with its national boundaries and tight control of knowledge no longer fits in the networked world. Organisational professionalism might provide a route for the idea of professionalism to survive, as it adapts to the new environment. This may be how autonomy is now able to express itself.

In summary, assertiveness and autonomy are complex issues for the locum pharmacist and present practical and emotional difficulties. Some of these difficulties may be ameliorated by discussion and sharing with peers.

3.6 Experiences with pharmacy staff colleagues

Participants discussed pharmacy staff within the focus groups spontaneously. They reported finding staff a useful information resource during the working day. This use of staff in this way links to section 3.3 where information resources were discussed further. Some of this knowledge was apparently implicit, and could not be found any other way:

“On a very...mundane level, erm, when you land in a given shop, a lot of what you need to know is only in the minds of other people.” FG1 (David, male over 40)

This information appeared to be very local, practical detail of how the pharmacy operated, and locums relied upon staff to induct them into these details:

“when I start in the morning I make the introductions and, erm, I manage the expectations by saying, ‘I will do what you ask me to do but you must tell me, you must put it in front of me otherwise I’m not going to know to do it because I don’t know how you usually do it here’ and that usually sets the expectations for the day so I’m not supposed to have this sixth sense where I’m supposed to know” FG4 (Quinn, female, under 40)

The social interactions with staff in pharmacies were recognised as part of the working experience. Positive, friendly working relationships were valued:

“Also there’s the companionship for staff, 99% are very, very good, very friendly” FG5 (Yan, male, over 40)

One participant noted that the nature of the staff in the pharmacy was a more significant factor contributing towards the quality of her working environment than aspects of the company where she was present:

I found that it's not the actual company it's the staff that you work with?” FG1 (Barbara, female, under 40)

Where relationships between the staff were poor, these tensions had a negative effect on the working experience for locums:

“It wasn’t anything about the shop it was the staff and that you’ve got two, erm, factions and you’re caught between the two which was really hard, erm, you’ve got this to-ing and fro-ing from the MDS room and the general dispensary and I’m just thinking, ‘Roll on 1 o’clock, I just want to go home”” FG4 (Steven, male, over 40)

Participants also described various approaches to both establishing their authority and understanding the staff dynamics as part of the induction process when working in a new

pharmacy. There appeared to be negotiation of power relationships, as in this example where Christine described identifying the 'boss' amongst the staff:

"You've got to find out the pecking order, that's the prime job when you go in as a locum, you find out who's head boss". (B:yeh laugh) FG1 (Christine, female, over 40)

There was also a process of negotiation described in the initial interactions with staff in order to establish the working pattern of the day. In the following example, the negotiation involved the locum projecting a certain image and using assertive behaviours with staff:

"Everytime you go somewhere new it's like, erm, it's like an interview really, you're kind of trying to sell yourself (E:it is yeh). You're trying to get the staff to do erm to do their job, er, efficiently so you can do your job efficiently". FG2 (Fran, female, under 40)

When a locum enters a pharmacy for the first time, an initial interaction with staff occurs. Participants discussed how they need to make rapid assessments of staff competency when they started working with unfamiliar individuals in a strange pharmacy:

"And the other issue there is have you got enough, you, you are quite right, you don't know what their qualifications are (C:no) and if you quickly find that out, you still don't know what's going to be the pressure of business throughout the day" FG1 (David, male, over 40)

This issue of unfamiliarity was not just about staff competency, but about possibly competent staff having their own ways of working that locums felt they needed to adapt to. This adaptation to existing working systems was felt to be a risk reduction strategy:

"And how do the staff w... you've got to be able to pick up very quickly how the staff in that place work (F:work) to allow them to do their job as they feel comfortable (F:yeh) so they don't make mistakes (E:mm). Because the worse thing you can do is impose a system on somebody..." FG2 (George, male, over 40)

The concept that system change was a potentially risky manoeuvre was clearly expressed and locums appeared to make effort to adapt to existing systems and not impose unnecessary change:

"But it would be very dangerous to get the staff to change for one day (Christine:mmm; Andrew:yeh). So you don't, you work with it." FG1 (David, male over 40)

Views were expressed by participants on pharmacies that did not have a regular manager and were operated solely with locum cover. The significant role of pharmacy staff in this situation was recognised. It appeared that locums relied heavily on staff to provide service continuity:

"Some weeks it was 6 different pharmacists [in the pharmacy] but the staff are the strength then because they're the glue that holds everything together" FG4 (Steven, male, over 40)

It was further recognised that some staff had then developed attitudes to being managed by locums that were difficult to locums, perhaps in response to staff lacking leadership for a period of time. Participants recognised that they needed to exhibit assertive behaviour to deal with perceived power imbalances between pharmacist and staff:

"I think you find two things, they're [staff] either deprived of any sort of leadership (F:yeh) or there's one of the members of staff who takes (F:takes control) takes, takes too much (all laugh) and you have to shake them off with ????? (all laugh) and that's an interesting situation (all laugh) to deal with". (FG2 George, male, over 40)

This imbalance of professional power was described in the following situation where staff had lacked leadership and evidently formed their own coping processes. Here, the locum explicitly described using assertive behaviour with staff to exert professional power:

"I've worked in places like that [pharmacies without a manager] and because they're so used to not having a manager for quite a while is almost like a cartel forms and like they'll be resistant to any kind of authority, any kind of... they rule the roost now and that kind of what happens really. Basically what you have to do is be quite assertive" (Peter, male, under 40)

Participants also described how company management appeared to recognise the importance of staff in keeping the pharmacy business operational in the absence of a pharmacy manager, which the locum felt potentially undermined their own authority with staff. Clearly the third player here in the locum:staff power balance was the employing organisation. Locums felt the power of the organisation to undermine the locum's professional authority with staff:

"They [company managers] will always, always favour their own staff over you as a locum because they don't need you even no matter how good you are or how good you think you are they'll find someone else to replace you, erm, so they'll keep their own staff happy so that the staff will run the shop for them so they look after their own business. FG3 (Mike, male, under 40)

One participant described a disparity between interpretation of company targets by staff and professional decision-making by the locum:

"They [staff] try and implement the knowledge that they have coming through from their seniors, area managers to the best of their ability: But they have a habit of applying it in quite black and white fashion and they don't have that professional autonomy for, to be able to say for example, "This is our target, we must do 'x' amount of MUR's" they don't have that professional autonomy to say, "Actually you do an MUR where its indicated and reasonable and justified and there's gonna be a benefit to the patient" they just think, "Why don't you do this MUR?" (Quinn, female, under 40)

Participants also reported staff not having confidence in the locum's ability as a pharmacist, or making assumptions on the pharmacist's ability:

"There's often an assumption by the staff, for some reason, I'm not quite sure, that you won't know the answer." FG1 (David, male over 40)

"They [staff] say come back when the regular pharmacist is in even though you're here and you can help" FG1 (Barbara, female, under 40)

Locums' consideration of staff is integral to previous discussions of information resources, autonomy and feedback on performance. Staff provided locums with relevant, very local information resources and there was a process of induction and negotiation of roles and responsibilities between the staff and locum at the start of a working day. Locums recognised that this negotiation involved management of risk, as staff competency needed to be rapidly assessed, and any change in routine processes had inherent risk.

The social aspects of working with staff were important to participants, positive and negative social contact could have a significant impact on the locum's working day. Social motivations for locum working have previously been recognised (Shann, Hassell 2006). For pharmacies run without a regular manager, locums recognised the major role that staff play in maintaining the service, which locums felt was also recognised by employers. Some participants also felt that staff had unwarranted negative impressions of locums and in some cases undermined their authority. Relationships between staff and locums appeared intense and multi-faceted. Particularly in pharmacies without a regular manager, the positive and negative impact of staff on professional pharmacy practice is worth further examination.

The themes of the focus groups have now been described. The next section considers some of the research quality issues around undertaking the focus groups and considers how these issues may have impacted on the results.

3.7 Quality issues for the focus groups

The use of focus groups is a well-established technique to determine how a group of individuals constructs meaning around a topic and a number of strategies were employed to assure the rigour of the process. The researcher was supported in undertaking the groups by experienced colleagues and the same researcher moderated all groups, maintaining consistency. The inductive approach taken to the research meant that the process was open to new ideas being presented, outside the initial framework of the topic guide. Divergent views were actively sought during the data collection process and also the analysis, and are clearly presented in the results.

It was intended that the analysis ran alongside the data collection, such that coding of transcripts was taking place as further focus groups were being run. The impact of the early data analysis on future data collection can be identified from changes to the depth of probing during later interviews – some subjects, identified as being important from the data analysis, were explored in greater depth in later interviews. This however was not a perfect process – time delays for transcription meant some focus groups were run ahead of the earlier analyses. However, as the data analysis process includes the researcher listening to the recordings and considering the issues raised, later focus groups were influenced by reflection on the preceding ones.

The focus group results presented here represent the views of the participants involved at a point in time as interpreted by this particular researcher. The research sites were chosen as being convenient for the researcher (within a 90-minute drive) and locums in other areas of

the UK may experience different issues, particularly in regard to availability of employment and pay rates.

All recruits who approached the researcher were accepted as participants, as the maximum number for the focus groups was not reached. Participants who wished to take part in research may have different views and agendas to those who do not. Fortuitously, each group contained a range of participants from the sampling criteria (Table 2: Composition of the focus groups: gender, age, whether worked in one pharmacy or a variety). A fee was paid for participation. All participants accepted the fee and this may have been a motivation for taking part. In the north west England focus groups, the researcher was known to some of the participants through professional networks and this may have influenced participation and group dynamics (some reflection on this was undertaken in the post-focus group note-taking).

The participants were willing volunteers and as such may not share characteristics with locums who chose to ignore the invitation, or who were not within the networks to become aware of the invitation. There is inevitably a bias from this effect, and the research should be considered in this context. It is a truism that locums who are able to be contacted via existing pharmacy networks have greater contact with those networks than those who are not contactable. Locums outside the networks necessary to become aware of the research invitation may be even more professionally isolated than those who responded. In defence of the sample, certain key messages from this research are supported by existing literature (isolation, difficulties accessing learning). In addition, it may be assumed that these messages could be even more pronounced in groups which are further isolated.

There is also the possibility that different communities of locum pharmacists exist, the networks used in this research having identified one, but others may be available. The networks used to identify participants in this study were 'standard' pharmacy routes, in that they were linked to pharmacy professional bodies and organisations. Other networks undoubtedly exist (for example, company networks, locum agency networks, alumni groups) and samples from these sources may have yielded a different variety of views. Using the networks relating to professional bodies could be seen as attracting participants who were more likely to have views that followed the 'party line' issued centrally by professional bodies. Participants who identified more with other networks may have had a different perspective.

Analysis of the demographics of the participants (age, gender, working patterns) was not undertaken in relation to differentiating opinions and experiences by these factors. The purpose of having a range of different types of participants within the groups was to generate as diverse a range of views as possible in a practical manner, not to identify factors relating to a subset of the population. This was not felt to be appropriate as locums are a very diverse group to start with, and to stratify the sample without consideration of individual motivations and situations was not considered meaningful. The number of other factors that may influence experiences would confound any interpretations based on those for participant selection. Other factors might include the main sector of pharmacy worked in, pre-registration experiences, personal financial pressures, but this is speculation and a subgroup analysis was not undertaken due to lack of information on how these other speculative factors might

influence the locum experience. This may prove an interesting area for further research in pursuing a 'typology' of locums.

3.8 Summary

To restate the initial research objectives, the purpose is to investigate professional engagement among locum community pharmacists in terms of their:

- Networking with other pharmacists and professional colleagues
- Professional identity as a pharmacist

To clarify this investigation, the following research questions were proposed, the first two being relevant to this first phase of the research:

- How do locum community pharmacists network with pharmacist colleagues?
- What is the value of networking to locum community pharmacists?
- Do the networking interactions on the LocumVoice forum contribute to development of professional pharmacist identity?

Locums constitute a significant proportion of the community pharmacy workforce and consequently play a significant role in delivery of patient care. It is known that locums are isolated workers and that anecdotally, they have a poor reputation for quality of service – a bad press. This series of focus groups has reinforced a number of factors that already exist in literature on locum community pharmacy, including the difficulties around undertaking CPD activities and lack of processes for feedback on performance. This research creates an innovative, integrated picture of a number of factors supporting locum professional engagement, particularly the mechanisms for feedback on performance, the role of staff in the locum experience and the importance of networking with colleagues.

In particular, this research has highlighted the reported benefits of networking from the locum's point of view. From the focus groups, locums reported using colleagues to reduce their working isolation and for getting feedback on performance, benchmarking their practice, sharing resources, emotional support to reduce stress, support for being assertive by sharing experiences and for enhancing their own professional growth.

The focus groups also revealed both positive and negative experiences of online networking. The next section will address the final research question, by examining the use made of an online locum forum and considering if some of the professional needs expressed in the focus groups may be being met by this method of networking with colleagues.

Phase 2: Locums' interactions online

Phase one of this study explored the nature of the UK locum community pharmacy workforce and provided some insights into some of the professional engagement issues faced by locums. Networking with colleagues was identified as a significant issue for locums – that they value the interactions with colleagues yet lack opportunities to do so. This next phase explores a setting where locum community pharmacists may interact on an online forum.

The next chapter describes how the online forum was investigated, with the results explored and discussed in chapter 5. Chapter 6 provides a conclusion to the study.

4 LocumVoice: locums' interactions online

4.1 Introduction

This phase of the research aims to determine the types of interactions that are undertaken by posters to the forum and to describe the content of the posts, with a view to considering how these interactions may contribute to locum professional engagement. This chapter describes how the forum was selected, ethical considerations for the research, the methodological approach and the practical details of obtaining the research data. The reader is directed to the glossary on page 9 for definitions of terms used.

4.2 How the forum was selected

Pharmacists may interact in a number of online places, and a decision was required as to which site would provide a suitable research location. A list of likely sites was created from personal knowledge of the researcher, from discussion with locum pharmacists and from Google and Facebook searches. A number of sites were discovered searching in May 2013, including:

<http://www.LocumVoice.com/viewforum.php?f=8>

<http://www.pharmacy-forum.co.uk/you-locum-pharmacist/>

<http://www.rpharms.com/sector-groups/locum-group.asp>

<http://www.thestudentroom.co.uk/showthread.php?t=158014>

<http://www.pjonline.com/forum>

<http://pharmlink.com.au/faq/sitemap/>

In addition to the above, various locum agency and pharmacy company websites and Facebook pages were also located.

A list of criteria was created to assess the currency of the sites. In essence, the chosen site should be well-used by individual locum community pharmacists and also used recently. An initial list developed from consideration of issues such as frequency of posting and how recent the latest entries were. Other criteria such as the number of posters (the more the better) and an indication of the nature of posts (whether by organisations, such as course adverts, or by individuals) were also added as the sources were examined. The detail of this review is given in appendix 7.8.

This process rapidly reduced the list of possible sites to two – LocumVoice and Pharmacyforum – due to lack of traffic on the remaining sites. The final criterion was accessibility. A positive response for research to be undertaken was received from the owner/moderator of LocumVoice, so this was selected as the research site. Fortunately, it also rated as the site with the most relevant traffic.

4.3 About LocumVoice

LocumVoice was a UK internet forum for locum pharmacists – not specifically community pharmacy locums. At May 17 2013, it had 2094 registered users, 728 of whom had ever posted a message. Most members used pseudonyms, but there were some (apparently) named posters. The site was moderated. The site required participants to register and login before posting, but posts were publicly viewable. Permission to access the site for research purposes was obtained from the site owner Lindsey Gilpin on December 14 2013. Permission was also obtained to refer to the site by name in this thesis and any related publications. In November 2015, the LocumVoice was closed down by the administrator and is no longer available online. The implications of this are discussed further in the conclusion in section 6.2.

4.3.1 Who were the posters to LocumVoice?

Online, there is often very little way of confirming anyone's identity or indeed characteristics (Jacobson 1999). The site posters mostly used pseudonyms (some did choose to post what appear to be their names). Posters may or may not be locums and they may or may not be pharmacists. They may not have been UK-based. However, the characteristic that participants in this forum did share is that they chose to register with and use a UK locum pharmacist online forum. It is a not unreasonable assumption therefore that the vast majority of posters will feel some affiliation and identification with UK locum pharmacy issues, regardless of their actual status.

4.3.2 Sampling areas within the site

The LocumVoice website consisted of four main areas which are shown in Table 3, along with a description of the number of posts at the time:

Table 3: The posting areas within the LocumVoice forum

	Topics at 17/5/13	Posts at 17/5/13	Date of last post at 17/5/13
“Introduce yourself – this is an area where you can introduce yourself to other members and say a quick ‘hi’”	217	1060	12/5/13
“Discussion area – feel free to post your own opinions or post your own topics. Please note, you must be registered to post here”	5738	95113	17/5/13
“Extra-curricular activities – anything non-pharmacy based”	280	3691	15/5/13
“How to be a locum pharmacist”	67	403	13/3/13

Based on this assessment of number of posts and how recently the areas were used, the ‘discussion area’ was chosen as the one most likely to yield information useful to the research objectives – this in itself is a sampling decision. ‘Extra-curricular activities’ was excluded as being unlikely to cover pharmacy-related activities. ‘How to be a locum’ was potentially a useful section but posting traffic was not sufficient to warrant inclusion.

September 2013 posts were examined to determine the volume of text in one month’s postings. This was to estimate the volume of data that would be obtained per month, to ensure that sufficient data were gathered for the analysis.

The posts for the month were copied into a Word document and the word count obtained. The document was then deleted. Approximately 65,000 words were retrieved, which suggested a body of text of approximately 130,000 words over two months. This was felt to be adequate to provide a reasonable sample for analysis.

Some consideration was given to whether posts on the forum have any seasonality – whether there are times in the year when posting is more frequent. A count of posts (new threads and the number of posts in each thread) per month over the last year was undertaken to review this. The number of new threads started per month was also counted, as it was noticed that a popular thread would strongly influence a monthly post count (ie, one popular thread in a month could have several hundred posts).

The results are shown in Table 4:

Table 4: Posts per month on the LocumVoice forum

Month	Sep 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13
Posts/month	1963	1737	1472	2377	1315	1606	1047	1818	1977	869	623	1222	1447
Threads/month	82	99	100	114	78	81	56	73	71	39	51	67	69

It was felt that, apart from the possibility of a summer dip, sufficient data would be available for analysis at any period during the year. Following ethical approval, the data collection period was set as February 10 to April 9 2014.

4.4 Ethics and online research

Having established that the LocumVoice forum was a suitable and available site for research, some of the decisions involved in online research are now considered. Research online is in most respects similar to research in any other setting, but there were a few specific issues to be considered in the online environment. When undertaking research online, the degree of interactivity between the researcher, the research process and the participants needed to be considered (Eysenbach, Till 2001), as this may affect the ethical considerations and also possibly the research outcome. The research undertaken here was unstructured, non-participant observation, in that no interaction with posters to the site by the researcher was planned or undertaken, and there was no pre-planned structure for data generation (Bryman 2012 page 237). The researcher had also never posted to the site prior to the research.

The research process was not totally covert, because, as described in section 2.4, in order to obtain consent, a message announcing the research was posted on the site. On the last date of data collection, this announcement had been viewed 333 times by posters (the site recorded the number of views), indicating at least some awareness by posters of the research process. However, the fact of research taking place was not mentioned in any forum discussion and despite the fact that the researcher's contact details were included in the message for further information, no contact from posters was received by the researcher.

A number of ethical questions have been suggested for online research that takes place opportunistically and with passive consent, that is, when the website has not been specifically designed or instigated for research purposes. Those questions are:

- When and how is material posted classed as public or private?
- Does the analysis of messages posted online represent an intervention of any kind?
- What are the expectations of participants online concerning how the information will be used?
- How can individuals' anonymity be protected? (Whitehead 2007 page 788)

These questions are now considered. LocumVoice was a public forum, in that no login was required to view posts – at the time of the research they were freely available on the internet, but participants had to register to post. However, as mentioned by Sixsmith and Murray (2001), what might be considered public or private space is a contested issue, for example, a private conversation might take place on a public park bench. What is perhaps more relevant online from an ethical point of view is the participants' beliefs about the privacy or otherwise of the forum, rather than the actuality of it being publicly viewable. There should also be consideration of the uses to which participants might reasonably expect their data to be put. It has been stated that having to register means participants are more likely to regard the forum as a private space (Eysenbach, Till 2001) and to not expect to be researched. Eysenbach and

Till (2001) also conclude that the participants views on the privacy or otherwise of the forum must be considered. This is not a clear decision however, as Seale (2006) undertook research into UK cancer forums which are publicly viewable and require a registration process to post. The researchers took the view that “because these are open access public forums postings were considered to be in the public domain for ethical purposes” (Seale 2006 page 348), meaning that individual consent from posters was not sought.

Whilst the LocumVoice forum was publicly viewable at the time of the research, it was a login forum where there is little expectation that research activity would take place. The public availability of the information was acknowledged by the facilitators, who would delete posts that provide too much personal detail about individuals.

In summary, the forum, whilst public, was not a place where participants would reasonably expect to be researched. For this reason, the research was announced beforehand to participants and a process of consent was instigated.

Consent has two aspects for this research – consent from the forum owner and consent from the forum users. Consent from the forum owner may not be strictly speaking essential for the research to take place, but was obtained and co-operation from the forum owner facilitated the research process.

Consent from forum users is more problematical, given they are a largely anonymous and transient population. Eysenbach and Till (2001) note a ‘prospective’ method of consent, posting information that gives participations the opportunity to withdraw from the forum or the research; and ‘retrospective’, asking participants for their permission to use previously posted material.

Prospective consent can be intrusive, as participants may change their behaviour as a result of the awareness of being researched. Retrospective consent can be ineffective as participants may no longer be involved in the forum so unavailable to consent. Retrospective consent may also provoke a negative reaction from participants, given the fact that they were probably not expecting research to be conducted on their words.

A process of general prospective consent was put in place for the research. This involved a message (posted as a ‘sticky’, or message that remains at the top of the message board list) that alerted forum users to the fact that research was taking place during a specified time period in the future. A brief summary of the research and contact details of the researcher was included. Consent was ‘opt-out’ – users who did not wish their information to be included were advised to email the researcher to state this. Any information from that user would then be deleted from retrieved data and not used in the analysis. A list of any users who declined to have their information included in the research was kept in a password-protected file by the researcher to enable this process of data deletion from the results.

Whitehead (2007) raises the question of if the analysis itself constitutes an intervention. The consent process is relevant here, as it was the only contact that the researcher made with the forum. The impact on the forum users of knowing that they are being ‘observed’ during a particular time period is not known.

Flicker et al (2004) have put forward a series of ethical guidelines for researching internet communities, which includes guidance on information that potential participants should receive about the research. This suggests including a web link to information on the researchers and institution responsible for the research and their contact details, a description of the aims of the research, any potential harm or benefits, any conflicts of interest, steps taken to ensure confidentiality and anonymity and details of ethical approval obtained. A link to the University of Central Lancashire School of Pharmacy and Biomedical Sciences was created providing the information for participants shown in appendix 7.10.

Most posters on LocumVoice used pseudonyms that they created as part of their registration process, but not all did. Some participants used a pseudonym as their login name, but added their real name (or what is apparently their real name) at the end of their post. Jacobson (1999) notes that pseudonyms are sometimes a valuable property of the user. Pseudonyms may be carried by an individual across several different forums and may build a reputation for the user, creating a 'digital persona'. As such, pseudonyms may have meaning and value for the user, and may become well known in a particular community. Because of this, all pseudonyms created by users, and all real names, have been anonymised in this research. Where necessary, new code names for individuals have been created by the researcher to report findings. Information linking the new code name to a pseudonym or (apparently) actual name has been kept in a password-protected file by the researcher.

Part of the ethical consideration of this research is any potential harm that may occur to participants as a result of the investigation. Reputational harm to the forum was also considered. Eysenbach and Till note that privacy issues 'should be considered whether publication of the results (especially when mentioning the group name) may negatively affect group members or harm the community as a whole' (Eysenbach, Till 2001 page 1104). Given the fact that there are only a small number of locum pharmacy forums in the UK, the researcher considered that there was little to be gained by not revealing the name of the forum. It will be obvious to the reader that the forum is one of three or four, which does not provide sufficient anonymity. The forum owner confirmed that she was happy for the forum to be named in the research thesis and any publications.

In considering whether harm may occur to participants from the research, the already public nature of the posts was relevant. There was a moderation team within the forum that screened posts before publication and did occasionally post warnings about content (examples of unacceptable posts might include discussing identifiable patient information or illegal activities). It was considered by the researcher that the research posed no additional reputation threat to the forum or to the posters. In summary, the ethical considerations for this online research have established a process of announcing the research on the site via a sticky and respecting poster-created pseudonyms as well as proper names.

Having considered ethical issues around online research and established the viability of the site as a research location, details of the data collection and analysis process are now described in the following sections.

4.5 Data collection

A sticky was posted at the top of the discussion area of the LocumVoice forum for two weeks prior to the start of data collection on February 10 2014. This was part of the consent process and announced that research would be taking place and provided a contact link for further information. The last day of data collection was April 9 2014. The next day, all threads from the period February 10 to April 9 2014 were copied and pasted from the site. Each thread was copied into a separate Word document (for storage purposes) and then amalgamated into a single document. Parts of threads that were outside the data collection period were not copied.

4.5.1 Data cleaning

The downloaded material from the site contained a variety of extraneous words and characters (metadata) that were incidental to the research, for example, headers for each post that contain the poster's name, the date and time. The data was 'cleaned' to remove this metadata leaving only the typed text of the posters. The protocol for data cleaning is shown in appendix 7.11.

The data collection process thus yielded a Word document containing all posts created during the research period, cleaned of metadata.

4.6 Analysis of the online forum

The objectives for the online phase of the study were to determine the type of interactions undertaken by posters to the site and to describe the content of the posts. The analysis of the interactions and the content was undertaken concurrently as described below.

4.6.1 Approach to the analysis

As described in section 2.2, this study has a broadly inductive, constructivist approach; inductive meaning that there is no initial hypothesis to be proven, the data itself should be allowed to drive development of ideas and constructivist in that it is put forward that there is no objective truth about the situation to be uncovered, more an interpretation by the researcher and the research process.

In the light of this, the approach to the online phase of the research will be discussed. The first phase of research described in chapters one to three consisted of a series of focus groups, where the researcher was clearly part of the process of data generation and analysis and this influence was explored in section 2.3. In this next phase, the influence of the researcher was much less, but was still present. The online phase is essentially non-participant observation of the site – the researcher had very minimal influence on the process of data generation on the site, other than announcing that data collection was taking place. The influences of the researcher on the analysis process as described in section 2.3 will however still apply. The

constructivist approach is sustained by consideration of and reflection of the role of the researcher in interpretation of the data.

4.6.2 An integrated thematic and interaction process analysis

The research aims and objectives created a focus for development of the analysis process. It was important in order to achieve the objectives to identify the topics being discussed and also to highlight the interactions occurring between posters. The interplay between these two elements was significant, so the analysis process had to facilitate integration of the content and the interactions. In terms of interpretation of the data, how posters were talking about issues needed to be integrated with the issues that were being discussed. This research study explores professionalism concepts within locum community pharmacists' interactions – an analysis that studied interactions of posters discussing non-pharmacy issues (eg music, football) would not provide meanings that were pertinent to pharmacy professionalism. It is in the discussion and interaction around pharmacy topics that professional mores are developed. Hence, in analysing and presenting the results, it was necessary to demonstrate the types of interactions that were occurring around *pharmacy-based* topics. To facilitate this, the analysis of the types of the interaction and the content were run simultaneously, and the results presented together. To achieve this, an adapted version of Bales' interaction process analysis was used, which is described in the next two sections. In summary, to explore professional engagement, some appreciation of the professional content of the data is required, along with an appreciation of what the research participants were doing with that content. Either part alone does not provide the complete picture.

4.6.3 Interaction process analysis

To determine the types of interactions that might be occurring, the researcher investigated frameworks that described interactions in communication that could be applied to an online discussion forum between peers. One framework that strongly influenced this study is Bales' framework for interaction process analysis (Bales 1950). Bales' framework was derived from study of small group dynamics and is concerned with the 'emotional tone' of interactions rather than the content (Stewart 1984). Bales' framework was originally developed to examine small group interactions and applied to voice recordings. There is experience of satisfactorily using Bales' interaction process analysis framework with online, non-verbal interactions (Fahy 2006) so the framework was considered appropriate for use in an online, peer discussion forum.

Bales' interaction process analysis was derived from observation of small interacting groups of individuals, so it was felt necessary in this study to demonstrate that the forum did actually consist of small groups, to validate use of Bales' analysis. This demonstration is discussed in section 5.1 and the data to support it provided in appendix 7.14.

Bales presents his method of interaction process analysis as a 'type of content analysis in the basic sense' (Bales 1950 page 258) in that the method uses observation of the data to identify the purpose of each act. The basis of the method is to categorise communication behaviour in

small groups ‘act by act’ to identify the nature of the interactions between participants. Based on his empirical observations, Bales identified twelve categories of interactions that could be grouped and paired, as shown in Table 5.

Bales’ framework describes a balance, or tension, between the task or process areas and the social-emotional areas. There are four ‘function’ areas (column one in Table 5), relating to positive and negative socio-emotional interactions and task areas. These are then further divided into twelve process categories which are paired into six groups of orientation, evaluation, decision, tension management and integration. Bales suggests that these six pairs as being stages of problem solving activity in groups, though does comment that this is an over-simplistic view (Bales 1950). In brief terms, interactions will commonly start with some process of orientation, or deciding what a particular situation is about, followed by an evaluation process of what attitudes should be towards the situation. This is followed by control processes, where the group consider what to do about it, followed by decision. Bales put forward that these processes applied to all group processes, not just those with a clear problem-solving agenda.

Table 5: Bales’ framework used for the analysis.

Function	Process	Pairs
Social-emotional area - positive reactions	1. Show solidarity: raises others’ status, gives help, reward	1 and 12 Integration
	2. Shows tension release: jokes, laughs, shows satisfaction	2 and 11 Tension management
	3. Agrees: shows passive acceptance, understands, concurs, complies	3 and 10 Decision
Task areas – attempted answers	4. Gives suggestion: direction, implying autonomy for other	4 and 9 Control
	5. Gives opinion: evaluation, analysis, expresses feeling, wish	5 and 8 Evaluation
	6. Gives orientation: information, repeats, clarifies, confirms	6 and 7 Orientation
Task areas – questions	7. Asks for orientation: information, repetition, confirmation	7 and 6 Orientation
	8. Asks for opinion: evaluation, analysis, expression of feeling	8 and 5 Evaluation
	9. Asks for suggestion: direction, possible ways of action	9 and 4 Control
Social-emotional area – negative reactions	10. Disagrees: shows passive rejection, formality, withholds help	10 and 3 Decision
	11. Shows tension: asks for help, withdraws out of field	11 and 2 Tension management
	12. Shows antagonism: deflates others’ status, defends or asserts self	12 and 1 Integration

4.6.4 Limitations and adaptation of interaction process analysis

Bales' interaction process analysis provides a framework for examination of the types of interactions that are occurring on the online forum, but does not provide a method of integration of the interactions and the content required to meet the research objectives.

It is worth reiterating that the purpose of identifying the content of the posts was not to thoroughly survey the topics discussed. For this study, the content is only of use or interest when it is integrated with the types of interactions undertaken, to investigate the role of those interactions in developing professional identity. This has an impact on both the method of analysis, and how the results are presented in this thesis (discussed in section 5.2).

To an extent, Bales' framework may provide too simplistic a view of interactions. For example, the fields of opinion and orientation are necessarily very broad and will contain within them a number of important concepts that may be missed if the interaction is provided with such a broad label. The framework does provide identifiers for each category (for example, orientation provides evaluation, analysis, expresses feeling, wish) but in its basic application Bales' interaction process analysis may be insufficiently nuanced and produce too crude an analysis to meaningfully deliver the research objectives.

To counter these two reservations, the analysis was adapted by the researcher in two ways. Firstly, a method of integration of the interaction types and the content was devised. This involved simultaneously categorising the interaction type of the data and undertaking a thematic analysis of the content. This meant the two elements could be linked. Secondly, to ensure that the depth of meaning in the interactions was captured, the researcher created a code for each type of interaction based on her interpretation of what was happening, for example, 'asking a question' or 'sharing a memory'. Then a further process of grouping these interactions into Bales' twelve process categories occurred. This allowed for a more sophisticated interpretation of the broad categories. In this way, Bales' interaction process analysis provided a framework for the data analysis, but the more subtle detail of the interactions was not lost, and it was possible to link the interaction type to the content discussed. This supports the overall inductive approach to this study.

In summary, both these adaptations were important to achieving the research objectives. Taking the viewpoint that there is no 'recipe book' approach to research method, the researcher considered the appropriateness of existing frameworks and methods to achieve the research objectives and made the adaptations that would help achieve the research outcome. The practical application of these two adaptations is described in the next section.

4.6.5 Analysis process

The cleaned data within the Word document was copied and pasted into an Excel spreadsheet. This created a file where the first column contained a series of lines of text. Each line could contain one or more sentences from the data – the format was dictated by the paragraph breaks created by posters in their threads. The paragraph of text created by the poster (one or

more sentences) was thus the unit of analysis. This was taken as the unit of analysis to maintain context – it was found easier to determine the purpose of the interaction and its content from sections determined by the natural breaks created by the posters. A sentence-by-sentence analysis was possible, but the loss of context made analysis more difficult.

The following columns were created within the Excel spreadsheet, with a description below of the purpose of the column:

Text	Function of the post	Bales' process	Function codebook notes	Content of the post	Content theme	Content codebook notes
The downloaded data sectioned by natural paragraph breaks	A word or phrase that summarised the interaction's function.	A grouping term that categorised functions into Bales' processes	Notes on the meaning of the function to aid coding.	A word or phrase that summarised the post's content.	A grouping term that categorised content into themes.	Notes on the meaning of the content to aid coding.

Each unit was then examined to determine a function for the types of interaction taking place and to code the content of the post – what it was about. The codes were added under the column headings next to the text.

Lines of text in the spreadsheet were often multiple-coded – several functions and content codes were allocated to the section of text. Additional lines were added into the spreadsheet under each post to accommodate this. The filter facility within Excel was used to maintain an overview of the developing codes and also to rationalise the codes and themes as they developed. The codebook notes columns contained a justification of the theme for each line in sufficient detail to enable another to identify the derivation of the theme.

A memo document was also created to track the researcher's thought processes and notes on the developing themes (appendix 7.12). A review of developing themes was undertaken each time several hundred lines had been analysed, when the existing themes were examined for clarity of definition. This was done in collaboration with the research supervisory team where the researcher was asked to clarify and justify the coding process. At these points, some themes were combined with others or divided into separate themes where appropriate. Notes of these changes were made in the memo document to describe the development of the themes. At the same time, notes were made on the emerging overall themes, in terms of defining the theme and consideration of the relevance of the theme to the research objectives. Again, these considerations were discussed with the supervisory team. In this iterative way, the identified themes changed and developed as the analysis progressed.

It was important for the analysis that the content themes were integrated with the interaction themes, so the following process was followed to link and explore the content in the context of the interaction. Each main interaction theme was isolated in Excel using the filter facility. This revealed all lines of text coded to that theme and alongside, identified the content themes also associated with that interaction. For example, filtering the 'information' interaction theme

identified 25 content themes that linked with information provision. At this point, the researcher re-examined the raw data in this new context of integrating the interaction and the content, which avoided losing context and facilitated interpretation of the results.

At this point also, the research objectives were reconsidered in the light of the developing findings to determine what was relevant in the context of those initial objectives, and also what new concepts were developing that might not have been originally considered, but were still relevant to the overall research aim. This supported the overall inductive research approach, whilst still keeping focus on the research aim.

The conclusion of this analysis process was a description of the types of interactions being undertaken on the forum, linked to the content of the posts. As mentioned above, this integrated analysis was felt necessary to demonstrate any professional purpose of the forum for participants. In the next section, ethical considerations for the research are considered.

4.7 Summary

This chapter has described the nature of the LocumVoice forum and how the analysis was conducted. Ethical considerations for online research and how these were dealt with have also been discussed. The data collection consisted of a download of two months' posts from the discussion area of the LocumVoice forum. The data were analysed using an adaptation of Bales' interaction process analysis, which integrated consideration of the type of interaction with the content of the posts. The results of the analysis are described in the next chapter.

5 Results of the online analysis

The research questions posed for this study were:

- How do locum community pharmacists network with pharmacist colleagues?
- What is the value of networking to locum community pharmacists?
- Do the networking interactions on the LocumVoice forum contribute to development of professional pharmacist identity?

The focus groups undertaken in phase one of this study highlighted the difficulties that locums face when attempting to interact with colleagues, reinforcing previous research about the isolation of their role. The value of networking to locums was reported as using colleagues to reduce their working isolation and for getting feedback on performance, benchmarking their practice, sharing resources, emotional support to reduce stress, support for being assertive by sharing experiences and for enhancing their own professional growth. Locums in the focus groups had mixed views on the value of online networking and the second phase of the study aimed to analyse the types of interactions that were occurring on an online locum forum. The details of that analysis are presented in the sections that follow. Firstly, consideration is given to whether the forum did actually consist of small groups of interacting individuals, required for use of Bales' framework.

5.1 Does the forum consist of small groups?

Bales suggested that groups of between two and twenty individuals would be manageable for using interaction process analysis, but with no clear upper limit to numbers. He put forward that the main factor was that groups should be sufficiently small that members were able to recognise and acknowledge reactions of others (Bales 1950). How the posters interacted on the forum would impact on the validity of this research, for example, a list of single posts by individuals with no response from others would not constitute any obvious interaction. This section reflects on if small groups of interacting individuals exist within the LocumVoice forum.

A numerical analysis of the posting activity was undertaken, which is provided in appendix 7.14. This demonstrates that the forum did consist of a number of engaged individuals coming together as small groups to discuss issues. Of the posters who interacted during the research period, half were significantly engaged with discussion on the forum and half less so. The forum was not dominated by one or two individuals, most initiated conversations obtained a response and these responses consisted of multiple interactions from a number of individuals. The appendix provides the data to support these statements.

In summary, analysis of the details of the numbers of threads, posts and posters has shown that small interacting groups do exist on the LocumVoice forum, that were not dominated by

one or two individual posters. This supports use of Bales' interaction process analysis in this setting. The results of the analysis are now described, starting with an explanation of how the results will be presented.

5.2 How the results are presented

Through analysis a series of codes were produced, based on the types of interactions that were occurring and also codes based on the content of the text. An example of the coding process is provided in appendix 7.13. The research participants on the forum are referred to as 'posters' in this chapter (see glossary on page 9).

The results are illustrated by quotes from the forum and the quotes are provided verbatim, as copied from the forum. Thus, any capitalisation, emphasis or spelling errors are those of the posters. Posters' names and pseudonyms were replaced as part of the anonymisation process with the word 'Poster' and a number to identify each poster. These are left in the quotes where it is illustrative of the interaction.

In total 2009 lines of text were analysed. As described above in section 4.6, each line represented sections of text of one or more sentences – the returns created by the poster were used to differentiate the sections. A total of 5092 lines were actually present, but the balance was made up of the name of the poster as created automatically by the website software and of also blank lines between posts.

The results are presented in this chapter organised into Bales' two main divisions – socio-emotional and task areas (see Table 5). Within the task areas, the processes of orientation/information, opinion and suggestions are described. In addition, the content that posters discussed is also considered, alongside the interaction type. It is important to note that text was very often multiple-coded, in that the text may have consisted of more than one interaction or content theme. This is reflected in presentation of the results, particularly where links are made between the different types of interactions that may have been occurring simultaneously. An example would be where a piece of information was provided, along with an opinion on that information. The two adaptations that were made by the researcher (described in section 4.6.4) are also evident the results presentation; the more nuanced descriptions of interaction types are provided and the content of posts is presented integrated with the interactions.

The Bales' framework was used as an outline to present the results of the analysis, but it is important to note that the analysis was an adaptation of Bales, integrating the content of the posts with the types of transactions. As mentioned in section 4.6.4, this study does not provide a survey of the content of the forum, but uses the content data to support the analysis of the interactions between the posters. The next sections therefore present the results of the analysis under the headings of Bales' interaction process analysis, including discussion of the content.

5.3 Sharing suggestions, opinion and information

Giving and requesting information, suggestions and opinion relate to Bales' process categories as shown in the table below. The sections below describe the types of interactions that were occurring on the forum that were coded to these categories, and the content themes associated with the interactions.

Table 6: Bales' task areas

Function	Process
Task areas – attempted answers	4 Gives suggestion: direction, implying autonomy for other
	5 Gives opinion: evaluation, analysis, expresses feeling, wish
	6 Gives orientation: information, repeats, clarifies, confirms
Task areas – questions	7 Asks for orientation: information, repetition, confirmation
	8 Asks for opinion: evaluation, analysis, expression of feeling
	9 Asks for suggestion: direction, possible ways of action

5.3.1 Suggestions

Suggestions imply direction or particular ways of action. Posters gave a variety of suggestions to others, some in response to requests, though many were unprompted. Often the intent behind the suggestion seemed more directive than the word indicates – the researcher created codes of 'instruction' and 'exhortation' to describe the greater force of the suggestion.

These more forceful suggestions often formed part of discussion threads on development issues related to the pharmacy profession as a whole. Pharmacy development concerned issues such as new pharmacy services and ways of working as pharmacists. The examples below were coded exhortation and appear to represent a call to action, with the posters urging others to take a particular stance or action:

'We need to form 'firms' of pharmacists (and other health professionals) to apply for commissioning for Pharmaceutical Care. Do it now with your colleagues because you may need 3 years accounts when applying for commissioning' Poster 7, line 508

'It is no good saying what pharmacists could do - no one will listen. Tell them what you ARE doing' Poster 7, line 511

'Let's get moving immediately on this and get our people back into decent work and as Poster10 says let's clear the GP and A&E backlog' Poster 8, line 280

Suggestions also related to the pharmacist's job role and the types of tasks that a pharmacist should be undertaking. In this next example, the poster suggested roles for pharmacists and pharmacy technicians in a text section that also demonstrated the opinion of the poster. This quote also represents an interesting demonstration of the rhetorical device of repetition of a word three times ('let', 'let', 'let') which provides added emphasis to the suggestion:

'LET the technicians dispense the 80% of standard repeats that require little pharmacist intervention. Let the final check be done by an ACT as long as the pharmacist has clinically checked the script. Let pharmacists concentrate on the 20% of prescriptions that really NEED a pharmacists input' Poster 2, line 311

The job role of the pharmacist was explored in the next example, with suggestions from the poster about the future of the profession. Again, this is a directive backed with the poster's opinion:

'Forget dispensing and selling medicines - there will always be plenty of pharmacists to do that. Forget talking about counselling, medicines optimisation and encouraging compliance because you don't do that. You think you do but you don't' Poster 7, lines 519-521

Political discussion relating to pharmacy also provided strong imperatives to action, with posters urging others to become more politically active within the profession. This thread discussion raises involvement with elections to the Royal Pharmaceutical Society English Pharmacy Board and Northern Ireland Pharmaceutical Society Council:

'If you don't agree with the way I think things should be then get in touch, start a discussion, vote for whoever you think represents you best - but start standing up for your own future!' Poster 4, line 1071

'And whether you agree with Poster 21 or not. make use of your vote. Apathy gains you NOTHING' Poster 2, line 1080

Some posters did request suggestions from others on the forum, but these were not as frequent as unprompted suggestions provided by posters. In relation to the development of the pharmacy profession, one poster posed a plea:

'Where are we going wrong?' Poster 8, line 506

Not all posts were of such a general nature. Some posters asked for suggestions of their own individual situations. As an example, this poster asked for a suggestion for action when faced with a dispensing job role that they felt was unsatisfactory, relating to the tasks that pharmacists should undertake. Again, this is supported with opinion from the poster on the appropriateness of the task:

'I initially rejected as I felt and feel this is not a pharmacists-job. Popping out tablets for hours. Am I too arrogant? I feel this is not in my "job description"' Poster 24, line 1139

In summary, posters did ask for and give suggestions for action in their interactions on the forum. The majority of suggestions were provided unprompted and not in response to requests. Requests for suggested actions were much less frequent. Suggestions related most

commonly to pharmacy professional development issues, which encompassed pharmacy politics, development of the pharmacy profession and services and the nature of the pharmacy job role. Some of these were general discussion and others related to particular work situations for posters. However, most suggestions appeared to be forceful calls to action directed at the other posters, nicely summarised by the following quote:

'Looking forward to returning to being a LocumVoice agitator' Poster 5, line 644

This picture of political agitation and discussion of broad themes of pharmacy professionalism and development supports the proposition that the forum assists in development of professional mores and values. Benson et al (2009) have described values as those things which make the profession worthwhile. What those things are is socially created by interaction between individuals (Ashforth, Mael 1989). The exhortations and suggestions for action demonstrated on the forum can be construed as examples of value-making in action – small groups of individuals creating a sense between them of what it means to be a pharmacist. This is described by Resnick et al (2004 page 258) as shared thoughts that enable members of a group to create a 'common interpretive framework for their experiences'. Sharing experiences about appropriate tasks for a pharmacist to be undertaking in a pharmacy helps create part of that framework.

5.3.2 Opinions

Sharing opinion was by far the most numerous type of interaction on the thread. In addition, opinion was often sought on hypothetical situations or more general issues, rather than specific situations. A typical format for a thread would be for a poster to provide a piece of information (often a link or news article) and then ask for opinion on the situation, prompting responses from a variety of other posters. Posters often brought their own experiences into the discussions also. The types of issues discussed included learning activities, counselling of patients, the job role of the pharmacist, professionalism issues and pay.

Learning activities formed the focus of a number of discussions where opinion was provided. This included straightforward opinion on the value of a learning activity:

'I did Good Brian (sic) Bad brain . It was interesting' Poster 2, line 36

'The drugs and addiction course was VERY good. And all these courses are that great price of FREE' Poster 3, line 38

Opinions on learning preferences were also provided, with posters giving their views on the types of learning activities that they had undertaken, such as role play and video:

'The workshops are OK I was at one last night as it happensalthough it included a role play section....great for those who like me do role play for a hobby but as a teaching tool it loses a lot when the participants are uncomfortable with the concept' Poster 2, line 79

'Just completed first week of Medicines Adherence course. Basically it contains first few pages of CPPE Consultation skills for pharmacy practice, but I feel that I understand the concept of

non-adherence better after watching videos. I find this form of learning much more enjoyable that (sic) dry CPPE booklets' Poster 3, line 45

Posters also gave opinions on pharmacy practice activities such as counselling patients. The next example was prompted by a hypothetical question from another poster, asking if counselling patients to take their medicines as directed by the prescriber was always a good thing. A series of posters then gave their opinions on a variety of scenarios:

'If I am talking to a patient who doesn't want to take an anti-depressant because they find the side effects unacceptable (and as long as withdrawal is not going to be a problem) I would not necessarily try to persuade them to take it - it would depend on the circumstances' Poster 2, line 173

'If I was confronted with a patient who didn't want to take Metformin for their PCOS, its their choice and I would not push it' Poster 3, line 176

Opinions were also shared on the concept of 'thinking like a pharmacist', which described the thought processes and behaviours of a pharmacist. This links with the content theme of the pharmacist's job role described above. Posters shared opinions on professional behaviours by discussing pharmacy practice examples. One example of a conversation around this topic is described below, where a poster asks for opinion by posing a hypothetical scenario. Other posters then respond with various opinions, leading to a summary of their professional thought processes by the original poster. The four text sections below, which are part of the same thread, illustrate the interaction:

'Do you encourage your patients to take their medicines as prescribed? If so, why?' Poster 7, lines 89-91

'I would ALWAYS do my best to persuade a reluctant patient to take all their medication but if they are obviously reluctant I would suggest they go and have another chat with their doctor, or at very least TELL their doctor they are not taking them' Poster 2, line 98

'This is a trick to stop you thinking like dispensers and start thinking like pharmacists' Poster 7, line 144

'My brain thinks like a pharmacist not a dispenser anyway!' Poster 2, line 149

A second example of sharing opinion on professional attitudes and roles is provided by the next text segment. This thread was initiated by a poster presenting information from an article in the Sunday Times newspaper supportive of the developing role of the pharmacist, which prompted discussion on what that role should be. The two text sections below are from the same thread and illustrate posters responding to a prompt for discussion by putting forward their own opinions on the role of the pharmacist, showing how the conversation developed. The first poster put forward an opinion on new roles for pharmacists (hence this is also a suggestion for action), followed by another poster who presented barriers to the idea:

'The real need in the NHS, now that pharmacists have been released from invention and synthesis of new medicines and also from compounding, dispensing and even full checking, is for pharmacists who can prescribe and diagnose' Poster 8, line 298

'the public may not be able to make the most of their pharmacists who are often discouraged from spending much time with patients and are instead forced to put through as many prescriptions as possible with the minimum level of staffing' Poster 8, line 317

This pattern shown above of a hypothetical question or scenario being presented to prompt debate was repeated a number of times on the forum. Opinions were also provided about real-life situations presented by posters, such as whether a particular task was appropriate for a pharmacist to undertake. This next example provides an opinion on a query from a poster as to whether they, as a pharmacist, should spend time dispensing medicines into monitored dosage system trays:

'It isn't an easy question. On the one hand popping out the tablets is a waste of pharmacists skills and knowledge. On the other hand checking the trays have been set up correctly with the correct tablets in the correct time slots can be a nightmare' Poster 2, line 1164

Opinion gathering, as opposed to giving, was much less frequent on the site, which is to be expected from a numerical point of view, with the natural flow of conversation whereby someone asks a question or poses a problem and others respond. The responses will naturally be more frequent as a variety of people reply. Again, some requests for opinion were around hypothetical, general situations. The example below poses a question about prescribing values:

'We are told that patients are 'over medicated' - do you believe that?' Poster 7, line 138

Similarly, in the following example, the poster presents a link to a news article on the meningitis B vaccine and poses the following question. This demonstrates posters sharing information and then discussing the implications in more general terms:

'Now are the manufacturer's trying to make too much profit or are constraints on the NHS causing manufacturers to sell to the NHS at less than it costs to make it?' Poster 2, line 819

This process of asking for general comment based on a specific situation is repeated in this example below, where the poster presents information that a locum pharmacist is working for a very low rate of pay and prompts general discussion with the following statement:

'What has happened to this profession?' Poster 8, line 1040

Sharing of opinions is a further way of creating a set of common values, or culture. Festinger (1957) described 'social comparison', the mechanism whereby for an individual, uncertainty is reduced by comparing their own situation with others in a similar position. This relates strongly to development of professional identity, highlighted particularly by the quote '*thinking like a pharmacist*' cited above. Between them, posters are sharing views on pharmacy situations. An interpretation of this is that in doing so, they are creating their own framework of meaning about what it means to be a pharmacist – a 'common interpretive framework' as

described by Resnick (2004). By presenting current news issues to each other, posters explore the meaning and interpretation of these issues from a pharmacists' perspective – the two-and-fro of opinion around the topic establishes a position for those taking part. This is interpreted as an indicator of professional identity formation.

5.3.3 Information

Information provision was also a frequent type of interaction on the forum. Posters requested and provided information about a number of pharmacy issues, which are explored in the quotations below. A few non-pharmacy topics are also described. As described above, information and opinion often appear within the same threads.

Information was often shared about learning activities, the most frequent interaction type being posters offering information to the forum by posting a link or comment on a learning activity. The two quotes below illustrate simple provision on information on the existence of a learning activity:

'Just completed first week of Medicines Adherence course' Poster 3, line 40

'The CPPE have information out on preparing a business case to tender to commissioning groups' Poster 2, line 80

Information on pharmacy practice issues was also shared, including details of medicines use. In the example below, the poster provided a link to a news article about a new indication for a drug:

'Hope I got the whole link this time. In case I haven't its about Oxytocin being a possible treatment for anorexia nervosa' Poster 2, line 778

Some posters did ask for information, though this was less frequent than unprompted information provision. In the quote below, the poster poses a question relating to a pharmacy practice issue:

'Ketamine for depression will they develop an oral form?' Poster 2, line 933

This again prompted other information sharing, with another poster providing some supporting information and anecdote on this topic:

'Ketamine is being used orally as an adjunct in intractable pain. I have seen two community patients on long term. Both were using Ketalar orally' Poster 16, line 940

Two further posters then engaged in storytelling activity around the same topic. Within the same ketamine thread, the first poster tells an anecdote about related drug therapy:

'There used to be a Continental treatment for depression which involved continuous barbiturate dosage so that the patient remained in a semi-coma for weeks at a time. One also recalls that Michael Jackson spent much of his last weeks under treatment with ketamine' Poster 10, lines 947-949

Another poster then picks up on the same issue in the thread with a story of their own:

'When I joined Roche in the 60s, they had an ultra long acting Barbiturate. For some reason, Allonal comes to mind. Will check' Poster 14, line 959

These two examples of oxytocin and ketamine demonstrate posters giving and requesting information on drug-related issues. The information sharing also prompted posters to share stories and histories of their experiences related to drug therapy.

General health and NHS issues were also raised, again via posters providing a link to a news article and offering the information to the rest of the forum. This line below was provided along with a link to a BBC news article on fraud:

'All about fraud in the NHS' Poster 2, line 867

This introduction then prompted a series of other posters to recall stories of their own experiences. In the example below from the same thread as the quote above, the poster provides a story that relates to his/her past involvement with fraud issues:

'In my PCT days, just before I retired, I was asked to meet with a new Director of Finance. What systems, he wanted to know, did we have in place to prevent fraud arising as a result of collusion between independent pharmacists and single handed GP'? He was quite surprised when I said none, there being only two indies in the patch, although there was one small multiple, and IIRC there were no single handed GP's' Poster 6, lines 891-893

Another example of storytelling involved posters sharing experiences of patients' medicine-taking behaviours. Various descriptions of patients' seemingly irrational behaviour were provided, the example story below relates to a patient's understanding of inhaler use:

'Another one I have come across is constantly testing Salbutamol inhalers as someone told them to always do a test spray. This has morphed into testing the inhaler every hour or so to make sure it is still working, and that it hasn't run out. Ever walked into a room with a salbutamol mist?' Poster 4, lines 124-126

A further tale relates to patients' experiences of medicines and served to illustrate their opinion on a patient-centred approach to counselling patients on their medicines. Whilst this is a long quote, it is presented here as a good example of storytelling. Again, opinion and information are presented together. The poster presents her/his opinion on patient autonomy in medicines-taking and illustrates the point with a story:

'I also respect the fact that the patient knows their own body and how a drug makes them feel. Many years ago when I was still doing my degree we were told the story about lots of little of old ladies who complained that their tablets were making them feel ill Nothing had changed in their medication same dose same brand. Individually they were ignored - but it soon became apparent that there were a LOT of little old ladies saying the same thing. It turned out the manufacturing process had been changed and suddenly twice as much drug was being made available. Thus was born the new idea of 'bioavailability' The drug was Digoxin. Normal dose

then 250mcg. Normal dose now 125 mcg. The little old ladies were quite right. The new tablets WERE making them feel ill' Poster 2, line 168

Memories were also shared. This example relates to a medicines pricing issue within the pharmaceutical industry, where a poster recalled a scenario relating to this topic:

'Old dodderers like myself may remember the Roche controversy where, essentially, the firm justified their prices because of their continuing research effort and DH replied that, in their opinion, Roche were doing too much research, a policy which has propelled them into the first rank of pharmaceutical companies' Poster 10, line 836

Information was also requested and provided on pharmacy business and work issues. The example below demonstrates a poster enquiring about situation of a dispensing doctor's business (DD) alongside a community pharmacy:

'Can a DD operate from the same room as a community pharmacy ?' Poster 19, line 974

Another poster responded with information, bringing an element of disparaging humour (other examples of humour as a social interaction are discussed in section 5.4):

'See the Dispensing Doctors Association website. I can't bring myself to quote it' Poster 10, lines 980-982

Information about the job role of the pharmacist was also requested. This links to the opinions expressed in section 5.3.2 above, and is included in this information section as it relates to Bales' 'orientation' process. In the quote below, the poster provides information on work tasks that he/she has undertaken and also provides opinion (Nomad is a brand of monitored dosage system tray). This quote also demonstrates power and assertiveness issues with the locum appearing to be pressurised into an unwanted course of action:

'After speaking to the manager I had to agree to do these nomads. The last two Sundays I was popping out tablet after tablet. I hate it' line Poster 24, 1143

Other work information shared related to career paths and choices. The poster in the quote below describes the nature of her/his current work:

'I left my job with a small independent group in September. Looking at the description of an independent pharmacy consultant, that looks like what I have become. I've returned to locum work, but will be starting as part-time practice pharmacist in a local surgery next week' Poster 5, line 565

Within the same thread, a second poster responded to the quote above requesting information about pay rates:

'Thats good to hear! May I be VERY cheeky and ask what sort of hourly rate you get? Not exact rates - but an indication of whether you get more than £15.00 ph (or even more than £20.00 ph!)' Poster 2, line 571

Nearly all the topics where information was provided related to pharmacy. As an example of a non-pharmacy topic, one thread concerned the impact of music on emotions, posting a link to an article on music therapy. This still related to health and wellbeing however, as illustrated by this quote:

'So you hear the music you think 'This is nice' It makes you feel happy. Depending on the beat your heart rate (and possibly breathing) will alter with the physiological effects of that. The limbic system in the brain will be activated - all that dopamine makes you feel good!!' Poster 2, line 362

Of the total of 67 threads within the data sample, only four related to non-pharmacy topics. These threads covered music therapy, 3D printing, business management buy-out and development in rural India, all of which in some way still related to health and wellbeing. This demonstrates that the content focus of the forum was clearly pharmacy-based.

The LocumVoice forum is clearly badged as a locum pharmacy discussion area, and some consideration was given to how much of the content related to issues that were locum-specific versus general pharmacy topics. There were some issues that were clearly specific to locum pharmacy, such as pay rates:

'Over on the website Pharmacy Forum there is an EU pharmacist asking if a rate of £12.50 an hour for a pharmacist to work up to 13 hours a day and do mid-night shifts is acceptable'
Poster 2, line 1040

And also discussion of the role of the locum:

'Up to now I had "lazy" days: I "cleaned" those baskets they couldn't finish through the week, I do EHC, CD-check' Poster 24, line 1133

However, as demonstrated in numerous quotes presented above, general pharmacy issues and politics were also introduced and discussed. These were most commonly presented as hypothetical scenarios, which requested opinions on how to resolve the situation. As a specific example, in the three lines below, a poster raises an issue of an ambiguous dose on a prescription for a controlled drug, which then prompts a range of discussion about different possible scenarios:

'A CD prescription must have the number of tablet(s) to be taken e.g. in this case it should be 1 BD & not just BD. So this prescription is not valid. Poster 44

Exactly. How can we tell what the dose is to be from what Poster42 has written? It is certainly not clear that it should be 30mg twice a day, assuming so would be purely guesswork. The law is clear, and the question which heads the thread is "Can you dispense it legally?", not "What would you do in reality?"' Poster 20

I read the prescription as as Morphine Sulphate Controlled release (drug and form) 30mg (dose to be taken) Twice a day (directions). How about Morphine Sulphate Controlled Tablets 20mg BD 28 (twenty eight) 10mg tablets?' Poster 2, lines 2437-54

So posters were discussing some issues specific to locum pharmacy, but more commonly using their interests and experiences to discuss pharmacy issues more generally.

To summarise this section on information sharing, this was a frequently-occurring activity on the forum and was most often integrated with opinion (that is, facts were shared along with views on those facts). Some posters made requests for information, but mostly information was offered unprompted. Information was also passed on via storytelling and sharing of memories. Nearly all the information shared was pharmacy-related. Topics covered including information about learning activities, pharmacy practice issues such as clinical drug information and patient counselling, NHS issues such as fraud and drug pricing and issues relating to the job role of the pharmacist and pay. A few non-pharmacy issues were raised but these all still related to health and wellbeing in some way. Some issues were locum-specific, such as pay and working conditions, but topics were commonly related to more general pharmacy issues.

Locums have been identified as an isolated pharmacy group (Shann, Hassell 2006) and as experiencing some difficulties accessing learning opportunities compared to other groups (Donyai, Herbert et al. 2011). The forum activity reveals some requests for information, but offering of information unprompted was more common. This suggests the forum is not used as a 'question and answer' resource but rather an area for sharing views on issues. This again supports the concept of the forum as a mechanism for development of professional identity. The prevalence of storytelling activities and memory sharing also supports this. Information is not just current data, but also historical background to situations, supporting development of culture and values. The historical background also provided a context for discussion of current issues. Resnick (2004) identifies this as 'culture building'; storytelling provides a way of exploring complex ideas to provide explanation. Beauchamp and Thomas (2009) also note the importance of stories to developing cohesive group identities. The putting forward of new ideas as topics for discussion support the concept of the forum as a source of interactions that aid development of professional identity. Shared stories and memories create a foundation of culture that reinforce that identity (Becker, Carper 1956a).

This section has considered the results structured around Bales' task areas of suggestion, opinion and orientation (information) and these areas comprised the majority of the interactions in the sample of the site examined. The next section considers interactions in the socio-emotional areas – solidarity/antagonism, tension and agreement.

5.4 Solidarity/antagonism, tension and agreement

The number of lines coded to socio-emotional areas was much fewer than for task areas. Despite this, examples of interactions were found for all of Bales' socio-emotional processes, even if some were infrequent. This section provides a brief description of some of the social processes within the forum.

Table 7: Bales' social emotional areas

Function	Process
Social-emotional area - positive reactions	1 Show solidarity: raises others' status, gives help, reward
	2 Shows tension release: jokes, laughs, shows satisfaction
	3 Agrees: shows passive acceptance, understands, concurs, complies
Social-emotional area – negative reactions	10 Disagrees: shows passive rejection, formality, withholds help
	11 Shows tension: asks for help, withdraws out of field
	12 Shows antagonism: deflates others' status, defends or asserts self

Bales' processes 1 and 12 (showing solidarity and antagonism respectively) relate to raising or lowering the status of others. On the forum, process 12 showing antagonism expressed itself via challenging posts which queried another poster in an assertive manner. The following example refers to political engagement and presents a challenge to the other poster to defend their political inactivity:

'If you are not prepared to put yourself out for others, do not expect them to put themselves out for you. So, (Poster 8) and co. what is your excuse?' Poster 14, line 447

Posters showed solidarity for others by comments which backed up the views expressed by others. The next two quotes show support for others' views:

'Hahaha, spot on, Poster 2' Poster 7, line 187

'The points you raise convince me that you are thinking like a pharmacist' Poster 7, line 190

Solidarity was also provided by use of in-house abbreviations and code words. These were abbreviations and phrases which had meaning for those inside the group (as they weren't explained) but may be unfamiliar to outsiders. An example is 'DD' referred to above, abbreviating 'dispensing doctor' and understood by other posters without explanation. Two other interesting examples are the use of code names for pharmacy companies. The examples shown here refer to 'the Owl', indicating Rowlands Pharmacy due to its owl corporate logo and 'the shoe company', indicating Boots Pharmacy.

'The Owl tried at one time to fill MDS trays in centralised depots' Poster 10, line 1260

'I left the shoe company recently and I'm in the process of setting myself up as a locum' Poster 47, line 3077

In addition, posters alluded to other pharmacy companies, the following example refers to the Co-operative Pharmacy (now renamed Well Pharmacy) by reference to issues with the Co-operative Bank which were in the news. It is presented as a rather coy phrase:

'Pharmacy chain associated with the troubled bank' Poster 36, line 1921

All these code words were used without further explanation and appeared to be fully understood by other posters as no clarification was requested.

There was evidence that some posters knew each other in 'real life', indicated by the following excerpt that describes a meeting at a conference between two individuals and acknowledges that the poster may have recognised other group members if they had attended the event:

'Well, with the exception of (name) (good to meet U BTW), non of you turned up for this awesome event' Poster 7, line 432

Tension (relating to Bales' processes 2 and 11) related in this analysis to positive and negative social interactions, key ingredients in relationship building within a community. Positive social interactions included use of emojis such as a 'smiley' 😊 (many lines within the text provided examples), the use of greetings and humour. At its most basic sense, greetings included saying hello at the beginning of posts:

'Hi all' Poster 1, line 4

Some examples of humour on the site include the following. The first is a rather wry and self-deprecating statement:

'Just the maunderings of a near octogenarian' Poster 10, line 953

Humour was also indicated directly on the site, by the use of laughter words:

'Hahaha, that's my normal state' Poster 7, line 968

One example of rather sarcastic humour was integrated into a thread discussion on registration issues of pharmacies within dispensing doctor premises where the poster appears to provide an opinion on the situation by use of a ridiculous statement:

'You just get a big tin of floor paint and separate the dispensary from the registered premises' Poster 4, line 1024

The only example of tension generation was provided by use of symbols to illustrate profanity when discussing a Department of Health (DoH) issue:

'&%@ing bean counters! Especially in the DoH!' Poster 6, line 848*

The final pair of socio-emotional processes was agreement/disagreement. Overt, direct disagreement was rare, however, posters often provided a contrary opinion within a thread as part of a debate about the issue. An example of direct disagreement occurred in a thread about the value of music therapy, when a poster responded to another's music choice with the following symbolism for 'boring':

appreciation of qualitative research rationales, the process can unacceptably shift the focus of the research (Barbour 2001). This is also ably described by Denzin as the 'politics of evidence' (Denzin 2009), the political element being who has the power to decide what constitutes evidence in the first place. So any checklist approach comes from a particular perspective, which is not always transparent.

Walsh and Downe (2006 page 118) describe how varying epistemological and philosophical positions can make indiscriminate use of checklists inappropriate: 'the range of criteria exists along a continuum from endorsing positivist notions of reliability, validity and generalisability to a minimalist approach'. In essence, the quality approach should match both the research aims and the methodology. Reflecting this, Barbour provides criticism of common 'checklist' approaches such as triangulation and respondent validation from this epistemological point of view (Barbour 2001).

The researcher gave much thought to the process of research quality and how to express this within the thesis. Whilst appreciating the conceptual issues considered above, it was felt by the researcher that the methodologies and approach used in this study were sufficiently mainstream to justify use of the COREQ checklist. This was used to inform the writing of this thesis, contributing to the content of the methodology chapters and how the results are presented and discussed. It was selected as representing a current, contextually appropriate source, being recommended by relevant journals such as International Journal of Pharmacy Practice (Bond, S 2015). In summary, this research study has not taken a proscriptive approach towards applying a quality checklist to the process. The existence of checklists has however undoubtedly guided the description provided in this thesis, particularly COREQ, but they have not been used in a way which is at odds with the research methodology.

Taking a constructivist approach to the research leads to consideration of concepts of validity, or closeness to truth, in different terms. If we all create our own version of reality based on our perceptions and experiences, then the concept of an absolute truth to be uncovered by research ceases to be meaningful. Hence, validity as a closeness to 'truth' becomes a problematical concept, and other words have been put forward to describe quality in qualitative research, such as trustworthiness or credibility. As this research represents this researcher's interaction with participants to create a particular situated version of 'truth', the feasibility of the research process to deliver the stated results should be examined (Bryman 2012 page 391) – how likely is it that the process would have delivered these results?

The following concepts have guided this discussion of credibility:

- Sincerity, in terms of the reader understanding the positioning and influence of the researcher
- Transparency, in terms of the reader being provided with a thorough description of the processes of the research
- Coherence, in terms of the reader making sense of the argument through the work

These three concepts are now considered in a little more detail.

Sincerity should explain the positioning of the researcher in the context of the research situation. The researcher as research instrument has been discussed in section 2.3. The aim of exposing the researcher to scrutiny is well expressed by Watt in her statement, 'I cannot shake off my biases, but I can make them known' (Watt 1997 page 94). Practical examples of this exposure were completion of reflective statements after each focus group, maintaining a reflective diary during the data collection and analysis period and writing a reflexive statement (detailed in section 2.3). By exploring the researcher in the context of the research it is hoped that readers are able to 'construct their own perspectives' on the authenticity of the research (Rooney 2005). This also mirrors quality criteria provided by both the COREQ framework and broader frameworks (Walsh, Downe 2006). The experience of the researcher as a locum community pharmacist herself contributed both strengths and weaknesses to the research. The strengths derive from an intimate understanding of pharmacy issues which enabled focus groups to quickly work together based on a shared language and agenda. The main limitation also derives from assumptions around this shared language and agenda which may not have existed, an example being the assumption by the researcher of a shared understanding with participants of the term CPD.

To evidence transparency, a thorough description of how the work was undertaken should be provided. This thesis has attempted to provide a thorough description of the research process, particularly the analysis (section 2.8.1) and methodology (section 2.2). Triangulation was not considered an appropriate approach for this study as the two data collection processes described in this thesis (the focus groups and analysis of the online forum) were meant to be complementary, not comparative. Respondent validation/member checking of themes identified in the focus groups was also not utilised, due to the constructivist approach to the study, the acknowledgement of the role of researcher in the research process and also as participant interaction was a key part of the focus group method and this may not be recognised by individual respondent validation (Barbour 2001).

Coherence should be evidenced by presenting an argument that makes sense. To some extent, this must be judged by the reader, but the researcher has attempted to create a coherent argument through adequate signposting and justification for the claims put forward. The discussion section aims to link the research findings with existing literature and also put forward some interpretation of the findings. The researcher aimed to provide enough detail of the research processes to create a 'decision trail' that would provide clarity for the reader (Walsh, Downe 2006).

Generalisability of qualitative research to the wider population has been a contentious issue (Halkier 2011), however generalising to theory has been put forward as an approach (Bryman 2012). This relies upon analytical generalisability - the 'quality of the theoretical inferences that are made out of the qualitative data' (Bryman 2012 page 406), or using 'theoretical concepts to enable a more general perspective on specific qualitative patterns' (Halkier 2011 page 787). This study was not intended to be generalisable to the entire UK locum population but has raised some themes and ideas which may be useful considerations for practice. This section has considered some of the strengths and limitations of the study, to assist in determination of the value of the results.

5.6 Quality issues for the analysis of the online forum

Strengths and weakness of the online forum analysis are now considered. This phase of the research study explored the interactions and content of an online forum for locum pharmacists and described the community aspects of this, and how this may be constructing professional identity and behaviours.

In order to justify use of Bales' interaction process analysis, it was felt necessary to demonstrate that small groups of interacting individuals did exist on the LocumVoice site. The LocumVoice forum was examined as part of this research to investigate a place where locum peer to peer interaction occurred. Whilst the main analysis of the forum examined individual interactions between posters, the overall structure and nature of the forum was also examined. If the research sample consisted of threads initiated by the same one poster, this would require a different interpretation to a variety of posters starting threads. Similarly, if none of the threads had had any response from others, or the forum was significantly dominated by one or two individuals, this would not constitute an interactive forum. It was therefore necessary to examine the pattern of posting on the forum to establish that it was indeed a communicating group of varied individuals. The analysis in section 5.1 provided the basis for demonstrating this, showing that the forum consisted of small groups of varying individuals who are interacting on the site about pharmacy issues. As noted in section 5.1, this small group activity provided justification for the use of Bales' interaction process analysis framework (Bales 1950).

Significantly, the data analysed was a brief sample of posts over a two month period, so can only report what was posted during that time. As such, it provides a snapshot of the site activity at a particular time. Analysis of posting activity demonstrated that this time period was not exceptional in any way (see section 4.3.2 for description of this). In terms of the content of the site, this research was not intended to be a survey of the content topics. A thematic analysis of the topics discussed was undertaken to demonstrate that content was relevant to pharmacy and to illustrate professional engagement by means of the interactions undertaken around the pharmacy content. A forum of locum pharmacists discussing football results would give a very different interpretation to one discussing pharmacy issues, so the research required that the content be explored to show relevance to pharmacy professionalism. Having demonstrated the content was pharmacy-related, further analysis of the content themes enabled linking of the interactions to concepts of professionalism, for example, sharing opinions on the job role of the pharmacist. Other content themes that may exist in the forum elsewhere outside the sample may have enabled a different interpretation. Within this sample, a large proportion of interactions were opinion sharing and sense-making. Again, this may have been different with another sample.

The nature of the forum itself may have also influenced the behaviours and content witnessed, including being a site that was moderated, required registration to post, the fact that it was a public listserv format and was being marketed as a discussion area for locum issues. It may be that locum forums that are less public or operate on different media (via Twitter, Whatsapp or Facebook for example) may attract a different demographic and serve a different function for

participants. The attractions of the LocumVoice forum for a certain type of pharmacist may have yielded particular types of interactions that would be different in other settings. Despite indications that it is the interactions that matter, rather than the medium (Herring S 2010), different online media may attract different groups of pharmacists who conduct different interactions from those studied on LocumVoice. Preferred formats for interaction would be worthy of further investigation, which is reflected in the statement from the LocumVoice moderator in section 6.2, that forums for online communication had moved to different formats over the lifetime of the site.

The influence of the researcher on the research process has been discussed in section 2.3. The researcher is an experienced locum pharmacist, who was familiar with the LocumVoice site but had never interacted with it. Prior experience of the site may have influenced the interpretation of the posts and choice of examples presented in the thesis. In essence, the researcher may have reported what she found interesting. To counter this potential influence, the reflective processes in section 2.3 were followed and the views of the supervisory team were sought on the interpretations made by the researcher.

5.7 Summary

This chapter has described the interactions and content of data downloaded from the LocumVoice forum. It shows that posters create small, temporary social groups via construction of threads. Posts are very task-focused with posters asking for and providing opinion and information, and asking for and receiving suggestions for action. The forum is strongly focused around pharmacy issues, with very little non-pharmacy content being posted.

Socio-emotional support forms only a small proportion of posts and is overwhelmingly positive when it does occur. However, the forum does provide a sometimes challenging environment for discussion of pharmacy issues, with forceful suggestions for action provided. Whilst overt disagreement was rare, contrary opinions were often provided as part of discussion. The forum also acts as a method of sharing information. This was sometimes related to specific drug issues but more often addressed more general issues such as learning activities and job roles. The information shared also consisted of historical background to issues, providing a context for current discussion.

The key findings from this phase of the research are that posters are forming identity as pharmacists via their interactions in the following ways:

- Value-making: sharing opinions and views on what it means to be a pharmacist
- Creating a common culture: 'thinking like a pharmacist'
- Sharing information: information supports a joint opinion-forming base that develops ideas between individuals

- Community formation: common jargon language helps develop a robust community where ideas can be shared

Whilst the results are presented here grouped into Bales' processes to provide a clear framework, the reality of the data is that all the processes are often integrated within a single thread or post – a lot of the processes happen at the same time. A common mode of interaction was for a poster to provide a link to some information and give an opinion. This would then be responded to by other posters who gave their opinions and suggestions for action. Social interactions such as greetings and humour were interspersed. More information and opinion was offered than overtly asked for, but the act of providing unsolicited information could be construed as an invitation for others to comment.

The data analysis presented a picture of an engaged, respectful, vibrant and sometimes challenging group of individuals discussing pharmacy issues online. There is evidence of the interactions between posters contributing to development of professional identity through use of storytelling, jargon, exploring values and pharmacy culture. The coming together of small groups of individuals around a topic of interest suggests communities of practice are being formed and reformed within the forum.

The significance of the interactions on the forum for locum community pharmacists will now be discussed in the next chapter, which provides a conclusion to the research.

6 Conclusions: locums and professional engagement

6.1 Introduction

This research study has explored issues surrounding professional engagement of locum community pharmacists. The two phases of the study have provided a broad overview of the professionalism issues facing locums, and also examined in detail an environment where locums meet to interact on pharmacy topics. As locums constitute a significant proportion of the current community pharmacy workforce, anecdotally may have a poor reputation for commitment and often work outside existing quality assurance processes (Jacobs, Schafheutle et al. 2013), this research illuminates locum professional engagement and describes one setting where some networking issues may be addressed. The study of the online forum builds on the focus group themes to shed light on how locums may be developing and maintaining professional identity and mores through their online interactions. Implications for further research are discussed throughout the chapter and conclusions and implications from the results are drawn. However, prior to that, the demise of the LocumVoice site is considered in the next section.

6.2 Closure of LocumVoice

As mentioned in section 4.3, the LocumVoice website is no longer available online. On November 12 2015, the following email was sent from the LocumVoice administrator to all registered users of the forum, including the researcher:

“Good afternoon,
I am sad to inform you that LocumVoice is closing with immediate effect. Administering and moderating this board is no longer possible with the resources available and with the lack of respect and professionalism displayed at times. Given changes in the past 5-10 years in methods of online communication, the need for a forum has changed and other formats may be more suitable.
With Best Regards,
LocumVoice Administration Team”

The closure of the site and reference to disrespectful and unprofessional behaviour clearly deserve some consideration as part of this thesis. Wenger (1998) put forward that communities of practice have a lifecycle and the closure represents the end of the lifecycle for the forum. Within the sample of this study, the atmosphere of the forum, whilst challenging, was respectful and professional amongst the posters present at that time. This had clearly changed according to the email and reasons for that will be speculative. The reference in the email to changes of format may be relevant. Since the data sample for this research was taken

in 2014, new online applications for communication have been created and become popular, for example, Whatsapp. The forums on which conversations are taking place may have shifted from the listserv format to formats which are more applicable to increasing use of mobile devices. The death of LocumVoice founder and moderator Lindsey Gilpin in 2014, an enthusiast and advocate for locum community pharmacy, may also have influenced the demise of the site. In addition, the comments relating to lack of respect and professionalism should be considered. Within the sample analysed in this study, respectful interactions were noted. However, the data analysed in this thesis represent the interactions of the forum participants at a particular point in time, with a corresponding particular set of circumstances, including both the technologies and the personalities involved. The picture revealed during different periods of the site's lifespan may have yielded different results. The site closure provided an interesting conclusion to this research. This chapter now proceeds by addressing how the research aims and questions have been addressed by the results.

6.3 Discussion and implications of the research

In section 1.9, the aim of the research was stated as being to investigate professional engagement among locum community pharmacists in terms of their:

- Networking with other pharmacists and professional colleagues
- Professional identity as a pharmacist

To clarify this investigation, the following research questions were proposed:

- How do locum community pharmacists network with pharmacist colleagues?
- What is the value of networking to locum community pharmacists?
- Do the networking interactions on the LocumVoice forum contribute to development of professional pharmacist identity?

These questions are now discussed, the first two in the next section 6.3.1 and the third in section 6.3.2 that follows. Whilst the results of the two phases of the research (the focus groups and the online forum) have been discussed separately in chapters 3 and 5, these are now integrated to bring together the concepts to address the research questions.

6.3.1 Locums and networking with other pharmacists

That locums feel isolated is an existing finding in the literature (Shann, Hassell 2006) and locums in this study also identified that creating and maintaining networks takes effort, and is part of their professional 'work'. Within the focus groups, networking with other pharmacists was identified as valuable by locums for a variety of reasons – as an information source, for benchmarking practice, to provide a 'listening ear' to reduce stress, for problem-solving, to discuss ethical and moral dilemmas and to facilitate professional growth as a pharmacist. These reasons support the notion of socialisation processes contributing to development of

professional identity by an individual, which helps create shared values and beliefs (Ashforth, Mael 1989). A significant finding was that locums attempt to use pharmacist colleagues for professional benchmarking – comparing practice – and appear to actively seek out opportunities for this to occur. This has resonance with the General Pharmaceutical Council's planned continuing fitness to practise framework for pharmacists, which includes reference to 'peer to peer discussion to encourage the development of formative relationships with peers' (General Pharmaceutical Council 2016). In the focus groups, locums described using training events for networking (with varied success), maintaining pharmacist friendships and online resources (again, with varying success). That locums recognise the value of communication with peers is a valuable finding in this research; that they find creating networks effortful is worth consideration, as more effective facilitation of networking opportunities by professional bodies would meet both the wishes of locums and the aspirations of the fitness to practise framework. This facilitation should however recognise that effective communities need their own control over their meeting space, and that communities do have a life cycle and will form and reform over time.

The purpose of investigating the LocumVoice site was to examine the types of interactions that were undertaken by posters and to reflect on the purpose and value of those in the light of the focus group findings. The forum represented a reasonably tight-knit group who identify as locum pharmacists and have come together to discuss pharmacy issues. This supports the idea of the forum as a community of practice, defined by Wenger (1998) as a coming together of individuals around a particular focus. As described in section 5.3, some issues discussed related to locum specific topics, many others to more general pharmacy subjects.

There are other aspects to the interactions on the forum that indicate the existence of a cohesive group. The use of jargon and storytelling were identified in the data analysis. Jargon within the forum is demonstrated by use of technical terms ('Nomad') and abbreviations ('DD') without clarification – there was a common understanding of meaning that did not require further explanation to group members. In addition, an invented 'joint language' of jargon was created via use of codes for organisations, such the 'owl' and 'shoe company'. Creation and repetition of these cultural customs reinforces group identity, as described by Resnick et al (2004).

Pseudonyms were used by most posters to the site, but there were some individuals who used what appeared to be their real names and some who logged in with a pseudonym but signed off their posts with their name within the thread, thereby identifying themselves. There was also some evidence that posters had met in real life situations. This sharing of identities and meeting outside the forum space supports the idea of them as a cohesive group. The analysis has therefore demonstrated the existence of an online community of locum pharmacists via examination of their interactions, the development of cultural customs and their focus about a topic of joint concern (pharmacy). The nature and content of the interactions observed is now considered further.

Analysis of Bales' socio-emotional processes revealed a very largely positive range of social interactions with little overt disagreement but considerable challenge to opinion. Humour was evident but very little tension generation between posters occurred. Groups do not need to be

friendly to function, but with a voluntary activity such as posting to a pharmacy forum, a pleasant social environment may be important. This links to an issue identified in the focus groups, where participant Ursula expressed that she had left one online forum due to unpleasant interactions on that site (section 3.4). The LocumVoice site was also moderated, which may have an impact on negative posting (Fahy 2006). Fahy's study of an online educational conference using Bales' interaction process analysis also noted that negative socio-emotional reactions were significantly less in that study than Bales observed, as also the case in this study. Fahy attributed that result to the presence of a moderator (lecturer) and the task focus of the students in the conference. A similar, professional approach to the LocumVoice forum may be the case with this research, with pharmacists acting respectfully towards their peers. Also, the LocumVoice forum was moderated, which may have an impact on the emotional tone. This may shed some light on the forum's closure and lack of respect demonstrated later in its lifespan, as the closure email (section 6.2) refers to moderation difficulties within the resources available.

The closure of the Locumvoice site provides throws interesting questions at the research results. It is relevant here to consider Tuckman's stages of group development – forming, storming, norming, performing and adjourning (Tuckman 1965). This theory puts forward that groups have a natural cycle of coming together, learning how to work together, being productive on a task and then naturally breaking apart. It could be possible that this research has interacted with the site in its 'performing' phase and then indirectly witnessed the 'adjourning' phase. Interaction at the site at other stages of its lifecycle may well have yielded different results. This concept has implications for research of any group. Nevertheless, this study has shown active professional identity building and positive, co-operation interaction on the forum at that point in time.

On the LocumVoice forum, posters were sharing knowledge (for example, links to information sources) and also sharing views on the application of knowledge (for example, interpretation of controlled drug information). This study builds on information obtained by Whitaker et al (2003), which revealed benefits for the posters to an online site of increased professional confidence, gaining knowledge and overcoming professional isolation. The work in this thesis has explored the consequences for professional engagement of the interactions. Although there are differences between Whitaker et al's work and this research, the findings are similar.

To summarise this section, the focus group analysis identified locums as an isolated group who saw the benefits of their networks and recognised that networks take effort to create. An online group was then studied to consider the networking opportunities that occurred. The LocumVoice forum has been demonstrated to consist of a group of individuals who identify as locum pharmacists and who have a clear focus around an issue (pharmacy). Communities of practice were defined by Wenger as groups that 'develop around things that matter to people' (Wenger 1998). This makes a strong case for the LocumVoice forum to be considered a locum pharmacy community of practice, with small groups of individuals coming together to discuss an issue before moving on. The research contributes to existing information on networking activity of locum community pharmacists by highlighting the purposes of networking as perceived by locums and by describing networking interactions online that contribute to

professional engagement. The next section considers the issue of how the LocumVoice community may be developing professional engagement by creating identity as a pharmacist.

6.3.2 Locums and professional identity

The final proposed research question considered if the networking interactions on the Locumvoice forum contributed to the development of professional pharmacist identity and the findings are discussed in this section. As interaction with colleagues is a key component of creating professional identity (Noble, Coombes et al. 2014), it was pertinent to consider what is going on in those interactions that contributes to professional identity. 'Acquisition of ideology' via participation in informal groups has been put forward as one mechanism for development of professional identity (Becker, Carper 1956a page 297). Mechanisms for acquiring this ideology described in the results are now considered, which include sharing information, stories and opinions.

A defined body of knowledge was put forward in chapter 1 as one of the defining traits of a profession, with regulatory systems supporting a defined system of education and credentialing for members of the profession. As such, examination of locums' experiences of learning provides one route for consideration of locum professional engagement and identity as a pharmacist. The isolation experienced by locums does create some barriers to accessing learning resources for them, as they feel 'out of the loop' of local and national communication networks for information on learning. Not all locums in this study felt this way however, some locums in the focus groups recognised that the variety provided by the locum role created a lot of learning opportunities. They also considered that whilst locums felt they had to work harder than employed pharmacists to locate and access resources, plenty of resources were actually available. This may reflect the individual professional networks of the focus group participants. The temporary nature of the locum working environment also had implications for their learning. Feedback and follow-up on situations is more limited when the locum is only present for a limited time and this may impact on locums' ability to gather evidence of learning. Conversely, the additional variety of the locum role (the '2000 patients' issue described in section 3.3) was recognised as creating a range of learning opportunities. It is also important to note that there is no typical locum working pattern – the focus groups were sampled to create a range of locums working in a number of different pharmacies versus working in one pharmacy regularly. This range of views on learning opportunities may reflect the range of working patterns.

There was also a range of perspectives on the purpose of undertaking CPD and learning. These included practical issues such as defensive practice (having evidence of competence in case of error) and to achieve service accreditations to obtain employment, but also some locums did express their motivations in undertaking CPD in a more reflective sense, in terms of developing their professional skills and doing the best job for the patient. This is mirrored in the interactions described on the LocumVoice forum where locums shared practical sources of information (for example, links to websites) and also shared opinions on the application of knowledge.

Information and opinion was shared on the forum about a number of issues, the vast majority pharmacy-related. Within the LocumVoice sample examined, the type of content shared related to learning about pharmacy issues, pay rates, job roles, pharmacy politics, pharmacy development, pharmacy practice issues such as medicines information and patient counselling and wider health and NHS discussion. Content varied from a narrow focus around a particular drug to broad concepts of health and wellbeing and the state of the health system. Information sharing thus related to detail of pharmacy work (such as pay) but also provided a context or historical background for discussing broader pharmacy issues.

Sharing information helps practitioners become 'knowledgeably skilful' (Resnick, Levine et al. 2004) and is a process that of itself develops a social group. Professional identity is bound up with the culture of the group, of which a shared, negotiated knowledge is an integral part. By sharing information, group members are identifying with the group and also helping to develop the culture of what it means to be a locum pharmacist. Another signal of group identity creation or socialisation processes included the use of jargon – language that is clearly understood by the group but will be less clear to outsiders - demonstrated in this research by use of abbreviations and product names without further explanation.

Information and opinion sharing on the nature of the role of the pharmacist – the job role – was a particular feature within this research sample. Posters explored the nature of what it is to be a pharmacist, in terms of the tasks that should or should not be undertaken and also how to 'think as a pharmacist'. These tasks included both physical and cognitive roles, such as filling monitored dosage systems with tablets and counselling patients. Posters explored both the theory and the reality of what it is to be a locum pharmacist whilst undertaking these roles. The theory explored hypothetical situations (for example, would you always encourage a patient to take their medicines as prescribed) and the reality of real-life considerations such as not being re-employed if the poster did not undertake dispensing of monitored dosage systems. The skill mix issues within pharmacy were also explored by identifying roles that the pharmacist should be doing versus roles for pharmacy technicians and other staff groups. By recognising what they mean by 'thinking like a pharmacist', posters are defining and clarifying with each other what it means to be a pharmacist particularly, as opposed to another role. By exploring these issues of what it means to be a pharmacist and what pharmacists should be doing and thinking, posters are using professional socialisation processes to create culture and identity between themselves (Resnick, Levine et al. 2004).

Storytelling was another particular feature identified within the LocumVoice research sample. Posters were able to illustrate their opinions with tales of past pharmacy issues or situations. Storytelling has been identified as a powerful tool in identity creation (Beauchamp, Thomas 2009) and helps to create a shared culture. Previously, an example is cited where a poster gives her/his opinion on whether a patient should always be counselled to take their medicines as prescribed. The poster continues with an elaborate story that develops concepts of patient autonomy and respect for patients' views. By using a story related to pharmacy practice, and by including jargon words such as 'bioequivalence', the poster relays these patient-centred concepts in a way that is designed to communicate to other pharmacists directly. Stories communicate attitudes and values very effectively and the examples within this research sample demonstrate creation of pharmacy culture via the use of shared pharmacy stories.

Similarly, memories were also shared. The acts of storytelling and sharing memories may also have a 'credentialing' role, establishing the status of posters and lending credibility to their opinions. This again builds relationships, community and shared identity. Even using pseudonyms, online reputation may have a value to posters and establishing online credibility may be an important goal for some posters. Storytelling can 'weave a narrative' that develops professional identity (Andrew, Ferguson et al. 2009). By using stories, posters are contributing to development of their identity, both as individuals and as part of a group.

Within the sample examined, it was clear that the LocumVoice forum was not being used as an immediate information resource to solve pressing practical problems. For example, there were no examples of a poster requesting urgent information about a prescription they were dispensing or a patient query they had. The forum is therefore unlikely to be being used as a medicines information resource for immediate problem-solving. This raises the issue of the value of the forum to posters. Previous research has highlighted the contribution of online interaction to sharing learning, reducing professional isolation (Grindrod, Forgione et al. 2014), sharing perspectives and shifting professional behaviours and attitudes (Whitaker, Cox et al. 2003). This research supports these findings and, by linking the interactions with the content, demonstrates how professional socialisation processes are occurring on the site.

The volume of opinion and debate provided on the forum indicates that the group interactions help posters with sense-making, creating new mental models of situations, particularly via storytelling activity and reflection on practice (Desanctis, Fayard et al. 2003). Sense-making, in terms of giving opinion and creating models of thought, was identified in the threads which initiated debate by posing a situation. It is significant that many 'asking' and 'information providing' threads also ended up with some element of debate. Given that communities of practice can create a sense of belonging and identity (Wenger 1998), and sense-making can help shift and standardise practice, this may be a key purpose of this online community.

The analysis of the online forum also revealed a range of forceful suggestions or exhortations for action from posters, focusing on issues of pharmacy development and politics (for example, urging others to get involved in local commissioning processes or elections). This activism may provide a focus for attitude and behavioural shifts amongst the posters, evidenced by one poster referring to themselves as an 'agitator'. This political engagement and encouragement again demonstrates engagement with the wider pharmacy profession through the forum interactions. This reflects the political content noted in another discussion forum by Whitaker, Cox et al (2003).

In summary, locum participants in the focus groups noted that their lack of interaction with peers meant they were 'out of the loop' professionally and they would welcome greater levels of communication. The interactions observed on the LocumVoice forum demonstrated the socialisation processes of group interaction contributing to professional engagement by developing and maintaining identity. These identity issues centred about information transfer (what you should know as a pharmacist) and opinion (how you should think as a pharmacist).

Previous studies have examined the components of pharmacist identity and values (Elvey 2011), (Benson, Cribb et al. 2009). This study contributes to the field of pharmacy professionalism by observation of identity development within an online group.

6.4 Conclusion

Having considered the contribution of the research study to professional engagement in terms of networking with colleagues and identity building, this final section provides an overall conclusion, including implications for practice and consideration of areas for further research.

6.4.1 Implications for practice

The research objectives of this study were to describe professional engagement of locum community pharmacists by reference to their networking with colleagues and their professional identity as a pharmacist. Locum community pharmacists are an essential part of the workforce, providing flexibility for both employers and pharmacists and are key to maintenance of effective pharmaceutical service delivery. As described in chapter 1, locum community pharmacists constitute a significant proportion of the pharmacy workforce; they represent an isolated group, often sitting outside existing quality assurance and appraisal processes. This potentially makes locums a quality risk for pharmaceutical service provision, if usual governance processes are absent. Studies which examine the nature and experience of locum working have the potential to inform professional bodies on the difficulties and opportunities for locums. This may enable those bodies to develop adequate professional structures and resources to support effective and safe locum working. In the context of the research findings described in this thesis, networking activity of pharmacists may be considered one of the areas that professional bodies could effectively support.

The findings of phase 2 of this research study identified the existence of a community of practice of locum community pharmacists, with their interactions online supporting their own professional identity. Communities of practice should be self-generating and self-sustaining in order to function effectively (Wenger 1998). Knowledge management systems within organisations have recognised that over-facilitation of networks and communities can be counter-productive – it can break down communities (Roberts 2006). Micro-management of communities can destroy the very sense of community that contributes to their effectiveness. Communities of practice operate most effectively when they are internally driven around a common purpose. Rather than suggest that this research should encourage professional bodies within the pharmacy profession to facilitate *solutions* to networking, the research has shown the contribution to development of professional identity via a self-directed network of individuals. It may be that the efforts of professional bodies would be better directed at an earlier, less directive stage, in encouraging awareness of the benefits of professional networking and allowing practitioners to develop their own solutions to how that occurs. The natural lifecycle of any community also supports this idea. An online forum appears, from this research to offer an appropriate networking opportunity that shares pharmacy culture, values and information and helps develop pharmacy identity – what it means to be a pharmacist. However, it is only one way to achieve that and different groups of pharmacists will find their own methods to suit their needs. In addition, any community is likely to have a time-limited lifespan, meaning communities will disaggregate and re-form repeatedly. Hence, imposing communication routes on individuals may be counter-productive over-management. To summarise this point, professional pharmacy organisations may be wasting resources by provision of online forums (for example, the Royal Pharmaceutical Society forum, described in

appendix 7.9) and should instead direct attention to promoting the concept of professional networking, leaving practitioners to create their own preferred routes. This should ideally begin at undergraduate level.

This research study has demonstrated that some practitioners actively and instinctively interact regarding professional issues, implicitly developing professional identity and culture. Professional bodies within pharmacy may wish to ensure that this activity is more explicit. The General Pharmaceutical Council Standards of Conduct, Ethics and Performance states that pharmacists should develop their professional knowledge and competence. Recognising that competence requires reflection on and benchmarking of one's own practice versus colleagues, explicit professional standards on the existence of networking activity may be a useful development. To summarise this point, the value of networking activity should be explicitly recognised by pharmacy professional standards bodies.

Pharmacy, in common with other healthcare professions, is a team effort. A further potential implication of this research concerns networking across pharmacy teams, as well as between pharmacists. This study concerned locum community pharmacists, as an identified isolated group of practitioners. Pharmacy technicians and other pharmacy support staff may have similar isolation issues, and networking considerations may apply similarly to them. Organisations representing pharmacy technicians and staff could review the opportunities available for professional networking and facilitate where it is required.

6.4.2 Considerations for future research

The implications for pharmacy practice described above lead logically to considerations for further research. This final section now describes reflections on further development of the ideas linked to this research project.

Given the demise of the Locumvoice forum, one reasonable research question might be, where are those pharmacists interacting now? Surveying where networking activity is taking place may be interesting, but given the speed at which interaction sites move, is unlikely to be particularly useful. A more useful angle to take may be to determine that professional networking interactions are taking place, rather than be concerned about where. The interactions observed on this online forum during this research project have demonstrated contributions to development of professional identity. Posters were sharing what it meant to be 'thinking like a pharmacist' and developing concepts of the job role of the pharmacist. There are a number of angles that could possibly be considered relating to this, one key professional concept being ethical decision-making. Cooper et al (2009) note that the relative isolation of community pharmacists impacts on their ethical decision-making ability. The contribution of online forums to ethical considerations would be a useful suggestion for further investigation, exploring if benchmarking values and opinions versus peers online helped pharmacists with their ethical choices.

In addition, further research could usefully explore the ways in which the professional benefits of networking can be promoted, linking this to the utility of peer review and appraisal as part of the GPhC fitness to practise processes (General Pharmaceutical Council 2016). These

processes recognise the value of peer-to-peer discussion and this should be promoted as part of professional practice, in addition to regulatory fitness to practise processes. How this could be best achieved would be a valuable arena for study.

As mentioned above, pharmacists work in pharmacy teams and consideration could be given to networks within other pharmacy groups, including pharmacy students, newly qualified/foundation pharmacists, pharmacy technicians and pharmacy staff. Cross-group networking may provide additional benefits to interactions within groups. In addition, other groups may be similarly isolated to locum pharmacists. It is reasonable to assume that similar professional engagement issues may exist for the community pharmacy technician, which could be usefully studied. Within the focus groups in this study, locum community pharmacists' relationships with staff were a key feature of their working environment – it may be appropriate to consider how communities of practice can operate in a wider context than simply pharmacists.

In addition, further investigation could usefully be made into the development of networking skills amongst undergraduate pharmacy students. Recognising professional peer to peer interaction as a key, lifelong professional skill, having clear learning and assessment strategies relating to professional networking within the undergraduate curriculum may be a reasonable strategy. Undergraduate teaching strategies may also usefully include facilitation and assessment of professional networking activities, including with pharmacy colleagues outwith the University environment (for example, mentorship arrangements).

This conclusion has covered the implications for practice from the research findings, and discussed some further areas of research that could usefully be considered. In summary, the study contributes to knowledge of UK locum community pharmacists in that it describes the purpose and value of networking as perceived by locums and examines in detail the interactions occurring on an online community of practice that contribute to locum professional engagement and identity development.

End.

7 Appendices

7.1 Appendix: Reflexive statement

“At this point, I will write in the first person to facilitate this description.

I sense a need to recognise and describe how my own self is influencing the process of the research. I reached a point early in the analysis where I moved on from the purely descriptive phase in the focus groups and need to introduce some interpretation into the analysis. My attempts at this have made clear to me how much I have the potential to influence this process. Before I go any further, I need to try, as far as is ever possible, to be conscious of my position in this work.

This comment from Bryman (2012 page 405) struck me particularly: “the investigator him- or herself is the main instrument of data collection, so that what is observed and heard and also what the researcher decides to concentrate upon are very much products of his or her predilections”. I am the main research instrument in this project, and to not examine the nature of the main instrument would be a huge omission. At the start of the research process I wrote, after an hour’s quiet thought, a document entitled ‘My presuppositions’ where I tried to document what I felt were my prejudices and starting points, with pointers as to how I might manage these.

I am writing here about the analysis process, but my influence goes to the very roots of the research – the very idea of it derives from my experiences and concerns. The research objectives are derived from issues I considered important in my own professional practice, and I sought literature to support and justify my ideas. The focus group method I have chosen reflects my own comfort with my professional group, and how I conducted the groups was influenced by my relationship with the participants, what they knew about me and my background. Using an online forum reflected my own fascination with what was going on there.

Discussion by Watt (1997) about motivations and vested interests in research caused me to think about my own reasons for undertaking this research. I realised I felt passionate about community pharmacy and want it to be the best that it can. I wondered if I wanted to validate my own experiences as a locum – do I want to prove that I am of value as a locum pharmacist? Do I in some way need to document my own locum practice during the research – become an ‘insider’?

I also thought about how the act of running a focus group may have influenced how I ran future groups. I think I started with a clear agenda to cover four objectives, and I considered during the session whether I had covered these. I was less concerned about this in future groups. In

some ways, I became less directive (less concerned about sticking to objectives) but also more directive in some ways (using probing questions on interesting issues).

How much directiveness is the right amount? I have agreed research objectives. I have some responsibility to meet these objectives. I also have a responsibility towards the data – I'm doing the data a disservice if I bend/omit/influence it to fit my objectives. My objectives are a project of me. I should allow participants to influence the outcome!

This, and thinking about Dowling (2006) takes me on thinking about...

How has the research defined and limited what can be 'found'? This research is my baby. I had the passion for the subject and the desire to research it. I had to think about what 'professional engagement' meant – did the very fact that I came up with the term mean that I thought there was an inherent problem with it for locums? Was it loaded from the start? Did a bias enter the title? (Dowling (2006) describes how her title changed over time). Within my title I came up with components of engagement. Ostensibly these came from considering literature and discussing with supervisors. But what influenced what literature I looked for and selected? And what influenced the researchers of that literature (locum bad press, infinite regression of reflection!). So have my thoughts and feelings in defining a research question put barriers around what might be 'found' (acknowledging there's no universal truth)? And does it matter?

Yes, I think the fact that I framed my topic guide around components of professional engagement as I saw it has put in my biases at the start. I have mitigated this by trying to be relatively non-directive during the groups, to give participants the chance to vent/discuss what they wanted. The last point in each session was always 'is there anything else you'd like to talk about' which was always taken up by participants, sometimes at considerable length. In later groups, I tried to cover my objectives in the first hour, which left at least another half an hour for this open floor. So while I directed conversation around the four objectives, there was freedom to move away from these.

Does it matter? Yes, I think it does. My worry was that I would not hear anything 'new' to me in the focus groups. I acknowledge that 'old' things may not exist in the literature and therefore be worth recording. But there's something soulless about researching what seems to be blindingly obvious to the researcher. The researcher in me (my emotional need) wants to be surprised and excited by the research. This emotional need probably does influence how I conduct the research – I want to push it till I get that 'thrill' of the new. Is this good or bad? Possibly good: my familiarity with the subject gives me a finely honed sense of what is a 'finding' and I can chase that instinctively in a focus group. It is possibly bad in that I tend to overlook or ignore more routine data (stuff I feel I know already). There is material in this that is worth reporting.

Reading Dowling (2006) also caused me to think about the effect of the research on me. I don't think I've had a huge emotional investment in the research (are you sure? It's your baby..). I've felt very grateful that participants gave me their time. I felt comfortable with participants. I did feel part of a group – an insider. I think a shared background did make a difference (see below). I felt interested in and cared about the participants. This did affect how I questioned as

I didn't want anyone to feel uncomfortable (ethically I didn't want this to happen either). I feel pleased that pharmacy has some committed locums (will this influence what I write?)

How has me being a pharmacist affected participants? I think this has had an influence on the process. It may have affected reasons for participating – wanting to help a fellow pharmacist. I was known to some northwest pharmacists, this may have influenced their decision. Being a pharmacist audience, they may have felt a desire to give a good view of themselves – a non-pharmacist researcher may have revealed different things (and so may individual interviews). I think having a shared language helped the process considerably in terms of joint understanding. I was aware of collusion – thinking we had a shared understanding when we may not have done. I tried to deal with this by accepting collusion over 'things' (eg, joint understanding of pharmacy processes, though I did sometimes clarify these) but trying not to assume joint understanding of feelings, attitudes and experiences. For example, we talked without clarification about MURs, counselling, dispensing. I consciously tried to clarify feelings of isolation, difficulties with CPD, meeting colleagues etc. This assumption of shared understanding was probably my biggest difficulty.

Did the participants want to please me? I don't think so. Sometimes I think they wanted to impress me and others in the group (FG2). To be honest, I think in the focus groups, my presence eventually became peripheral. The groups were all very motivated (though some individuals less so FG3) and ran with the discussion easily after a while. I did let the talk run on and give them space to vent. I felt this was part of the emotional deal we had – they had a space to say what they wanted, even if it may not directly meet my objectives.

I feel more comfortable that the second online phase was an observational study – this meant I had no influence over the content of the posts whatsoever. My influence began only at the start of analysis. Whilst I recognise myself and my experience as a valuable research tool, I felt the need to have balances and checks in the process to regulate my input.

In terms of the research objectives, I did give some thought to my influence over exactly what these were, and how they were derived. I don't believe in an objective approach to literature, I take a constructivist view that we create our own reality based on our perspectives and will interpret information from that individual perspective. For this research study, I examined the literature to give me a basis for the research objectives, but then allowed the data to also inform me – an inductive approach. This meant that the original objectives were reframed in a subtle way as the research progressed. I would like to explain how and why I think this happened. When undertaking the literature review, I was learning about professionalism as I went along (my first draft of the review was effectively a description of that learning journey). I started with views based on structures of professionalism (institutions, nations, law) rather than an individual's perspective. As I learned, and as I was influenced by the results I was finding in my research, the individual perspective started to become more important (probably not surprising, as I was studying people not structures). This led me to consider professional identity and socialisation processes in more detail, and to revisit the literature on this. This iterative process of consideration of the results I was finding and looking again at literature was a key part of the development of the study. This reassures me that I did not meld the data too forcefully to fit with predefined objectives. Where it did not fit, I did try and let the data

tell its story and amend my thinking to the data, rather than the other way round. A thesis is hopefully written as a flowing, coherent story. The reality is more complex.

A final thought: in Baker (2007) there is mention of 'critical realism' – this recognises that yes, we view the world from a particular viewpoint, but the world also acts back on us to constrain the number of viewpoints that can be perceived. A reassuring thought that stops me going down the ontological plughole”.

7.2 Appendix: Focus group ethical approval



11 June 2012

Sarah Wilson / Alison Astles
School of Pharmacy & Biomedical Sciences
University of Central Lancashire

Dear Sarah / Alison

Re: STEM Ethics Committee Application
Unique Reference Number: STEM 062

The STEM ethics committee has granted approval of your proposal application '**Professional engagement of locum community pharmacists**'.

Please note that approval is granted up to the end of project date or for 5 years, whichever is the longer. This is on the assumption that the project does not significantly change, in which case, you should check whether further ethical clearance is required

We shall e-mail you a copy of the end-of-project report form to complete within a month of the anticipated date of project completion you specified on your application form. This should be completed, within 3 months, to complete the ethics governance procedures or, alternatively, an amended end-of-project date forwarded to roffice@uclan.ac.uk quoting your unique reference number.

Additionally, STEM Ethics Committee has listed the following recommendation(s) which it would prefer to be addressed. Please note, however, that the above decision will not be affected should you decide not to address any of these recommendation(s).

Should you decide to make any of these recommended amendments, please forward the amended documentation to roffice@uclan.ac.uk for its records and indicate, by completing the attached grid, which recommendations you have adopted. Please do not resubmit any documentation which you have **not** amended.

Yours sincerely

Kevin Butt
Vice Chair
STEM Ethics Committee

Response to STEM Application

Reference No (STEM 062)

Version No ()

Recommendation	Applicant Response
1. Should mobile telephone number be given in Key contacts Letter? UCLan number could be used (with answer phone message).	

7.3 Appendix: Illegal activities protocol

Protocol following revelation of illegal activities that may present current harm to others

Background

It is possible that the research may yield some responses from participants that disclose illegal activities, though this is not intended or actively sought by the research.

The mostly likely scenario is that a pharmacist discloses details of a situation where harm has or may come to a patient as a result of pharmacists' action, and this has not been previously disclosed. For example, the pharmacist discloses a dispensing error where the patient has been subsequently hospitalised, and the error has not yet been revealed to anyone else.

This action (dispensing error) is illegal, and the patient has to be protected from any further harm of non-disclosure.

Another example would be disclosure of fraudulent activity by third parties, such as prescription endorsement fraud by other pharmacy owners that the locum pharmacist became aware of as part of their work.

This issue can be considered from the point of view of the participant, the third party who may be at risk of harm and the researcher.

The participant

As part of the consent process, participants are informed that confidentiality cannot be assured in all cases. Pharmacists are used to working with confidentiality and its limits when concerning safety and legality so it is anticipated that this will be a familiar concept to them. The General Pharmaceutical Council 'Standards of Conduct, Ethics and Performance'¹ includes the following statement on the subject:

“Never disclose confidential information without consent unless required to do so by the law or in exceptional circumstances.”

The following statement explaining this caveat around confidentiality appears in the participant information sheet for this research project:

“In the interests of patients' safety, it may be deemed necessary to break this confidentiality if you describe some seriously unsafe practice where patients may still be at risk.”

It is not likely that illegal activities will be discussed during the focus group, and such discussion is not being sought by the research. The focus group topic guide has been reviewed to confirm that it does not promote such conversations. The issue will also be raised verbally as part of the introduction to the focus group.

Third parties

If it appears that a third party may be at risk of harm, the focus group will continue and the issue discussed with the supervision team after the event. If the team judge it appropriate, the participant will be encouraged to disclose the incident through their workplace procedures.

The researcher

The researcher should not feel compromised by the research activity. The researcher in this project is also a pharmacist, and is bound by the Standards of Conduct, Ethics and Performance. In order to ensure the research process does not compromise the researcher, the following approach has been taken:

- Ensure participants are fully aware of the confidentiality caveats as part of the consent process
- Review the focus group topic guide to ensure it does not promote such revelations
- A protocol has been developed to deal with any incidents should they arise

Protocol to be followed if a disclosure incident does occur

1. The researcher will recognise and note the disclosure. It is acknowledged that other participants may also recognise an illegal activity where others may still be at harm, and may highlight this to the researcher.
2. The researcher will move the conversation away from the disclosure and continue the focus group.
3. If other members of the group are concerned about the issue, the researcher will reassure them that there is a protocol to be followed.
4. The researcher will document the incident at the end of the focus group.
5. The researcher will speak to the supervision team and decide whether the situation requires any further action.
6. Further action will consist of encouraging the participant to disclose the activity through their workplace or regulatory procedures.

1. <http://www.pharmacyregulation.org/sites/default/files/Standards%20of%20conduct,%20ethics%20and%20performance.pdf>

7.4 Appendix: Focus group information sheet and consent form

INFORMATION SHEET

Professional engagement of locum community pharmacists

You are being invited to take part in a research study, led by Alison Astles, a pharmacist and PhD student at the University of Central Lancashire (UCLan). Before you decide whether to take part, it is important for you to understand why the research is being carried out and what it involves for you.

Please take time to read the following information carefully. Discuss it with others if you wish. If there is anything that is not clear or if you would like to receive more information, please feel free to contact me (Alison Astles) on 07580 956653 or AMAstles@uclan.ac.uk, or Director of Studies Dr Sarah Wilson on SEWilson@uclan.ac.uk.

Take time to decide whether or not you wish to take part.

What is the purpose of the study?

There is very little published information on locum community pharmacists, and they constitute over a third of the community pharmacy workforce. This postgraduate research project uses focus groups to explore **professional engagement of locum community pharmacists**. Examples of professional engagement activities include networking with other pharmacists and undertaking continuing professional development. Exploring this issue may help the pharmacy profession understand the nature of the locum pharmacy workforce and the implications of this pattern of working. It may also help identify resources or strategies that will support the locum pharmacist.

Why have I been chosen?

You have been invited to take part in this study as you have undertaken some locum community pharmacy work during the last year, giving you the necessary knowledge and expertise to contribute to this research.

What will happen to me if I take part?

If you decide to take part, you will take part in a group discussion called a focus group with other colleagues about your work experiences and perceptions working as a locum community pharmacist. The discussion will be guided by Alison Astles and will be flexible, but will be based around professional engagement of locum community pharmacists.

The focus group will be an evening meeting, held close to where you live or work. The discussion should take no longer than 1.5 hours.

The focus group will be sound recorded, typed up and analysed.

Reimbursement

As reimbursement for your time and travel, you will be given £30 for your participation.

Will information about me remain confidential?

When the discussion is typed up, the information will be anonymised by removing names of people and places. Your personal details will not be used in the analysis. We may use quotes from your focus group in reports or publications, but these will not be attributed to you.

The research team (that is myself and my supervisors at the University) will not reveal to anybody that you participated in this research. The study will respect patient confidentiality and you will be asked not to mention patients, colleagues or organisations by name. If any details of patients, colleagues or organisations are mentioned they will be removed from the transcripts of the interview data.

In the interests of patients' safety, it may be deemed necessary to break confidentiality if you describe some seriously unsafe practice where patients may still be at risk.

As a qualified pharmacist, all participants are bound by the GPhC Standards and Codes, and as such are obliged to put patient safety first. If any member of the focus group describes any seriously unsafe practice where patients may still be at risk, and where the pharmacist or pharmacy is identifiable, it may be deemed necessary to break confidentiality. For this reason we recommend you do not identify individuals or yourself in giving examples, but refer to 'someone I know' in the discussions.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw from the study at any time, and without giving a reason. You may also leave the focus group at any point, if you wish to, but the audio recording of the group will be retained.

What if there is a problem?

If you have any concerns about any aspect of this study, you should speak with the researcher Alison Astles who will do her best to answer your questions (see contact details).

If you remain unhappy and wish to complain formally, you can contact the UCLan School of Pharmacy and Biomedical Sciences Dean of School Professor Tony D'Emanuele on ADemanuele@uclan.ac.uk. Professor D'Emanuele is not directly involved in the research.

If you are affected by any of the issues under discussion, you can contact the confidential Listening Friends service for pharmacists on 0808 618 5133.

What will happen to the results of the research study?

The results of the study will be published in professional journals and at conferences. They will also contribute to the completion of a postgraduate thesis.

Who has organised the study?

The study is being supervised by staff from the Schools of Pharmacy and Biomedical Sciences and Psychology at the University of Central Lancashire. The Pharmacy Practice Research Trust has funded this study.

Who has reviewed the study?

This study has been approved by the University Research Ethics Committee in (*insert date*).

What do I do next?

Complete and return the enclosed consent form, in the postage paid envelope provided, indicating that you wish to take part in this study. Alternatively, telephone or email using the contact details below to arrange a convenient date to take part in the focus group.

Contact details for further information

If you wish to ask any questions about this study before deciding to take part, please do not hesitate to contact me at:

Alison Astles, MRPharmS
MB023 Maudland Building
School of Pharmacy and Biomedical Sciences
University of Central Lancashire
Preston PR1 2HE

Email: AMAstles@Uclan.ac.uk

Supervisors contact details:

Dr Sarah Wilson SEWilson@Uclan.ac.uk Dr Cath Sullivan CSullivan@Uclan.ac.uk

Thank you once again for taking the time to read through this information and considering taking part in this study.

CONSENT FORM

Professional engagement of locum community pharmacists

If you agree with the statements below please initial in the box:

	Initial each
box:	
I have read and understood the information sheet	<input type="checkbox"/>
I have had an opportunity to ask questions and discuss this study	<input type="checkbox"/>
I have received satisfactory answers to all my questions	<input type="checkbox"/>
I give permission for the researcher to use direct, anonymised quotes in publications	<input type="checkbox"/>
I give my permission for this interview to be digitally recorded	<input type="checkbox"/>
I agree to take part in the study	<input type="checkbox"/>
I would like to receive a summary of the research results	<input type="checkbox"/>

Name (PLEASE PRINT).....

Signed.....Date.....

Please indicate how you would prefer to be contacted to arrange your participation in the study. Please provide your telephone number / email address:

Telephone:..... Email:.....

Please complete the demographic information over the page.

About you:

Gender (please circle one): M F

Age (please circle one): Under 40 years old 40 years old or over

Please tick one of these:

In general, do you:

locum in the same pharmacy regularly

Or

locum in a variety of different pharmacies

Please keep the information sheet and return this consent form using the stamped address envelope provided, thank you.

7.5 Appendix: Focus group topic guide

Introduction and welcome/ housekeeping

Thanks for coming

I'm a PhD student and locum community pharmacist

Drinks/loos/fire alarms/name badges

Has everyone completed a consent form?

What we're here to do

We're here to talk about professional engagement of locum community pharmacists. This is not about me asking you questions, I'm going to put forward an idea and I'd like you to discuss it between you. So you need to be doing most of the talking.

Consent and recording

You've all signed the consent form and understand that we're going to be recording this session. This gets typed up by me afterwards. Try and avoid saying names of people or organisations, but don't worry if you do because when I type it up I will anonymise any names or anything could identify a person or a place. Don't forget I've no control over what anyone else here does with anything you say – shall we agree some ground rules about that?

Ground rules

Can we agree some ground rules? Can I suggest:

- *That people don't talk about what somebody else here said, outside this room – what's said here stays here*
- *Professional caveats around confidentiality if patients are still at risk of harm*
- *That we give space for everyone to have their say*
- *That everyone's opinion is valuable and is respected – we don't have to agree*

Can we agree to those? Does anyone have any other suggestions?

Let's start with introductions.

Give your first name and a bit about yourself as a locum, how often you work, whether you travel far and so on.

General warm-up

We've these objectives in mind for this research (show), can I start by asking what you think professional engagement means?

CPD
<i>All pharmacists have to do CPD. I'll start with a broad question – lets talk about CPD in relation to locums.</i>
Prompts:
<i>Access to resources</i>
<i>Time</i>
<i>Lack of feedback</i>
<i>No incentive</i>
Participation in service developments
<i>Pharmacy has changed a lot since the new contract. We've advanced and enhanced services. Taking the NMS as an example, do you have any thoughts on locum participation in services?</i>
Prompts:
<i>Do locums engage? Why? Why not?</i>
<i>Does it matter? Why? Why not?</i>
<i>Are there any barriers? What helps?</i>
Networking with colleagues
<i>As professionals, we have to work with other people .Tell me about who locums network with, and how they do it.</i>
Prompts:
<i>Types of colleagues</i>
<i>Methods</i>
<i>Usefulness of it/ What you get out of networking</i>
<i>What happens if you don't/can't do it</i>
Involvement with pharmacy organisations

<i>Another part of networking is involvement with pharmacy organisations. Are there any organisations that are important as/to a locum?</i>
Prompts
<i>What are the organisations?</i>
<i>Why are they important? Are some not?</i>
<i>What do locums get out of that involvement?</i>
<i>Are there any barriers to involvement? Anything that helps?</i>
<i>Are the organisations the right ones? Are they fit for the job for locums?</i>
Summary
<i>We started off with these objectives (show), and we've talked about (topics).</i>
Prompts
<i>Anything other than what we've already discussed?</i>
<i>Are any of those ideas different for a locum than for an employed or contractor pharmacist? Why? Why not?</i>

Conclusion

Is there anything else anyone wants to say?

I'll forward a copy of research findings to those who have indicated this on the consent form (chance to do so now).

Thanks for taking part

Safe trip back.

7.6 Appendix: Example of post-focus group discussion

FG1 July 23 2012 (Venue details)

4 Participants

Alison Astles/Nicola Gray

What went well? What was productive?

The group was friendly and chatty, we warmed up quickly and everyone seemed to have a clear idea about what they were there to do. The group were eager to chat, so I let them do their own thing for about twenty minutes, following their lead, then was a bit more directive to guide them to the topics I wished to discuss. I think the sections on CPD and service developments were easy to facilitate – participants had an instinctive understanding of what I wanted; the sections on networking with colleagues and organisations were less intuitive – I had to press these a little. I took my cues from the conversation, so the sections were roughly covered in the order: services, CPD, colleagues and organisations.

What could we do better? What was not productive?

Maybe twenty minutes ‘freestyle’ (relatively unstructured chat) at the beginning was a bit long – reduce this a little. Nicky fed back that she wasn’t sure where this was going at the start, but I felt reasonably in control. I will structure my introduction a little better and be less repetitive.

Even though we struggled slightly with them, I will do the sections on networking and organisations the same way for FG2. They were a little more difficult, but it may be that this is because they ARE more difficult for participants – that may be the outcome.

I’ll turn the tape on before I get them to do their introductions. Don’t forget to introduce the co-host!

Were any members particularly dominant or quiet?

No, everyone seemed to have their say and was willing and able to contribute. I think the group dynamics worked well. Two people had bought sheets of notes with them – they’d thought about it beforehand.

Was there anything significant about the interactions?

Participant A sat with arms and legs crossed away from the group on occasion, and had some strong opinions about ‘the state of pharmacy’ which didn’t engage the others usually. People were generally supportive of each other’s views.

Do we need any modifications to the topic guide?

I think I’ll leave the basic structure the same for now – discussion above. There was an idea of locums having ‘clout’ which I liked – I might remember this for next time.

What particular themes struck you?

The idea of locums having 'clout' – being able to influence a situation. This reflects literature about locums voting with their feet (not returning to a store) rather than working/commenting to improve services in a poor store. Also there is literature about locums influencing –or not – whether to undertake MURs, influencing staffing levels etc.

There was a repeated comment about '2000' – the population of patients in a pharmacy that a regular pharmacist knows really well, and that a locum doesn't. It was discussed in relation to learning and CPD. This is not a way of describing it that I've come across before, but others in the group seemed to relate to the description.

My performance:

Feedback from Nicky: overall fine, perhaps be a bit more directive to start, don't leave it freestyle for so long. At the start I summarised rather too much, but this reduced as the group went on. Nicky felt I got into my stride about half way through, with sufficient comment and follow-up of ideas.

Did I collude with participants about shared knowledge and assumptions?

I'm not sure. I'll listen again and think. I reflected with Nicky that I felt I'd heard it all before, as I was listening, but then thought that I need to be a bit more naïve about the research – just because I've heard it doesn't mean it isn't research and that it exists in the literature. I need to think clearly about all my pharmacy baggage, and not miss important points because they seem obvious to me. I need to start by a detailed analysis that includes everything, no matter how obvious to me.

Were instructions clear?

I think people had a clear understanding of what they needed to do, judging by their responses and behaviour. I need to a little more succinct with my introduction – it was a bit repetitive. I should include an instruction to not talk over each other if possible.

Confidence?

OK

Group management?

I was conscious of time, and roughly spaced working through the four topic guide themes according to the time available. We finished on time. The group was easy to manage as they were respectful of each other, not too much over-talking, good turn-taking.

Structure adapted from (Kidd, Parshall 2000)

7.7 Appendix: List of focus group transcription conventions

Issue	Action taken/indication
Participant names	Replaced with random alphabetical name
Yeh	Single yeh/yes are included. Multiple approving yeh, yeh, in blocks of speech by others are excluded to improve flow. Significant approvals are included.
...	Short pause – one second or less
(pause)	Longer pause – one second or more
(laugh)	Short laugh/chuckle
Erm	Included – indicates a thinking pause
Mmm	Included. Indicates approval.
CAPITALS	EMphasis
Colloquialisms	Wanna, coulda etc are written out in full – want to, could have
Dropped consonants	Added back in.
????	Indecipherable
?	Question, also rising inflexion.
Numbered line length	One person's speech
What's included:	Introduction from moderator is excluded from the transcript, up to the point where the moderator invites the first participant to talk. End: where moderator thanks participants and no more speech relevant to the topic occurs (goodbyes etc excluded).
Company names	Replaced with (company)
Geographical identifiers	Replaced with (descriptor), for example M62 replaced with (motorway)
Personal identifiers	Where a participant has a possibly identifiable job, this is replaced with (descriptor), for example, consultant to a named national organisation replaced with (company consultant)

7.8 Appendix: Professional engagement node list and description

Name	Description	Number of coding references
100 hour pharmacies	Where 100 hour pharmacies are mentioned.	7
Accreditation for services	Accreditation for advanced or enhanced services. Links with CPD node.	96
Adaptability	Where adapting to situations is discussed.	8
Agencies	Any reference to locum agencies	44
Assertiveness	Reference to locums being assertive, imposing their will	31
Blacklisted pharmacies	Pharmacies that get a bad reputation and nobody wants to work there	2
Blindly following the rules	Following rules regardless of own judgement. Applies to staff as well as locums. Links with staff node.	17
Choice of pharmacy to work in	How locums make choices about where they want to work	5
Clout power of locums	Locums having clout or personal power influence to change things	38
Commitment	Commitment to pharmacy, usually expressed as commitment to patients. This node is poorly done - do it again, there's lots I've missed.	8
Communication	General communication. Poorly done node - there's tons more. It's probably relevant to 'picking up and passing the baton' on - ie, how good and poor information transfer affects locum working.	29
Continuity of service	Picking up the baton - links to this node. Combine the two? Could also relate to patient safety node. Also links to communication node. Combine communication, continuity and picking up baton nodes?	15
CPD	Any mention of CPD. Links to accreditation and information resources nodes.	169
CPPE	Any mention of CPPE. Links to information resources and CPD (but kept it separate as it might be interesting for CC).	31
Different perspective	Locum adding something to a situation as they bring a new pair of eyes, look at an existing problem in a new way. Links to locum assessing quality node - locums making judgements about pharmacy service quality.	4
Don't rock the boat	About locums maintaining systems, sometimes even though they don't like them. Links to 'locums assessing quality' and 'staff' nodes. Probably links with assertiveness node too somehow. Mostly described as a positive (service continuity) but can also be negative (unassertive, lazy).	10
EHC	Any mention of EHC. Probably combine with enhanced services, but EHC is the most time critical enhanced service so gives locums more problems.	26
Enhanced services	Any mention of enhanced services. Links strongly to accreditation and CPD.	32

Ethical dilemmas	Where specifically mentioned. There are probably a lot more to be coded that aren't as explicit.	12
Feedback and appraisal	Where both feedback TO and FROM the locum on performance and quality are considered. Important node. Links with CPD, staff, locums assessing quality, locum competence.	151
Flexibility	References to being flexible. Is it different to adaptable? A poorly done but quite important node - think how to get these concepts out.	9
Great quotes		46
Independent pharmacies	References to independents. Links with SOPs, multiples, assessing quality	30
Induction of locum	Any reference to induction processes for the locum, usually by staff, maybe agencies. Important concept from my MPhil. Links to staff node.	16
Information resources	References to information sources used by locums. Links to CPD.	163
Internet use	Links to information sources node. Also has some negative connotations re staff. Probably not a stand-alone node - think about amalgamating with information resources, networking, staff nodes.	76
Isolation	References to isolation of locums. Links to networking node.	68
Lack of local knowledge	Locums not knowing the locale and local working practices. Well covered in my MPhil. Often links to staff.	9
Lack of support	Lack of support for locums from pharmacies. Think about this one. Links strongly to information resources and staff - consider amalgamating.	10
Locum assessing service quality	Locums making a judgement about pharmacy processes being good enough or not. Very important node. Links to feedback/appraisal node - work through the overlaps.	68
Locum competency	References to locums being competent. Important node. Links to CPD, feedback, information resources, staff, patient safety.	72
Locum loyalty	Loyalty or otherwise of the locum to the business. Possibly amalgamate with commitment. Links to competency, but more emotional.	10
Money	Any reference to money or payment. Links to accreditation, workforce issues.	122
Multiple pharmacies	Reference to multiples. Links to independents. Often links to accreditation, staff and money.	121
Multiple pharmacies (Associated)	Employees think differently to locums	1
MURs	Any reference to MURs. Probably amalgamate with enhanced services (even tho' advanced!)	97
Networking	Locums meeting other pharmacists. Doesn't really link to the communication node.	125
NMS	Any reference to NMS. Probably amalgamate.	10
Organisations	Reference to any organisations that locums find useful. Links to networking, but a bit different. Links more strongly to information resources.	93

Patient safety	Any references to patient safety, positive or negative.	14
Patient's best interest	Any reference to patient's best interest. Links to continuity and accreditation.	37
Pharmacies run on locums	Problems and issues of pharmacies without regular managers. An interesting node - new stuff.	34
Physical environment	Reference to the physical environment of the pharmacy impacting on locums. A poorly done node - there's a lot more here yet. A project in itself, so maybe not for professional engagement?	13
Problem solving	I think this can amalgamate to baton passing node, locum competency.	2
Professional engagement	I think this can amalgamate with CPD for now. There's also something about professional satisfaction in this.	2
Professional satisfaction	An underused node - go back and do this again. There's a lot more in this.	24
Reasons for locuming	Why locums locum. Well covered in previous research and in my MPhil, so probably not a major theme for this PhD.	37
Role of the locum	What they are actually there to do. Managerial vs clinical. This is reasonably well covered in previous research (and in my MPhil) so not new, but interesting and contributes to professional engagement.	5
Staff	References to staff. Lots of links. Well covered in my MPhil. Links to induction, CPD, information resources, continuity, baton-passing.	135
Standard operating procedures	Any mention of SOPs.	36
Status	Reference to professional position as a locum, how they are perceived by others. Well covered in my MPhil. Interesting idea, maybe not a priority idea for this project.	11
Stress	References to stress. Links to workload, information resources, locums assessing quality, staff. Well covered in other research, probably not a priority here.	28
Taking the baton forward	Relates to picking up yesterday's problems, and smoothing tomorrow's problems. Links to communication, information resources, induction, staff. A key locum concept.	10
Threats to future employment	Refers to issues which affect employment. Important concept and becoming more so. Links to accreditation, locums assessing quality, workforce.	33
Trust - are locums trusted	Interesting, probably amalgamate with status. Interesting rather than important I think.	16
Undermining the locum	Staff or others undermining the locum. Amalgamate with status. Links to staff, information resources, professional satisfaction.	13
Unprofessional activities	Amalgamate this with the role of the locum - same stuff.	21
Variety	Amalgamate this with reasons for locuming	1
Voting with feet	Deciding not to go back to a pharmacy because you don't like the conditions. Important node. Links with locums assessing quality, assertiveness, clout.	42
Why we locum	Reasons given for being a locum. Amalgamate with reasons	9

	for locuming	
Work harder as a locum	Amalgamate with information resources	2
Work pattern	How people work - regular days, ad hoc, full time, occasional day	8
Workforce oversupply	too many pharmacists in the market. Of growing importance. Links to voting with feet, money, accreditations, locums assessing quality	68
Workload	Could probably amalgamate with stress	14

7.9 Appendix: Decision factors for choice of discussion forum

Is it UK only?
Is it current? Date of last post, how many new topics in last xx months
What's the format, ie, posting statements and getting a response? Does it vary?
How popular is it? Some count of posts
How large is the total community? Registered users
Who runs it? Does this have an influence?
Do the topics have a particular focus?
What is the range of topics?
Who are the posters? Many organisational posters (eg agencies, RPS) or mostly individuals?
Am I able to access it for research purposes?

Search	Link	Comment
Google*/own knowledge	http://www.LocumVoice.com/viewforum.php?f=8	Locum voice
Google/own knowledge	http://www.pharmacy-forum.co.uk/you-locum-pharmacist/	Pharmacy Forum.
Google/own knowledge	http://www.rpharms.com/sector-groups/locum-group.asp	RPS group
Own knowledge	RPS LPF groups – see if they do cover any locum issues	No
Google	http://www.thestudentroom.co.uk/showthread.php?t=158014	Student room
Google	http://www.pjonline.com/forum	PJ Online
Own	Facebook?	

knowledge	Lloyds Pharmacy Locum. Can't find much else other than individuals (search 'locum pharmacist/pharmacy')	
Own knowledge	Twitter? Some individuals and agencies, (search 'locum pharmacist/pharmacy')	
	International	
	http://pharmlink.com.au/faq/sitemap/	
Agencies	http://www.teamlocum.co.uk/tag/pharmacy/	

Criterion	Locum Voice	Pharmacy Forum – Locum	RPS Group	PJonline forum
Date examined	15/4/13	15/4/13	8/5/13	8/5/13
Is it UK only?	Yes	Has international section	Yes	
Is it current? Date of last post:	15/4/13	14/4/13	19/4/13	Last used nearly four years ago
What's the format, ie, posting statements and getting a response? Does it vary?	Threads	Threads	Threads	
How many new threads in the last month?	78	12	1	0
How many different names in the first 100 posts?	37		7 posts in the last year (and one of them was me)	Total ever: 3 topics, 6 posts
Max number of posts in first 100 posts	12		22	

Usage	Max 90 on 24/3/13	Max 2063 16/10/12		
Total posts	98802	100696		
Total members	2074	10272	625	
Who runs it? Does this have an influence?	Lindsay Gilpin – posts quite a lot.	Elaine Hutton	RPS. LG moderates	
Do the topics have a particular focus?	Community locums.	Seems community based. Has a locum section.	Survey/ course adverts, some chat. One post recommends LocumVoice.	
What is the range of topics?	Rx issues, pharmacy politics, queries	Rx issues, pharmacy politics, queries		
Who are the posters? Many organisational posters (eg agencies, RPS) or mostly individuals?	Locum, some 'names'	Seem to be individuals	RPS members, individuals	
Am I able to access it for research purposes?	Probably	Maybe		
Pseudonyms used?	Mixed	Mixed	No	
Login required?			RPS members only	
Verdict	Seems most popular, accessible, go with this	Shares some pseudonyms with LocumVoice	Too quiet	Unused

7.10 Appendix: Text for online weblink

Use of an online discussion forum by locum pharmacists

This research study aims to describe the content of an online forum used by locum pharmacists. The study is being undertaken by Alison Astles, a PhD student at the University of Central Lancashire. The study aims to determine what use locum pharmacists make of the site by analysis of the content of their posts.

The study will examine the content of two months' posts copied from the site. Individuals will not be identifiable from the results as all names/pseudonyms will be removed.

Posts which breach confidentiality for individuals, promote illegal activity or are otherwise inappropriate may be highlighted to the moderator and if necessary referred to the regulator.

Ethical approval for this research was obtained from the University of Central Lancashire on January 14 2014.

If you wish to opt out of this research, please email Alison on amastles@uclan.ac.uk and your posts will not be copied from the site. You may opt out at any time up to three months from now.

If you would like a summary of the results when published, please contact amastles@uclan.ac.uk and you will receive an email summary in due course.

7.11 Appendix: Online data cleaning protocol

Remove:	Example:
Date and time – no use	Sat Feb 01, 2014 5:52 pm
Poster history - no use.	<p>Posts: 3135</p> <p>Joined: Mon Sep 21, 2009 7:18 am</p> <p>Location: Birmingham</p>
Hyperlinks such as ‘top’	
Individual footers linked to the poster’s name	<p>“Any views expressed do not necessarily represent those of any board or committee on which I sit.”</p> <p>Some of them are very individual and would be googleable, leading to identification of the poster. Some also include the poster’s email address and weblink.</p>
Text copied in posts (where poster is replying)	
Any posts outside the data collection period Feb 10 2014 to Apr 9 2014 inclusive (including text copied in posts).	
Headers	<p>Feel free to post your own opinions or post your own topics. Please note, you must be registered to post here.</p> <p>Post a reply</p> <div style="border: 1px solid #ccc; padding: 5px; display: inline-block;"> <input type="text" value="Search this topic..."/> <input type="button" value="Search"/> </div> <p>First unread post • 16 posts • Page 1 of 2 • 1, 2</p> <ul style="list-style-type: none"> • Report this post • Reply with quote
Footers	<ul style="list-style-type: none"> • Private message <p>Top</p> <hr style="border: 1px solid #ccc;"/> <ul style="list-style-type: none"> • Report this post

	<ul style="list-style-type: none"> • Reply with quote
Font	Changed all to Calibri font size 10 for readability.
Repeated thread headings with each post	

Change:

Names and pseudonyms	To a code. I've used Poster1, Poster2 etc so they are recognisable in a word search.
----------------------	--------------------------------------------------------------------------------------

Leave in:

Internet links (apart from poster's own websites in footers, which are removed)	Interesting.
Emoticons	Useful.
Names of people in public domain being referred to	Journalists, published authors

7.12 Appendix: Memos for online analysis – interactions

	<i>Rationalisation 1 – after 300 lines coded and discussion with Sarah</i>
<i>Memories</i>	<i>I combine ‘asking others for memories into ‘memory sharing’. It will be sufficient to have just one memory category at this stage.</i>
<i>Challenge</i>	<i>I’m not sure about ‘challenge’. I’ve labelled it as being provocative – maybe that’s a better word?</i>
<i>Humour as defuse</i>	<i>I’ve amalgamated this into humour. Only need one category at this stage.</i>
<i>Informal instruction</i>	<i>I’ve amalgamated this into instruction.</i>
<i>Opinion – asking for others’ opinion</i>	<i>Amalgamated into opinion gathering</i>
<i>Projecting professional image/ projection of professional image/ professionalism</i>	<i>Combined to professional image. Later amended to professionalism – a broader term that covers any professional issues.</i>
<i>Question/questioning other pharmacists/ question rhetorical</i>	<i>Combined into question. Difference between asking others for opinion and asking a question of others? I think asking for opinion is enquiring about what others think about a situation. Asking a question is asking for fact or what another would DO in a situation. However, perhaps question should just relate to asking for facts and not about others’ thoughts and behaviours (they would be opinion seeking).</i>
<i>Mode of action/saying what they did</i>	<i>Combined these two into mode of action</i>
<i>Affirmation/agreeing with another poster</i>	<i>Amalgamated into agreement</i>
<i>Wishing</i>	<i>Change this, I’ve put it as a hope that something will be a certain way – I’m not sure I can intuit that. I changed to mode of action – something that they would do. Actually, after discussion with SW I think wishing should be back in – there is something about wanting things to be a certain way that could link to professionalism ideas. Go with it for now. I’ve added wish as a hope that something will be a certain way eg,</i>

	<i>we have to get this right line 205.</i>	
<i>Taking up the suggestion of others</i>	<i>Changed to agreement. Too fine a distinction to be reliable.</i>	
<i>Making judgement</i>	<i>Combined with Opinion giving. I cannot distinguish between the two. Actually, I've changed my mind and put judgement back in – it's when someone describes how they chose a particular way. Or should it be describing decision-making?</i>	
<i>Information giving/ information sharing</i>	<i>Combined into information giving. Overall theme is information.</i>	
<i>Exhortation</i>	<i>Hmm, a difficult one, it is more than an instruction, it's a call to arms for a cause. I'll leave it in for now as it's quite a powerful idea.</i>	
	After 900 lines completed	
<i>Affirmation/agreement/ agreeing with others</i>	<i>Amalgamated into agreement. I looked also at approval, but this was different in that it was more a social support statement (eg well done, excellent).</i>	
<i>Challenge/disagreement</i>	<i>I wondered if these were different, and I think they are. Disagreement is saying, no, you're wrong. Challenge is more provocative and questioning – so what's your excuse? Deleted disagreement and changed to challenge.</i>	
<i>Assertiveness</i>	<i>I've subcoded these as challenge and I think that's more reasonable. They were provocative and slightly goading. Assertiveness is still an important concept, but can be discussed under challenge. Challenge is easier to recognise – I'm perhaps over-interpreting that posters are being assertive. I've deleted this code and changed it to challenge.</i>	
<i>Suggestion/ instruction</i>	<i>I've merged these two under suggestion. Instruction at first looked a little more directive than suggestion, but I think that distinction is too subtle to be worthwhile.</i>	
Overall theme	Themes review after 1000 lines	
	What this is about:	Why it's important:

Opinion	Giving their opinions on a topic, asking for others' views on a topic.	Sharing views on pharmacy issues, developing attitudes, forming opinions.
Identity	Defining what a pharmacist should be like, how professionals behave, setting professional norms, agreeing group behaviour, creating group sense, considering what pharmacists should do.	Creates and reinforces group identity, implicit group definition of professional behaviours.
Storytelling	Storytelling can entertain, educate, instil cultural and moral values. Posters discuss patients, the impact of their choices, politics, safety.	It is passing on information, developing the culture, questioning ways of thinking. Need to link this to content (ie, what they are talking about) to ensure it makes sense and describes the situation well.
Memories	Memories can be different from storytelling in that they don't necessarily tell a tale, they recall a past event that may be just factual, eg, how something was done. A story tends to have more of a purpose than just passing on recall. Memories include early career activities, people, work activities. Storytelling can (and often does) include memories.	Reinforcement of a shared history (via shared memories), sense of belonging to a group with a shared history (links to identity).
Wishes	This was reinstated as a theme as when they discuss pharmacy issues, it relates to a desire for things to be a certain way – aspiration, developing a vision. It often links to a call to action, so make links to content about this.	This relates to professional leadership, developing a vision, having thoughts on the way the profession or pharmacists should be, contributing to development of culture.
Call to action	I also called this exhortation – rallying others to take a course of action, contains very directive	Professional leadership, motivation, creating a culture, pushing in a direction, setting an

	language (we need to, tell them, go out now, lets get moving).	agenda
Agreement	Agreement is supporting the views of others.	Again, it would be good to link this to content, but it reinforces a sense of a joint agenda and way of thinking, helps create group identity
Challenge	Related to eg pharmacy elections and standing up and being counted. Usually came across quite aggressively. It was a request to justify an action or inaction, or opinion.	This is questioning professional behaviours/attitudes and demanding justification. It is culture- building. It is also assertive and provokes debate.
Decision making Is this a content issue?	When a poster describes how they made a decision about an issue. What they actually did comes under mode of action. It provides a rationale for the choice and motivations behind it. Sometimes it is in response to a challenge.	This provides some description of professional thought processes, and the attitudes that lie behind it.
Information	A major theme in numerical terms, consisted of providing links to sources, information about a situation.	Shows evidence of sharing resources around pharmacy issues.
Suggestion	Puts forward what someone else can do. I merged 'instruction' into this theme, which was a little more directive (ie, telling someone what to do).	Shows the forum acting as an information resource. Sharing views on correct mode of action. Acting as a supportive group. Some element of creating a culture (what you would reasonably do in a situation).
Mode of action Rename this	This is posters saying what they would do or did in a situation. Often in response to a question or challenge.	In terms of professionalism, this starts to create behavioural norms. Links to decision making as well.
Question	Questions ask for views or information. Sometimes they were rhetorical. Often they	The forum is acting as an information resource both for factual information and as a way

	seemed intended to provoke debate.	of exploring others' views on a situation.
Humour	Smileys, amusing stories, punchlines, tension reduction	A social function that helps with group cohesiveness and managing challenging interactions.
Social interaction	Smileys, greetings, expressions of approval.	A social function that helps with group cohesiveness . Oils the wheels.
	<i>Thoughts after 1200 lines</i>	
	<p><i>Can I group these broader themes? How do they speak to each other?</i></p> <p><i>What is a good way to present the story?</i></p> <p><i>Start to make links between interaction type and content.</i></p>	

7.13 Appendix: Example of coding of online analysis

Text	What is the function of this?	Is there a function theme?	Code book notes	What are they talking about?	Is there a content theme?	Code book notes
Just completed first week of Medicines Adherence course. Basically it contains first few pages of CPPE Consultation skills for pharmacy practice, but I feel that I understand the concept of non-adherence better after watching videos. I find this form of learning much more enjoyable than dry CPPE booklets.	Information giving	6 Gives orientation	In this case, information given is that they did a course and what it contains.	Description of learning activity	Learning	Saying what course they did
.	Opinion giving	5 Gives opinion	The opinion given here is their view of learning preference.	Learning preferences	Learning	Stating what they liked about a learning activity

7.14 Appendix: The existence of small groups on the online forum

This appendix describes the process for determining that small groups existed within the interactions on the online forum.

Considering the total population of people who interacted on the forum during the research period, 59 separate names or pseudonyms posted in some way, creating a total of 67 different threads. As individuals could potentially have multiple login names, it is possible that there are fewer people than this interacting. Nearly half of these 59 (27 posters) only posted either once or twice during the research period, either starting or responding to a thread. The remaining half (32 posters) were responsible for 90% of the posts during the research period (385 of 427 posts). Thus, there were a significant number (half) of posters who had a very limited interaction with the forum – and the other half was significantly engaged.

However, each thread is a separate conversation and the ‘small group’ may be taken as the interaction of posters within each thread, rather than activity across the data period as a whole. Whilst the data were analysed as a whole, each thread is effectively a closed interaction between a group of posters. Taking a closer look at the posting activity within each group reveals that the mean number of posts in each thread was 10, with a range of 1 to 48 posts and a mode (most frequent value) of five posts. The mode may be the most useful value here as the short ‘tail’ of threads with larger numbers of posts skews the mean. This shows that the interaction for the majority of threads lasted for about five posts. Seven threads contained only one post – that is, the original post, which was unanswered.

Table 8: Number of posts in each thread

Posts in each thread:	
Mean	10
Mode	5
Range	1-48

Next, the number of posters who took part in each thread was calculated. For each thread, the codename of every poster was identified and noted. If a poster contributed multiple times within a thread, for the purposes of this calculation they were only counted once. This gave an indication of the number of posters ‘present’ for each thread – to use a real life analogy, how many people were in the room during the interaction. For all posts, the mean number of posters present was 5, with a mode of 4 and a range of 1 to 15. Thus, it can be stated that most threads did constitute small groups of individuals.

Table 9: Number of posters present on each thread

Posters present on each thread:	
Mean	5
Mode	4
Range	1-15

Consideration was also given to whether the forum was dominated by one or two individuals. There were 59 individual posters who contributed to the discussion during the research period, providing 67 separate threads in total. Thirty four of the 59 individuals started a thread (that is, the other 25 posters only responded to posts).

Of these 34 thread-starters, 22 started one thread, four started two threads, two started three threads, three started four threads, one started five threads and two started seven threads. This demonstrates that the forum was not overly dominated by a small number of individuals.

Number of threads started by posters

Number of threads	1	2	3	4	5	6	7
Number of threads started by individual posters	22	4	2	3	1	0	2

Within the 67 threads created, there was a total of 667 responses, which is approximately 10 responses per thread, with a maximum of 48 responses to one thread. Seven threads had no responses (that is, just the original poster's comments). Overall, this demonstrates active engagement of posters with each other and with the topics under discussion during the research period.

7.15 Appendix: COREQ checklist

No	Item	Guide questions/description
Domain 1:		
Research team and reflexivity		
Personal Characteristics		
1.	Interviewer/facilitator	Which author/s conducted the interview or focus group?
2.	Credentials	What were the researcher's credentials? <i>E.g. PhD, MD</i>
3.	Occupation	What was their occupation at the time of the study?
4.	Gender	Was the researcher male or female?
5.	Experience and training	What experience or training did the researcher have?
Relationship with participants		
6.	Relationship established	Was a relationship established prior to study commencement?
7.	Participant knowledge of the interviewer	What did the participants know about the researcher? <i>e.g. personal goals, reasons for doing the research</i>
8.	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? <i>e.g. Bias, assumptions, reasons and interests in the research topic</i>
Domain 2: study design		
Theoretical framework		
9.	Methodological orientation and Theory	What methodological orientation was stated to underpin the study? <i>e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis</i>
Participant selection		

No	Item	Guide questions/description
10.	Sampling	How were participants selected? <i>e.g. purposive, convenience, consecutive, snowball</i>
11.	Method of approach	How were participants approached? <i>e.g. face-to-face, telephone, mail, email</i>
12.	Sample size	How many participants were in the study?
13.	Non-participation	How many people refused to participate or dropped out? Reasons?
Setting		
14.	Setting of data collection	Where was the data collected? <i>e.g. home, clinic, workplace</i>
15.	Presence of non-participants	Was anyone else present besides the participants and researchers?
16.	Description of sample	What are the important characteristics of the sample? <i>e.g. demographic data, date</i>
Data collection		
17.	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?
18.	Repeat interviews	Were repeat interviews carried out? If yes, how many?
19.	Audio/visual recording	Did the research use audio or visual recording to collect the data?
20.	Field notes	Were field notes made during and/or after the interview or focus group?
21.	Duration	What was the duration of the interviews or focus group?
22.	Data saturation	Was data saturation discussed?
23.	Transcripts returned	Were transcripts returned to participants for comment and/or correction?
Domain 3: analysis and findings		
Data analysis		
24.	Number of data coders	How many data coders coded the data?
25.	Description of the coding tree	Did authors provide a description of the coding tree?
26.	Derivation of themes	Were themes identified in advance or derived from the data?
27.	Software	What software, if applicable, was used to manage the data?

No	Item	Guide questions/description
28.	Participant checking	Did participants provide feedback on the findings?
Reporting		
29.	Quotations presented	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? <i>e.g. participant number</i>
30.	Data and findings consistent	Was there consistency between the data presented and the findings?
31.	Clarity of major themes	Were major themes clearly presented in the findings?
32.	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?

8 References

ALKHATEEB, F., CLAUSON, K. and LATIF, D., 2011. Pharmacist use of social media. *International Journal of Pharmacy Practice*, **19**(2), pp. 140-142.

ANDREW, N., FERGUSON, D., WILKIE, G., CORCORAN, T. and SIMPSON, L., 2009. Developing professional identity in nursing academics: The role of communities of practice. *Nurse education today*, **29**, pp. 607-611.

ANDREWS, J., 2010. Perhaps 'retail pharmacy' is a better description than community pharmacy. *Pharmaceutical Journal*, **284**, pp. 604.

ASHFORTH, B. and MAEL, F., 1989. Social identity theory and the organization. *Academy of Management Review*, **14**(1), pp. 20-39.

BADWAL, H.S., 2008. Locum pharmacists - bad image is not deserved. *Pharmaceutical Journal*, **280**, pp. 656.

BAKER, P., 2007. *Using Corpora in Discourse Analysis*. London: Continuum.

BALES, R., 1950. A set of categories for the analysis of small group interaction. *American Sociological Review*, **15**, pp. 257-263.

BARBOUR, R., 2001. Checklists for improving rigour in qualitative research: a case of the tail wagging the dog? *British medical journal*, **322**, pp. 1115.

BEAUCHAMP, C. and THOMAS, L., 2009. Understanding teacher identity: an overview of issues in the literature and implications for teacher education. *Cambridge Journal of Education*, **39**(2), pp. 175-189.

BECKER, H. and CARPER, J., 1956a. The development of identification with an occupation. *American Journal of Sociology*, **61**(4), pp. 289-298.

BECKER, H. and CARPER, J., 1956b. The elements of identification with an occupation. *American Sociological Review*, **21**(3), pp. 341-348.

BENSON, A., CRIBB, A. and BARBER, N., 2009. Understanding pharmacists' values: A qualitative study of ideals and dilemmas in UK pharmacy practice. *Social Science and Medicine*, **68**, pp. 2223-2230.

BIRENHAUM, A., 1982. Reprofessionalization in pharmacy. *Social Science and Medicine*, **16**, pp. 871-878.

BOND, C. and S, H., 2015. A different Equator. *International Journal of Pharmacy Practice*, **23**, pp. 235-236.

BRAUN, V. and CLARKE, V., 2006. Using thematic analysis in psychology. *Qualitative research in psychology*, **3**, pp. 77-101.

- BRITTEN, N., 1995. Qualitative research: Qualitative interviews in medical research. *British medical journal*, **311**, pp. 251.
- BRYMAN, A., 2012. *Social Research Methods*. Oxford: Oxford University Press.
- BUSH, J., LANGLEY, C.A. and WILSON, K.A., 2009. The corporatization of community pharmacy: Implications for service provision, the public health function and pharmacy's claims for professional status in the United Kingdom. *Research in Social and Administrative Pharmacy*, **5**(4), pp. 305-318.
- CAIN, J. and ROMANELLI, F., 2009. E-professionalism: a new paradigm for a digital age. *Currents in Pharmacy Teaching and Learning*, **1**, pp. 66-70.
- CALDWELL, I., 2007. What does it mean to be a member of a profession in 21st century Britain? *Pharmaceutical Journal*, **278**(461),.
- CAREY, M. and SMITH, M., 1994. Capturing the group effect in focus groups: a special concern in analysis. *Qualitative health research*, **4**(1), pp. 123-127.
- CASELL, C. and SYMON, G., 2004. *Essential Guide to Qualitative Methods in Organizational Research*. London: Sage.
- COHEN, H.E., 2009. The social side of pharmacy. *U.S.Pharmacist*, **34**(6), pp. 2.
- COOPER, R., BISSELL, P. and WINGFIELD, J., 2009. 'Islands' and 'doctor's tool': the ethical significance of isolation and subordination in UK community pharmacy. *health*, **13**(3), pp. 297-316.
- CRELLIN, J., 1967. The growth of professionalism in nineteenth-century British pharmacy. *Medical History*, **11**(3), pp. 215-227.
- CUSHING, A. and METCALFE, R., 2007. Optimizing medicines management: from compliance to concordance. *Therapeutics and Clinical Risk Management*, **3**(6), pp. 1047-1058.
- DAVIES, L., 2000, 2000-last update, How do pharmacists use evidence? [Homepage of Pharmaceutical Journal], [Online]. Available: <http://www.pharmaceutical-journal.com/the-environment-of-practice/20002701.article> [02/05, 2015].
- DENZIN, N., 1962. Incomplete professionalization: the case of pharmacy. *Social Forces*, **46**, pp. 375-381.
- DENZIN, N., 2009. The elephant in the living room: or extending the conversation about the politics of evidence. *Qualitative Research*, **9**(2), pp. 139-160.
- DESANCTIS, G., FAYARD, A., ROACH, M. and JIANG, L., 2003. Learning in Online Forums. *European Management Journal*, **21**(5), pp. 565-577.
- DINGWALL, R., 2008. Accomplishing Profession. In: ASHGATES CLASSICS IN SOCIOLOGY, ed, *Essays on Professions*. Aldershot: Ashgate, .

DONYAI, P., HERBERT, R., DENICOLO, P. and ALEXANDER, A., 2011. British pharmacy professionals' beliefs and participation in continuing professional development: a review of the literature. *International Journal of Pharmacy Practice*, **19**(5), pp. 290-317.

DOWLING, M., 2006. Approaches to reflexivity in qualitative research. *Nurse Researcher*, **13**(3), pp. 7-21.

EDMUNDS, J. and M, C., 2001. The reprofessionalisation of community pharmacy? An exploration of attitudes to extended roles for community pharmacists amongst pharmacists and general practitioners in the United Kingdom. *Social Science and Medicine*, **53**, pp. 943-955.

ELVEY, R., 2011. *Professional identity in pharmacy*, University of Manchester.

ELVEY, R., HASSELL, K. and HALL, J., 2013. Who do you think you are? Pharmacists' perceptions of their professional identity. *International Journal of Pharmacy Practice*, **21**(5), pp. 322-332.

EVETTS, J., 2011. A new professionalism? Challenges and opportunities. *Current Sociology*, **59**(4), pp. 406-422.

EVETTS, J., 2010. Organizational professionalism: changes, challenges and opportunities, *Organizational learning and beyond 2010*.

EVETTS, J., 2005. The management of professionalism: a contemporary paradox, KINGS COLLEGE LONDON, ed. In: *Changing teacher roles, identities and professionalism*, 10/19; 2005/10 2005.

EVETTS, J., Professionalism in turbulent times: changes, challenges and opportunities, *Propel International Conference, Stirling*, 2012, pp. 9-11.

EYSENBACH, G. and TILL, J., 2001. Ethical issues in qualitative research on internet communities. *British medical journal*, **323**, pp. 1103-1105.

FAHY, P., 2006-last update, Online and face to face group interaction processes compared using Bales' Interaction Process Analysis (IPA). Available: http://www.eurodl.org/materials/contrib/2006/Patrick_J_Fahy.htm [04/24, 2015].

FAULCONBRIDGE, J. and MUZIO, D., 2008. Organisational professionalism in globalizing law firms. *Work, employment and society*, **22**(1), pp. 7-25.

FESTINGER, L., 1957. *A theory of cognitive dissonance*. Stanford, CA, USA: Stanford University Press.

FLICKER, D., HAANS, D. and SKINNER, H., 2004. Ethical dilemmas in research on internet communities. *Qualitative health research*, **14**(1), pp. 124-134.

GENERAL PHARMACEUTICAL COUNCIL, 2016-last update, Continuing fitness to practise [Homepage of GPhC], [Online]. Available: <https://www.pharmacyregulation.org/registration/continuing-fitness-practise> [11/10, 2015].

GENERAL PHARMACEUTICAL COUNCIL, 2015-last update, Continuing Professional Development [Homepage of General Pharmaceutical Council], [Online]. Available:

<https://www.pharmacyregulation.org/standards/continuing-professional-development> [10/02, 2015].

GENERAL PHARMACEUTICAL COUNCIL, 2012. *Guidance on Raising Concerns*. London: GPhC.

GIDMAN, W., HASSELL, K., DAY, J. and PAYNE, K., 2007a. The impact of mandatory continuous professional development and training to deliver the new contract on female community pharmacists: A qualitative study. *Pharmacy Education*, **7**(3), pp. 223-233.

GIDMAN, W., HASSELL, K., DAY, J. and PAYNE, K., 2007b. Does community pharmacy offer women family friendly working conditions and equal opportunities? The account of female pharmacists over the age of 30. *International Journal of Pharmacy Practice*, **15**, pp. 53-59.

GOODE, W., 1957. Community within a community: The professions. *American Sociological Review*, **22**, pp. 194-200.

GRINDROD, K., FORGIONE, A., TSUYUKI, R., GAVURA, S. and GIUSTINI, D., 2014. Pharmacy 2.0: A scoping review of social media use in pharmacy. *Research in Social and Administrative Pharmacy*, **10**(1), pp. 256-270.

HALKIER, B., 2011. Methodological Practicalities in Analytical Generalization. *Qualitative Inquiry*, **17**(9), pp. 787-797.

HARDING, G. and TAYLOR, K., 1997. Responding to change: the case of community pharmacy in Great Britain. *Sociology of Health and Illness*, **19**(5), pp. 547-560.

HEALTH AND SOCIAL CARE INFORMATION CENTRE, 2015-last update, **General Pharmaceutical Services in England – 2005/06 to 2014/15** [Homepage of Health and Social Care Information Centre], [Online]. Available: <http://www.hscic.gov.uk/article/2021/Website-Search?productid=19328&q=pharmacy+types&sort=Relevance&size=10&page=1&area=both#top> [10/03, 2015].

HIBBERT, D., BISSELL, P. and WARD, P., 2002. Consumerism and professional work in the community pharmacy. *Sociology of Health and Illness*, **24**(1), pp. 46-65.

HICKSON, D. and THOMAS, M., 1969. Professionalization in Britain: A preliminary measurement. *Sociology*, **3**, pp. 37-53.

HMRC, 2009/03, 2009-last update, ESM4270 - Particular occupations: locum pharmacists [Homepage of HMRC], [Online]. Available: <https://www.gov.uk/hmrc-internal-manuals/employment-status-manual/esm4270> [02/12, 2015].

HOGG, M. and ABRAMS, D., 1999. *Social identity and social cognition*. 1 edn. Oxford: Blackwell.

HOGG, M. and TINDALE, R., 2003. 'Group Processes' in *Handbook of Social Psychology*. 2 edn. Oxford: Blackwell.

HOLLOWAY, S., JEWSON, N. and MASON, D., 1986. 'Reprofessionalization' or 'occupational imperialism'? Some reflections on pharmacy in Britain. *Social Science and Medicine*, **23**(3), pp. 323-332.

- HULL, H. and RUTTER, P., 2003. A cross-sectional survey of UK community pharmacists' views on continuing education and continuing professional development. *International Journal of Pharmacy Education*, **1**(2), pp. 12-12.
- HUSTON, S. and HOBSON, E., 2008. Using focus groups to inform pharmacy research. *Research in Social and Administrative Pharmacy*, **4**, pp. 186-205.
- JACOBS, S., SCHAFHEUTLE, E.I., PHARMS, M.R., JEE, S.D., ELVEY, R., HASSELL, K. and NOYCE, P.R., 2013. Existing arrangements for monitoring community pharmacies in England: Can they have a role in the revalidation of pharmacists? *Research in Social and Administrative Pharmacy*, **9**(2), pp. 166-177.
- JACOBSON, D., 1999. Doing research in cyberspace. *Field Methods*, **11**, pp. 127-145.
- JEE, S., JACOBS, S., SCHAFHEUTLE, E., R, E., HASSELL K. and P, N., 2013. An exploration of the utility of appraisals for the revalidation of pharmacy professionals in community pharmacy in Great Britain. *Research in Social and Administrative Pharmacy*, **9**(2), pp. 155.
- JOHN, C. and TURNER, J., 2010. Is it time to reduce our dependence on the locum pharmacy workforce? *Pharmaceutical Journal*, **284**, pp. 474.
- KIDD, P. and PARSHALL, \., 2000. Getting the focus and the group: enhancing analytical rigor in focus group research. *Qualitative health research*, **10**(3), pp. 293-308.
- KVALE, S., 1996. *Interviews: An introduction to qualitative research interviewing*. Sage.
- LAAKSONEN, R., DUGGAN, C. and BATES, I., 2009. Overcoming barriers to engagement in continuing professional development in community pharmacy: a longitudinal study. *Pharmaceutical Journal*, **282**, pp. 44-48.
- LATIF, A. and BOARDMAN, H., 2008. Community pharmacists' attitudes towards medicines use reviews and factors affecting the numbers performed. *Pharmacy World and Science*, **30**, pp. 536-543.
- LI, L., GRIMSHAW, J., NIELSEN, C., JUDD, M., COYTE, P. and GRAHAM, I., 2009. Evolution of Wenger's concept of community of practice. *Implementation Science*, **4**(1), pp. 1.
- MACDONALD, R., CHERAGHI-SOHI, S., SANDERS, C. and ASHCROFT D., 2010. Professional status in a changing world: The case of medicines use reviews in English community pharmacy. *Social Science and Medicine*, **71**, pp. 451-458.
- MAGIRR, P., GRIMSLEY, M., OTTEWILL, R. and NOYCE, P., 2004. The clinical autonomy of community pharmacists in England 1: Designing and testing a survey instrument. *International Journal of Pharmacy Practice*, **12**, pp. 223-229.
- MAGUIRE, T., 2013. Do not let your professionalism be sacrificed to your business interests. *Pharmaceutical Journal*, **290**, pp. 669.
- MATTINGLY, T., CAIN, J. and FINK, J., 2010a. Pharmacists on Facebook: Issues addressing the impact of online social media on pharmacy organizations and the profession. *Journal of the American Pharmacists Association*, **50**(4), pp. 424-427.

- MATTINGLY, T., CAIN, J. and FINK, J., 2010b. Pharmacists on Facebook: Online Social Networking and the Profession. *Journal of the American Pharmacists Association*, **50**(3), pp. 424-427.
- MAYS, N. and POPE, C., 1995. Qualitative research: rigour and qualitative research. *British medical journal*, **311**, pp. 109-112.
- MCNALLY, R. and ALBORZ, A., 2004. Developing methods for systematic reviewing in health services delivery and organisation. *Health Information and Libraries Journal*, **21**(3), pp. 182-192.
- MILLER, D. and JONES, S.C., 2004. Focus group to explore issues surrounding continuing professional development for locum community pharmacists. *International Journal of Pharmacy Practice*, **12**, pp. R50.
- MORGAN, D., 1995. Why things (sometimes) go wrong in focus groups. *Qualitative health research*, **5**(4), pp. 516-523.
- MUZIO, D., HODGSON, D., FAULCONBRIDGE, J., BEAVERSTOCK, J. and HALL, S., 2013. Towards corporate professionalism: the case of project management, management consultancy and executive search. *Current Sociology*, **59**(4), pp. 443-464.
- NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE, 2012-last update, **Appendix H Quality appraisal checklist – qualitative studies** [Homepage of NICE], [Online]. Available: <https://www.nice.org.uk/article/pmg4/chapter/appendix-h-quality-appraisal-checklist-qualitative-studies> [09/22, 2015].
- NEAL, M. and MORGAN, J., 2000. The professionalization of everyone? A comparative study of the development of professions in the UK and Germany. *European Sociological Review*, **16**(1), pp. 9-26.
- NHS ENGLAND, 2013-last update, Improving health and patient care through community pharmacy. Available: <https://www.england.nhs.uk/wp-content/uploads/2013/12/community-pharmacy-cta.pdf> [12/13, 2014].
- NOBLE, C., COOMBES, I., NISSEN, L., SHAW, P. and CLAVARINO, A., 2014. Making the transition from pharmacy student to pharmacist: Australian interns' perceptions of professional identity formation. *Social Science and Medicine*, .
- OLIVER, D., SEROVICH, J. and MASON, T., 2006. Constraints and opportunities with interview transcription: towards reflection in qualitative research. *Social Forces*, **84**(2), pp. 1273-1289.
- PARSONS, T., 1939. The professions and social structure. *Social Forces*, **17**(4), pp. 457-467.
- PDA UNION LOCUM MEMBERSHIP GROUP, 2012-last update, Are accuracy checking technicians being used as cheap pharmacists? [Homepage of Pharmaceutical Journal], [Online]. Available: <http://www.pharmaceutical-journal.com/opinion/comment/are-accuracy-checking-technicians-being-used-as-cheap-pharmacists/11092802.article> [10/09, 2015].

- PEREPELKIN, J. and DOBSON, R., 2008. How does ownership influence the role orientation and professional autonomy of community pharmacy managers? *Canadian Pharmacists' Journal*, **141**(2), pp. 95-97.
- PHARMACEUTICAL SERVICES NEGOTIATING COMMITTEE, 2015-last update, The Pharmacy Contract. Available: <http://psnc.org.uk/contract-it/the-pharmacy-contract/> [10/02, 2015].
- PLATTS, A. and TANN, J., 1999. A changing professional profile: ethnicity and gender issues in pharmacy employment in the United Kingdom. *International Journal of Pharmacy Practice*, **7**, pp. 29-39.
- POPE, C. and MAYS, N., 2006. *Qualitative research in health care*. Blackwell Publishing.
- POWER, A., GRAMMATIKI, A., BATES, I., MCKELLAR, S., JOHNSON, J., DIAK, H., STEWART, D. and HUDSON, S., 2011. Factors affecting the views and attitudes of Scottish pharmacists to continuing professional development. *International Journal of Pharmacy Practice*, .
- RAPPORT, F., DOEL, M., HUTCHINGS, H., WRIGHT, S., WAINWRIGHT, P., JOHN, D. and JERZEMBEK, G., 2010. Eleven themes of patient-centred professionalism in community pharmacy: innovative approaches to consulting. *International Journal of Pharmacy Practice*, **18**, pp. 260-268.
- RESNICK, L., LEVINE, J. and TEASLEY, S., 2004. *Perspectives on socially shared cognition*. Washington: American Psychological Association.
- ROBERTS, J., 2006. Limits to communities of practice. *Journal of Management Studies*, **43**(3), pp. 623-639.
- ROONEY, P., 2005. *Researching from the inside - does it compromise validity? A discussion*. Dublin: Dublin Institute of Technology.
- ROYAL COLLEGE OF GENERAL PRACTITIONERS, 2015-last update, Revalidation [Homepage of RCGP], [Online]. Available: <http://www.rcgp.org.uk/revalidation.aspx> [12/12, 2015].
- ROYAL COLLEGE OF PHYSICIANS, 12/01; 2011/10, 2005-last update, Doctors in society: medical professionalism in a changing world. Report of a working party [Homepage of Royal College of Physicians], [Online].
- ROYAL PHARMACEUTICAL SOCIETY, 2013. *The history of the Royal Pharmaceutical Society*. London: Royal Pharmaceutical Society.
- ROYAL PHARMACEUTICAL SOCIETY, 2011a. *Reducing workplace pressure through professional empowerment*. London: Royal Pharmaceutical Society.
- ROYAL PHARMACEUTICAL SOCIETY, 2011b. Social media and social networking. *Pharmaceutical Journal*, **287**, pp. 508.
- RUTTER, P. and DUNCAN, G., 2011. Pharmacy professionalism and the digital age. *International Journal of Pharmacy Practice*, **19**(6), pp. 431-434.

- SCHOFIELD, J.A., 2009. It's the locum's decision whether to do an MUR (letter). *Pharmaceutical Journal*, **282**, pp. 309.
- SEALE, C., 2006. Gender accommodation in online cancer support groups. *health*, **10**(3), pp. 345-360.
- SESTON, E. and HASSELL, K., 2009. *Pharmacy workforce census 2008: main findings*. London: Royal Pharmaceutical Society of Great Britain.
- SHANN, P. and HASSELL, K., 2006. Flexible working: Understanding the locum pharmacist in Great Britain. *Res.Soc.Adm.Pharm.*, **2**(3), pp. 388-407.
- SHANN, P. and HASSELL, K., 2004. *An exploration of the diversity and complexity of the pharmacy locum workforce*. London: Royal Pharmaceutical Society of Great Britain.
- SHCHERBAKOVA, N. and SHEPHERD, M., 2014. Community pharmacists, internet and social media. *Research in Social and Administrative Pharmacy*, **10**(6), pp. e75-e85.
- SIXSMITH, J. and MURRAY, C., 2001. Ethical issues in the documentary analysis of email posts and archives. *Qualitative health research*, **11**(3), pp. 423-432.
- SMITH, F., 1998. Focus groups and observation methods. *International Journal of Pharmacy Practice*, **6**, pp. 229-242.
- STEWART, M., 1984. What is a successful doctor-patient interview? A study of interactions and outcomes. *Social Science and Medicine*, **19**(2), pp. 167-175.
- TONG, A., SAINSBURY, P. and CRAIG, J., 2007. Consolidated criteria for qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, **19**(6), pp. 349-357.
- TONKISS, F. and PASSEY, A., 1999. Trust, confidence and voluntary organisations: between values and institutions. *Sociology*, **33**(2), pp. 257-274.
- TRAULSEN, J. and BISSELL, P., 2004. Theories of professions and the pharmacist. *International Journal of Pharmacy Practice*, **12**, pp. 107-114.
- TUCKMAN, B., 1965. Developmental sequence in small groups. *Psychological Bulletin*, **63**(6), pp. 384-399.
- WALSH, D. and DOWNE, S., 2006. Appraising the quality of qualitative research. *Midwifery*, **22**, pp. 108-119.
- WATT, D., 1997. On becoming a qualitative researcher: the value of reflexivity. *The Qualitative Report*, **12**(1), pp. 82-101.
- WEINBREN, E., 11/02, 2012-last update, Locums remain silent about safety issues for fear of losing work [Homepage of Chemist and Druggist], [Online]. Available: <http://www.chemistanddruggist.co.uk/news/locums-remain-silent-about-safety-issues-fear-losing-work> [02/02, 2015].

WENGER, E., 2014/05, 2011-last update, Communities of practice: a brief introduction. Available: <http://wenger-trayner.com/introduction-to-communities-of-practice/> [03/14, 2015].

WENGER, E., 1998. Communities of Practice: Learning as a Social System. *Systems Thinker*, **9**(5), pp. 2-3.

WHITAKER, S., COX, A. and ALEXANDER, A., 2003. Internet networking for pharmacists: an evaluation of a mailing list for UK pharmacists. *International Journal of Pharmacy Practice*, **11**, pp. 25-32.

WHITEHEAD, L., 2007. Methodological and ethical issues in internet-mediated research in the field of health: an integrated view of the literature. *Social Science and Medicine*, **65**, pp. 782-791.

WHITTEMORE, R. and KNAFL, K., 2005. The integrative review: updated methodology. *Methodological Issues in Nursing Research*, **52**(5), pp. 546-553.

WILENSKY, H., 1964. The Professionalization of Everyone? *American Journal of Sociology*, **70**(2), pp. 137-158.

WILSON, H. and BARBER, N., 2013-last update, **Review of NHS Pharmaceutical Care of Patients in the Community in Scotland** [Homepage of Gov.Scot], [Online]. Available: <http://www.gov.scot/Publications/2013/08/4406> [10/03, 2015].

YUEN, E., 2009. The word 'bullying' comes to mind. *Pharmaceutical Journal*, **282**, pp. 309.