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Of Shepherds, Sheep and Sheepdogs? Governing the Adherent Self through Complementary and Competing 'Pastorates'

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Abstract

Foucault's concept of 'pastoral power' describes an important technique for constituting obedient subjects. Derived from his analysis of the Christian pastorate, he saw pastoral power as a prelude to contemporary technologies of governing 'beyond the State', where 'experts' shepherd self-governing subjects. However, the specific practices of modern pastorate have been little developed. This article examines the relational practices of pastoral power associated with the government of medicine use within the English healthcare system. The study shows how multiple pastors align their complementary and variegated practices to conduct behaviours, but also how pastors compete for legitimacy, and face resistance through the mobilisation of alternative discourses and the strategic exploitation of pastoral competition. The article offers a dynamic view of the modern pastorate within the contemporary assemblages of power.

Keywords

Foucault, governmentality, healthcare, medicines, pastoral power

Introduction

The re-publication of Michel Foucault's (2007, 2008, 2011, 2012) lecture notes from his time at College de France has rekindled interest in many of his well-known concepts, and prompted curiosity in ideas that were less developed towards the end of his life. Elden

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(2016) describes this period of Foucault's work as focusing ostensibly on his history of sexuality (Foucault, 1998), through which he developed his 'genealogy of governmentality'. For sociologists dealing with contemporary government 'beyond the State' (Rose and Miller, 1992), his lectures elaborate the ways social actors are constituted and governed through the 'conduct of conduct' (Foucault, 1980). Although Foucault is criticised for his lack of attention to agency (Power, 2011), these lectures sketch out the relational practices and technologies through which obedient and self-governing subjectivities are constituted, including the possibilities for counter-conduct (Foucault, 2007).

Within these lectures Foucault introduces the concept of 'pastoral power' as a particular technique for constituting and governing obedient subjects (Foucault, 2007). The concept is elaborated through his analysis of Christian texts, which metaphorically construct the pastor as a 'shepherd' watching over and guiding the moral conduct of the 'flock' (Foucault, 1982). More significantly, Foucault saw the Christian pastorate as a 'prelude' to, and significantly integrated within, the contemporary technologies of government, both within and beyond the State (Golding, 2007). The modern pastorate is associated, for example, with the way 'experts' promote morally desirable behaviours (Rose, 2007). Pastoral power is analytically significant because it operates at the 'nexus' of discipline and subjectification (Waring and Martin, 2016), or coercion and consent (Rose, 2007). On the one hand, pastors survey and discipline subjects, and on the other, nurture self-governing subjectivities.

Despite the significance of pastoral power within Foucault's genealogy of governmentality, the concept was little developed before his death (Elden, 2016), and is implied within his writings on confession (Foucault, 2011). Subsequent use of his concept often remains as a descriptive metaphor for 'expert power'. In this article, we interpret pastoral power as involving more dynamic and contested relational practices. We elaborate these ideas by looking at the government of patients' medicines use within the English National Health Service (NHS). This empirical context highlights the intention of policy makers to promote obedient subjects with regards to their medicines. Through looking at the changing government of patients' medicines use, our study brings to light the changing relations of pastoral power, which we interpret, provocatively, as being similar to the metaphorical relationship between 'shepherd, sheep and sheepdog'.

Foucault's Pastoral Power

Foucault's work examines how 'regimes' of truth, as articulated through social discourses, constitute the subjects of which they speak, and in turn position these subjects within relations of power. He describes how in contemporary society various 'dispositifs' – knowledge and discourses; institutions and administrations; and scientific, philosophical and moral statements – constitute and govern subjects. His work emphasises expert institutions in the categorisation, surveillance and disciplining of 'abnormal' subjects, such as the ill or criminal (Foucault, 1991, 1994). Although Foucault's ideas are often used to describe how 'subjects' are governed through expert knowledge, it is important to recognise how these discourses not only construct the subjects of surveillance (the known) but by necessity the medium of surveillance (the knower). We return to this theme throughout our article.

Foucault's later work on governmentality looked further at how the contemporary 'art of government' is realised, less through sovereign or disciplinary power, but through

reflexive subjects governing their own behaviours (Foucault, 1980, 2007). For Foucault, the 'conduct of conduct' is realised through various State and non-State technologies that inscribe and normalise behavioural imperatives *within* individual subjectivities (Dean, 2010; Lemke, 2001; Rose and Miller, 1992). This 'subjectification' involves the constitution of subjects that are actively concerned with governing their own ethical behaviours (Foucault, 2011). Again, he saw an important role for experts in facilitating the relational (therapeutic) spaces within which actors are supported to care for themselves.

In his genealogy of governmentality, Foucault (2007) develops the concept of 'pastoral power' to describe how certain actors are involved in the formation of obedient, self-governing subjects. Although instances of pastoral power can be found in pre-classical systems of authority, where sovereign leaders assume religious designations, his analysis focuses on the Christian pastorate. He saw the Christian Church as concerned with embedding religious and political power within local communities; with pastors 'shepherding' the moral conduct of the 'flock' through religious instruction, hearing confession, and promising salvation (Golding, 2007).

Foucault (1982) describes pastoral power as involving four elements. First, '*analytical responsibility*' where pastors are accountable for the moral behaviour of their flock, especially the 'strayed' sheep. Second, '*exhaustive and instantaneous transfer*' where responsibility for the moral conduct of the community, and the standing of the pastor, is allocated through their relations with both the church *and* congregation. Third, '*sacrificial reversal*' where pastors must be willing to sacrifice themselves for the good of the flock. And fourth, '*alternate correspondence*' where a pastor's reputation is enhanced when moral behaviours are fostered among the most sinful. In short, the pastor's standing within the Church and community is dependent upon their ability to guide the flock away from immoral behaviour.

Although concerned with community, Foucault (2007) saw pastoral power as an individualising form of power. He describes an inherent paradox, where the pastor must assure the moral conduct of the community through attending to individual 'stray sheep' (Foucault, 1982). This is realised through focusing on the moral behaviours of individuals in relation to the expectations of the community. In subsequent writings Foucault (2011) describes how pastoral encounters constitute the individual subject as knowing of itself through confessional encounters. Confession is not merely about penitence and atonement, but 'conversion' through the internalisation of the ethic to govern the self. It is the individualising character of pastoral power and its concern with subjectification that makes it integral to his genealogy of governmentality (Elden, 2016):

What the history of the pastorate involves, therefore is the entire history of the procedures of human individualisation in the West [...] a prelude to what I have called governmentality through the constitution of a specific subject, of a subject whose merits are analytically identified, who is subjected in continuous networks of obedience, and who is subjectified through the compulsory extraction of truth. (Foucault, 2007: 184–185)

Although not explicit, Foucault suggests pastoral power is embedded within broader political institutions, such as the proto-bureaucratic structures of the Christian Church, which arguably provide a template for the modern State. He suggests, for example, a hierarchical relationship between the local congregation, the priest and more senior

Bishops. More significantly, pastoral power combines elements of his earlier writing on discipline and his later work on subjectification. On the one hand, the pastor is a 'relay' of surveillance and discipline, and on the other, they promote self-reflexive and self-governing subjects. Pastoral power is therefore a key concept within Foucault's genealogy of governmentality, linking his earlier studies of discipline with his later studies of subjectification.

Indeed, Foucault (1982) saw pastoral power as extending beyond ecclesiastical institutions to be integrated within the contemporary apparatus of government. The 'modern pastorate' offers salvation, not in the next life, but in the current life through promoting desirable, healthy or prosperous lifestyles (Foucault, 1982). This is exemplified by the therapeutic encounters of the 'psy' disciplines, which Rose (2007) sees as based upon informed consent, choice and empowerment. A number of studies use the concept to explain, for example, how university students are enrolled in systems of voluntary compliance (Howley and Hartnett, 1992), how organisational standards are promoted within professional communities (Bejerot and Hasselbladh, 2011; Ferlie et al., 2013; Waring and Martin, 2016); how ethical workplace behaviour is shaped by corporate leaders (Bell and Taylor, 2003); and how self-governing patients are constituted through their interactions with health experts (Holmes, 2002; Rose, 2007; Wilson, 2001). These studies often use the concept to account for particular forms of expert power, but there is little explanation of the relational practices of pastors when seeking to constitute self-governing subjects, or indeed the limits of their influence or scope for resistance. In addition, the relationship between the pastor and the wider assemblages of government is rarely elaborated. In this article we examine the contemporary practices of pastoral power with the aim of better understanding the contingent aspects and dynamic practices of the modern pastorate and its contribution to the conduct of conduct.

The Government of Patients' Medicine Use

Foucault's ideas have been applied extensively to the social organisation of healthcare (Petersen and Bunton, 1997; Turner, 1995). As well as showing how health professionals discipline patients through clinical categorisation and surveillance, contemporary health policies encourage patients to make more appropriate lifestyle choices and care for themselves (Armstrong, 2014; Petersen, 1997). His theories have found particular application to the social organisation of pharmacy and medicines (Ryan et al., 2004). Whereas medical power is typically associated with the ability to 'know' illness, the power of the pharmacy profession is associated with its ability to transform inert drugs into therapeutic medicines (Dingwall and Wilson, 1995). Barber (2005) describes the profession's ability to observe and predict the therapeutic properties of medicines as its 'pharmaceutical gaze'. With growing demand on family doctors, health policies have extended the role of community pharmacists, from their traditional responsibilities for medicines preparation and dispensing, to the provision of health education and direct care (Hassell et al., 2000). Jamie (2014) describes, for example, how the pharmacist's 'gaze' is increasingly concerned with regulating the patient's body in new care settings through new technological algorithms. When viewed through the lens of governmentality, such

reforms re-construct pharmacists, not only as disciplining patient behaviours, but encouraging patients to be more responsible for their own health (Ryan et al., 2004).

Our study extends this analysis by looking at the changing responsibilities of pharmacists, doctors *and* patients in the government of patients' medicine use. The use of medicines in society remains a prominent social issue, especially with growing concern about antibiotic use and antimicrobial resistance (Laxminarayan and Heymann, 2012). A parallel issue is patients' use of medicines when not under direct supervision of healthcare professionals. It has been found, for example, that many patients fail to take their medicines as prescribed, resulting in poor health outcomes, extended treatment and additional costs (Pound et al., 2005). The established model of patients' medicines use centres on a triangular relationship, whereby the doctor diagnoses the patient's condition and 'prescribes' medicines with instructional guidance; the pharmacist 'dispenses' the medicines and offers further guidance; and the patient is expected to 'follow' this guidance with minimal supervision. Research suggests, however, that patients often fail to 'adhere' to prescribed instructions because, for instance, they are worried about side-effects (Pound et al., 2005). In response, health policies have called for family doctors and pharmacists to promote more adherent patient behaviours (Mossialos et al., 2015).

In the English NHS, two 'advanced services' have been introduced to monitor and promote patients' medicine use – Medicines Use Reviews (MUR) and the New Medicines Service (NMS). Through these schemes, pharmacists are commissioned to monitor medicine use and provide complementary education, alongside the family doctor (Department of Health, 2013). The NMS aims to promote adherence among patients prescribed new medicines for long-term conditions, such as asthma, type-2 diabetes and hypertension. It is organised as a series of 'one-to-one' patient–pharmacist consultations. The first is arranged around 14 days after being prescribed a new medicine, with a further consultation around 21 days later to review behaviour change. In these interactions, the pharmacist encourages the patient to reflect upon their medicines use, to talk about non-adherence and to consider why they might not follow instruction. This enables the pharmacist to identify knowledge deficiencies, misguided beliefs and inappropriate behaviours, with the goal of offering personalised education to promote adherence (Barber et al., 2004). Significantly, the NMS is based on a 'self-regulatory' model of behaviour change (Cameron and Leventhal, 2003), which aims to foster adherent behaviours through cultivating more self-aware and self-governing patients.

Advanced services, like the NMS, raise sociological questions about the changing jurisdictions and power of healthcare professions (Abbott, 1988). Although they might expand pharmacy's jurisdiction, Harding and Taylor (1997) suggest extended roles in advice-giving might reduce professional status, because they depart from the profession's specialist pharmaceutical knowledge. More significantly, others describe how such extended roles are often 'delegated' by more powerful professions, consumers, and corporate bodies (McDonald et al., 2010; Nancarrow and Borthwick, 2005).

Taking a Foucauldian perspective, however, power is not conceived as being possessed or located within a profession (or over others), rather it flows through the discursively constituted practices of professional subjects, and associated assemblages, institutions and technologies. From this perspective, policies such as the NMS

re-constitute professional practices, with an emphasis on cultivating more adherent and self-governing patients, in line with societal expectation that citizens take greater responsibility for their health (Rose, 2007). As such, the NMS represents a topical and relevant case for the application and elaboration of Foucault's pastoral power. Returning to the aforementioned metaphor, we tentatively suggest that the changing government of patients' medicine use might resemble the relationship found between the 'shepherd', 'sheepdog' and 'sheep'; where the doctor provides supervisory guidance (through diagnosis and prescribing), and where pharmacists actively 'herd' patients (through reflective consultations), which together nurture more obedient and self-regulating patients. Our study examines how these complex and dynamic pastoral relations are enacted.

Methods

The research examined the government of patients' medicine use following the introduction of the NMS; carried out between spring 2012 and autumn 2013 (Elliott et al., 2014). In the first instance, textual analysis of relevant health policies, training documentation and expert testimonies was undertaken to understand the governing rationality of the NMS, and to identify the practices and technologies through which the NMS was to be realised. The study next investigated the implementation of the NMS within 23 community pharmacies located in three regions of the English NHS (London, Midlands, Yorkshire), reflecting variations in pharmacy ownership, size, location. Following an ethnographic approach, non-participant observations were carried out for up to five days in each setting to understand the social organisation of services and interactions between pharmacist, patients and General Practitioners (GPs). Observations were undertaken in a variety of clinical and non-clinical settings, such as medicine preparation and patient-facing interactions. As part of the fieldwork, 20 patients enrolled in the NMS were observed during their interactions with pharmacists and other healthcare professionals; taking into account differences in age, gender and ethnicity. This included each patients' NMS consultations, and short (10 minute) 'before and after' interviews with both patient and pharmacist. All observations were written up in field journals, and all NMS consultations were audio recorded. Nineteen patients, 47 community pharmacists and 11 GPs subsequently took part in a longer (40 minute) semi-structured interview to explore their experiences of the NMS. The study received favourable ethical approval through standard NHS research governance systems.

Qualitative data analysis followed an interpretative approach with the aim of understanding the practices and subjectivities of pharmacists, patients and GPs constituted through the NMS. This involved an initial phase of open coding to describe the social organisation of the NMS. Coded extracts of data were analysed through constant comparison, with all authors comparing interpretations to clarify the consistency of codes and conceptual relationships. In line with our theoretical interests, the coded data were systematically related back to the concepts outlined above, with particular emphasis on understanding how pastoral relationships were formed and realised through the NMS.

Findings

Complementary Pastors

Our first theme considers how GPs and pharmacists work as distinct, but complementary ‘pastors’. In broad terms, the NMS requires GPs and pharmacists to coordinate and align their distinct ways of ‘knowing’ patients, resulting in a ‘multi-modal’ system of surveillance and education:

It’s a shared responsibility [...] keeping an eye on compliance and repeat prescribing, checking for side-effects, intolerance, reasons of non-compliance, so I think it is very much a similar role, and giving information and feedback [...] I personally welcome their increased participation in this process. (GP)

We have one of these pharmacists who comes half a day a week [...] who help us if we’re trying to change people on a particular medication to one that’s cheaper or better [...] or if we’re trying to meet a guideline. (GP)

GPs assume over-arching responsibility for patient health, situated in the primacy of the doctor–patient relationship. They describe four aspects of their practices as influencing patients’ medicine use: appropriate prescribing; providing medicines information to increase patient awareness; providing instruction on medicine use; and describing possible side-effects. GPs also emphasise continued monitoring of the patient’s condition, to assess the effectiveness (and use) of the new medicine (e.g. repeated blood pressure checks).

GPs also describe how work demands make it difficult to provide the personalised education necessary to enhance patient understanding. Accordingly, many welcome the extended roles for pharmacists to complement their interactions with the patient. For many, pharmacists were ‘assisting’ or acting under ‘*delegated*’ authority:

I don’t know whether my pharmacist colleagues would thank me for this but it feels to me as though the pharmacist probably has got more time [...] we can’t do it in 10 minutes, you’re scratching the surface. So somebody else spending a bit more time going through it is really important and I think we need to be singing from the same song sheet. (GP)

By the time you’ve done your prescription [...] you’ve only got sort of two or three minutes to give them salient points. So there isn’t this in-depth thing about the medication. (GP)

They are an absolute fountain of knowledge regarding medicine, well they do help us enormously by pointing out possible interactions that we have missed. (GP)

While pharmacists’ core dispensing role remains relatively unchanged, the NMS creates extended opportunities to offer eligible patients educational guidance when prescribed a new medicine. Our observations showed how pharmacists used structured questioning to explore patients’ understanding and experiences of their medicines. This includes asking patients to explain why they had ‘missed a dose’ or not taken a medicine ‘as instructed’. These interactions have a confessional quality, where patients are encouraged to talk about their ‘problematic’ behaviours, and where pharmacists check misguided

assumptions and foster self-awareness of lifestyle choices. It is also made explicit to patients that both the pharmacist and GP will continue to monitor medicine use, suggesting more overt forms of surveillance:

[My role is] one, to educate patients in new medication. Two, to ensure they take their medication appropriately, three answer any questions so that they retain compliance [...] because an awful lot of people, stop taking their medications because of the side-effects in the first couple of weeks. (Pharmacist)

You get to tell people information [...] several times in case they forget. To reassure them about the side-effects and then you get to pick up on potential side-effects that they need to see the doctor about. (Pharmacist)

Some pharmacists see their new roles in patient education as substituting for over-worked GPs. The subordinate position of the pharmacist, relative to the GP, is further illustrated by their lack of legal authority to amend prescriptions. For example, where a prescribed medicine needs changing, the pharmacist is required to refer the patient back to their GP. Many pharmacists also feel GPs do not fully appreciate their unique contributions to patient education or are perhaps threatened by these extended roles: '[y]es, I think there's a lot of suspicion amongst GPs about what this is about, that we're trying to do part of their job, that we're trying to, not that we're trying to but that there's duplication' (Pharmacist).

The pastoral roles of GPs and pharmacists appears complementary, with the aligned goal of producing more adherent patients, through a combination of ongoing surveillance and personalised education. These modified relationships might be seen as corresponding with the tentative metaphor outlined above, with the docile patient (sheep) herded and checked by the pharmacist (sheepdog), and where both patient and pharmacist are supervised and directed from 'a distance' by the GP (shepherd). This resembles a hierarchical system of inter-pastoral power, corresponding with prevailing inter-professional status hierarchies, but it also reveals underlying tensions between pastoral actors.

Competing Pastors

Our second theme considers how the NMS exacerbates underlying status differences between GPs and pharmacists. Although GPs and pharmacists advocate a common 'belief system' around the necessity of medicines adherence, we found a 'schism' in terms of how and by whom patient behaviours should be influenced. This was articulated along three lines: their 'relationship' with the individual and community; the legitimacy of 'truth claims'; and the ability to offer 'salvation'.

GPs and pharmacists distinguish their pastoral status on the basis of their unique relationship with the patient. As above, GPs see the doctor–patient relationship as the primary clinical interaction, and inherently superior to the pharmacist–patient relationship. GPs describe having 'relational continuity' with patients, developed through many years of managing multiple health issues. This relationship is not narrowly confined to managing medicines, but involves a broader appreciation of patient health and life

circumstances. GPs argue the primacy of this relationship was apparent because patients are more likely to seek out their GP when they have significant health concerns. GPs interpret their relationship as offering more detailed and holistic ways of ‘knowing’ the patient, and influencing behaviour, whereas pharmacists have only limited influence over medicine dispensing (and are marred by commercial intent):

I think there is some cynicism [...] but there is always some suspicion from GPs of pharmacists, because obviously a lot of pharmacists flog all sorts of stuff but have no evidence behind it. I’ve never prescribed a cough medicine to anybody, ever, because there is no evidence that it has made any difference but, they make a fortune on it. (GP)

However, pharmacists claim patients often struggle to access their GPs and the brevity of the doctor–patient encounter makes it difficult to provide personalised guidance. In contrast, they describe themselves as having a more accessible relationship, because of their position on the ‘high street’ and being ‘embedded in the community’. In particular, they can offer a unique ‘reflective space’ to talk openly about medicines, and the necessary time to offer individualised guidance. Pharmacists also describe having long-lasting relationships with patients, especially those with chronic conditions, from which to notice subtle changes in patient behaviour and medicine use. Although they lack access to formal patient records, they describe their relationships as being ‘dedicated’ to medicines and ‘not complicated by other issues’:

You get to tell people information; you get to tell them several times in case they forget. To reassure them about the side-effects they might have, what they might be suffering and also get to pick up on potential side-effects they might be having, that they need to see the doctor about. (Pharmacist)

I think it can waste a lot of GP time because obviously people are going back time and time again because they are getting side-effects. They don’t realise they are normal and do disappear with time. (Pharmacist)

Second, the competition between pastors reflects divergent assumptions about the status of their respective professional expertise or ‘truth claims’. Although GPs acknowledge pharmacists might better understand how medicines work, they are unable to understand how medicines contribute to patient health. Because of their unique ability to diagnose *and* prescribe, GPs see themselves as having a superior form of biomedical expertise. Interestingly, they rarely justify the status of their medical knowledge, and instead prefer to question the narrow expertise of pharmacists, and their commercial interest:

You’re dealing with a person and not a disease. If it was just the disease you’d give something for it [...] [our] training has always been very patient centred [...] Pharmacists have almost taken a backward step into shop keeping [...] I think they should be coming forward and actually taking more responsibility for overall care, responsibility is the word I think [...] and I think if we [GPs] concentrated on more difficult things, you know the diagnoses, which is what we are trained to do. (GP)

Pharmacists see themselves as having a unique expertise from which to monitor and influence patient behaviours. This relates to their exclusive understanding of the pharmacology properties of medicines, which for some, is superior to doctors' limited understanding of how and when to 'prescribe' medicines, not how they work. GPs are also described as risking patient safety where they fail to identify the negative interactions between medicines. As such, pharmacists see themselves as monitoring, not only patient behaviours, but also the prescribing practices of doctors as a form of inter-pastoral surveillance:

A lady got admitted to hospital with migraines, and because we had her mobile number I phoned her and I said what's going on? She goes I'm in hospital, I've got migraine, I said oh really and that's since you started your amlodipine? [...] headaches is a common side-effect of it. Doctors didn't click onto it because they thought it was just her normal medication. (Pharmacist)

I don't understand why GPs don't see pharmacists as their support network, they tend to see them as being, almost like a school teacher who raps them on the knuckles every now and then when they don't spot a drug interaction, or they accidentally prescribe the wrong thing. (Pharmacist)

Through their differential relationships and claims to expertise, both GPs and pharmacists present themselves as uniquely positioned to promote adherent medicine use and ensure the patient's 'salvation'. For GPs, this takes a more disciplinary form, involving instructive orders and ongoing surveillance, premised on their biomedical expertise to compel adherent behaviour and monitor compliance. In contrast, pharmacists promote adherence through understanding how patients experience medicines and by fostering learning and reflection. This involves a softer, more subjectified form of pastoral power based on self-reflection, individualised guidance and the shaping of patient behaviours. As such, the study finds variegated forms of pastoral power that operate in different ways at the boundaries between discipline and subjectification (Waring and Martin, 2016).

Mediating Subjects

Patients are often regarded by both GPs and pharmacists as passive recipients of guidance – the 'docile sheep'. Yet, by encouraging patients to take greater responsibility for their medicines, patients are expected to *become* proactive and self-aware. Interestingly, this agency appears to mediate and exacerbate the tensions between GPs and pharmacists. The third theme examines the mediating actions of patients to these changing pastoral roles.

Patients generally welcome the 'additional' guidance provided through the NMS. Although most seem to prefer speaking with their GP, many described how GPs can be difficult to access, time conscious and usually give general 'directions' rather than personalised guidance. In contrast, pharmacists are seen as helping patients better understand their medicines and how they can be integrated into their everyday lives. Patients also describe feeling able to talk more 'openly' with pharmacists, without assumptions of wrong-doing or being made to feel guilty:

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

As a consequence of talking to [pharmacist] when I did eventually come out I knew everything about this new medicine, what it was intended to do, how it worked and the benefits that I could gain from it. And it's the first time really that that has ever happened. (Patient)

Some patients interpret pharmacists' advisory roles in more critical terms. For example, pharmacists' questions about medicines use and lifestyle are regarded, by some, as outside the legitimate scope of their professional expertise; pharmacists should therefore limit their interactions to the more technical aspects of dispensing. For many patients, the GP remains responsible for dealing with these wider issues, because they have a more detailed understanding of their health history. There is an impression that the pharmacist is, in some way, a 'substitute' for the over-worked GP: '[i]t was well worthwhile having a second opinion if you like on whether I'd either done the right thing not taking, not continuing with them [aspirin] or you know whether I should have' (Patient).

The study also found instances of resistance to *both* GPs and pharmacists. In consultations, for example, some patients refrain from giving direct answers to pharmacists' questions, or declaring non-adherence. It is also possible that some patients claiming to be adherent might be lying, because they do not want to appear to be seen as non-adherent. More interestingly, patients actively challenge professional guidance in a number of ways. First, some draw upon past personal experiences of their health condition, or similar medicines, to question the doctor's or pharmacist's guidance. For example, several patients described needing to modify prescribing instructions because they 'knew their own body better' or had negative experiences with a medicine in the past. Second, patients invoke alternative understandings of their medicines, usually informed by family, friends or news media. For example, prominent news headlines around the dangers of hypertension medicines (statins) were used to justify non-adherence. Third, patients counter the instructions of one professional by claiming to be following the guidance of the other professional. For example, patients countered their pharmacist's instructions about when or how to take medicines through claiming their GP had told them to do something different. Interestingly, it is less common for patients to use the guidance of the pharmacist to question their GP, reinforcing the idea of status differences between these health professionals in the eyes of patients.

These responses suggest a high degree of awareness and strategic agency on the part of patients to understand the competition between their health professionals, and to use this to enact their own influence. This potential for resistance is recognised by pharmacists and GPs, suggesting both groups appreciate the limits of their influence on patient behaviours:

At the end of the day you can talk to them for half an hour, they'll do exactly what they want when they get back home, they'll either take them, not take or bother yeah and if they have this preconceived idea that I'll try it for a day or two, if it doesn't do anything I won't take them [...] nothing you can say will change their mind. (Pharmacist)

The findings suggest patients are far from passive recipients of guidance, nor do they easily internalise expectations to take greater responsibility for their medicines. Professional advice and support is welcome, but patients often appear critical of pharmacists' expertise outside of their knowledge of medicines, and use alternative discourses to question both pharmacists' and GPs' advice. In addition, patients appear to reinforce the overarching primacy of their doctor–patient relationship, and importantly, play into the competition between GPs and pharmacists.

Discussion

Through studying the introduction of the NMS within the English healthcare system, our article set out to better understand the dynamic practices of the modern pastorate, and to clarify the contribution of pastoral power to the 'conduct of conduct'. As described earlier, the NMS was designed to promote more adherent and 'self-regulating' patients. This involved re-constituting the roles and relationships of doctors and pharmacists, with both assuming pastoral roles in constituting adherent patient subjectivities. Pastoral power is sometimes depicted as the 'shepherd' watching over and guiding the moral conduct of the 'flock' (Foucault, 1982) with disciplinary oversight giving way to subjectification. Like many contemporary apparatus of government (Rose, 2007), the NMS involves a complex assemblage of expert/subject relationships and technologies for inscription, normalisation and reflexive self-regulation. We extend this metaphor to tentatively interpret the NMS as re-constituting the role of the GP as the remote supervising 'shepherd' who prescribes both medicines and expected patient behaviours, but where the pharmacist acts as the more engaged 'sheepdog' who observes, monitors and checks the behaviours of the 'sheep' like patient. This extended metaphor is broadly consistent with Foucault's (1982) understanding of pastors being positioned hierarchically between local communities and wider ecclesiastical or political institutions, and more locally between the individual and the wider community. However, the extended metaphor elaborates the possibility for contemporary regimes of governmentality to involve *multiple pastors* operating in more dynamic and de-centred systems. As our findings show, this brings to light aspects of pastoral power not well understood, especially the variegated practices, the potential for competition and the possibilities for counter-conduct.

Consistent with our extended metaphor, the study finds the NMS re-constitutes the pastoral roles of doctors and pharmacists. To some extent, both professions recognise the importance of coordinating their distinct, but complementary practices. For doctors, the NMS offers the possibility to share, or delegate, responsibility for patient education to pharmacists, while maintaining overarching responsibility for patient health. For pharmacists, it creates opportunities to use their pharmaceutical expertise to inform more reflexive patient behaviours; extending their 'pharmaceutical gaze' (Barber, 2005) from the bio-medicinal properties of drugs, to how these drugs are used by patients. This relational configuration is significant because it shows how multiple pastoral actors align distinct ways of 'knowing' to monitor, re-constitute and govern subjectivities. In the case of medicine use, as with many other health concerns, a single source of expert 'knowing' might not be sufficient to achieve order, prompting the reconfiguration of distinct pastoral roles within a more coordinated system. This resembles a multi-positional or modal technique of pastoral power, which in navigational terms involves triangulating multiple

'readings' to determine the 'bearing' of the subject. It might be argued that contemporary regimes of governmentality are increasingly characterised by multiple forms of pastoralism that together contribute to the internalisation and normalisation of desirable, and self-governing, subjectivities (Curtis, 2002).

Although many studies invoke the concept of pastoral power, surprisingly few specify the types of relational practices used to articulate moral imperatives, watch over the flock, normalise self-governing practices and discipline subjects (Rose, 2007). Our study builds on recent research by Waring and Martin (2016) that describes pastoral power as involving four linked practices. The first involves 'constructive practices' where pastors translate governing rationalities into a form that is meaningful to the local community, such as specific behavioural expectations. The second involves 'inscription practices' where pastors encourage individuals to internalise and normalise these behavioural expectations. The third involves 'collective practices' where pastors relate individual behavioural expectations to the shared values of the wider community, fostering moral censure and collective reinforcement of desired behaviours. And the fourth involves 'inspection practices' where pastors engage in ongoing surveillance of individual and collective behaviours.

Relating this model to the NMS, there is clear evidence of construction, inscription and inspection practices. For instance, pharmacists use their pharmacological expertise to construct questions and educational prompts that encourage patients to reflect upon their behaviours and take responsibility for medicine use. Similarly, both GPs and pharmacists engage in inspection practices to assess patient adherence. Given its focus on individual adherence, there was no evidence of collective practices, which might account for some level of patient resistance given that behavioural expectations are not linked to, or reinforced by, collective behaviours. Beyond the case of medicine use, the linking of individual and collective behavioural expectations might be regarded as an essential feature of pastoral power.

Significantly, by showing how multiple pastors are involved in the conduct of conduct, the study reveals how pastoral practices are variegated and, at times, competing. There were marked differences in doctors' and pharmacists' pastoral relationship with patients. The pastoral obligations of GPs were relatively broad in remit and inclusive of multiple health and lifestyle matters, but practised in more time-limited and disciplinary ways, with an emphasis on categorisation, instruction and surveillance. In contrast, the pharmacists were more narrowly focused on medicine use, but expressed in more reflexive and therapeutic ways, with an emphasis on developing personalised education, inscription and self-surveillance. Turning to Foucault's (2011) writing on confession, the pharmacist appears, more than the GP, to be concerned with providing the reflective space to speak openly, to articulate feelings of guilt and to realise a 'conversion' of the self. The point to be emphasised is that pastoral power appears to take on different forms at the nexus between discipline and subjectification (Waring and Martin, 2016) or coercion and consent (Rose, 2007).

Although the study found pastoral practices could be coordinated within a wider regime of government, it also found instances of competition between pastors. The new roles for pharmacists could be interpreted, for example, through the sociological lens of competing professional boundaries (Abbott, 1988; Nancarrow and Borthwick, 2005). On the one hand, pharmacists have acquired extended jurisdiction within the division of

labour, but on the other hand, doctors retain over-arching responsibility for prescribing and delegating patient supervision to the pharmacist (Britten, 2011; McDonald et al., 2010). However, the NMS not only creates the conditions for new boundary disputes, but introduces competing discursive rationalities for professional practice (Pickard, 2009). Our findings suggest an important, but neglected aspect of the modern pastorate, where pastors compete, not simply over work jurisdiction, but more fundamentally to define the 'regimes of truth' through which subjectivities are formed. In the case of the NMS, these tensions were articulated discursively as each pastor being better positioned to 'access', 'know' and 'save' the patient. Each claiming to have a more legitimate and influential relationship with the 'congregation'.

The findings therefore suggest the equivalent of a theological 'schism', where both GPs and pharmacists work to promote adherent patient behaviours, but follow distinct practices to promote appropriate behaviour. These reflect underlying differences in the particular 'beliefs systems' of each pastor, and assumptions about their own abilities to offer 'salvation'. More significantly, this reveals a schism within the wider discursive field, and questions the idea that a single unifying discursive rationality is at work re-constituting subjects. Rather it indicates a plurality of discourses that at times converge, and at others diverge. This plurality helps explain the competition between pastoral actors, but more importantly, the dilemmas often faced by contemporary regimes of governmentality (Foucault, 2008; Lemke, 2001). Specifically, multiple and constantly changing societal discourses can make it difficult for subjects to internalise and normalise a stable 'truth', thereby leading to inconsistent subjectivities or ontological insecurities (Giddens, 1991). This has the effect of rendering regimes of governmentality fragile, unstable and in need of constant maintenance, often by pastoral actors (Waring and Martin, 2016).

The plurality of governing discourses, and the resultant competition between pastors, creates opportunities for agency and resistance among both target subjects *and* pastors. Far from being 'docile', patients were active in their reflective subjectification, especially through engaging in confessional behaviours. More significantly, patients used various discourses, from other areas of their life, to challenge behavioural expectations as a basis for 'counter-conduct'. In his writings on the Christian pastorate power, Foucault (2007) observes the potential for counter-conduct to religious teaching through the cultivation of mysticism, the formation of alternative communities or the return to scripture. In the contemporary context, the plurality of competing discourses, access to new information and the formation of counter-communities represents areas where pastoral power might be resisted (Waring and Martin, 2016). As noted above, the failure to link individual and collective behavioural expectations, creates another basis for counter-conduct to emerge in the absence of community-wide censure. A significant finding from our study is the potential for patients to recognise and use the underlying competition between pastors and the plurality of the discursive field to justify counter-conduct. That is, subjects can invoke the guidance of one pastor, or alternate social discourses, to explain their counter-conduct to the other. This reveals an aspect of agency that both stems from, and has the potential to undermine, the pluralistic discourses of contemporary governmentality (Dean, 2010). The plurality of the discursive field and consequent opportunities for agential resistance, are implicit but often overlooked features of Foucault's (2007) writing, which are especially significant in contemporary society for

explaining why governmentality so often seems to fail; because subjects are able to exploit opportunities for counter-conduct made possible by competing and unstable discourses.

Furthermore, this resistance has a recursive impact on pastoral agency. As suggested by Foucault (1982), pastors are accountable to wider political institutions for the moral conduct of their subjects, and where they fail, their own position is called into question. With the NMS, there are strong policy and professional expectations for pharmacists and GPs to promote adherent behaviours (Department of Health, 2013). Patient resistance (non-adherence) might question the legitimacy of pastors, and by implication require pastors to engage in strategic agency as they respond to resistant patients and secure their legitimacy with wider institutions. This reveals the inter-connected agency of both the 'knower' and 'known'. Pastors are not outside the relations of power 'looking in', rather they are equally constituted by these relations of power through 'inter-subjectification'; where the recursive actions and reactions of subjects has implications for their on-going and interconnected subjectivity. Again, this recursive inter-subjectification is an implicit feature of Foucault's (2007) that is rarely elaborated in the application of his ideas, especially in the study of expert-lay relations.

Foucault's concept of pastoral power is integral to his genealogy of governmentality, and despite many studies using it to describe the 'conduct of conduct', few have developed a detailed account of the relational practices of the modern pastorate. Looking beyond the case of the NMS, our article makes a number of extensions to Foucault's concept, which elaborate the practices and contributions of the modern pastorate within contemporary assemblages of government. First, the conduct of conduct relies upon multiple pastoral actors, located at different positions within the apparatus of government, and operating between formal institutions and local communities. Second, pastors follow variegated practices reflective of their discursively constituted roles and positions, with some enacting discipline and coercion, and others subjectification and consent. Third, the balance of discipline and subjectification is achieved through the coordination of multiple pastoral practices, which together categorise, inscribe, normalise and monitor desirable subjectivities. But fourth, pastors offer divergent pathways to salvation and can compete with each other to constitute and conduct subjects. This can undermine governmental regimes and create opportunities for counter-conduct. Fifth, the subjects of pastoral power are agential both in their own subjectification, and in their resistance to pastoral power, which can emerge from pastoral competition and discursive plurality. Finally, resistance to pastoral influence creates a crisis of legitimacy for pastors, who need to engage in their own strategic agency to counter such resistance and restore their legitimacy through experimenting with new ways of constituting and conducting subjects. This reveals how pastors, like their subjects, are constituted by prevailing discursive rationalities.

In conclusion, our study offers a dynamic view of the modern pastorate that is relevant to the sociological study of contemporary government with and beyond the State. As well as showing the variegated, complementary and competing practices of pastoral power, it shows how pastors operate at the nexus of discipline and subjectification, and are integral to the formation and maintenance of governmental orders. It reveals, in particular, how the plurality and instability of the discursive field, illustrated by competing pastors, creates opportunities for counter-conduct that can prompt governmental

regimes to fail, necessitating additional forms of ‘corrective’ pastoral agency. This suggests a more agential and recursive form of inter-subjectification between pastors and their subjects.

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