

Professional identity in pharmacy

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## Contents

List of tables .....	6
List of appendices.....	6
Abstract .....	7
Declaration .....	8
Copyright statement.....	8
Acknowledgements.....	9
Abbreviations.....	10
The author .....	11
1 Organisation of the thesis .....	12
2 Background to the study and literature review.....	13
2.1 Introduction.....	13
2.2 Literature review approach and methods.....	13
2.2.1 Overall approach towards and aim of the literature review.....	13
2.2.2 Search techniques and key sources of evidence .....	14
2.3 The pharmacy profession .....	15
2.3.1 Introduction.....	15
2.3.2 Historical context and the emergence of pharmacy as a profession.....	15
2.3.3 Pharmacists as dispensers of medical prescriptions .....	16
2.3.4 Other roles for pharmacists.....	17
2.3.5 The pharmacy profession today.....	19
2.3.6 Pharmacy policy in the 21 <sup>st</sup> century .....	20
2.3.7 Summary and comments.....	21
2.4 Theories about identity .....	21
2.4.1 Introduction.....	21
2.4.2 Selves and identities.....	21
2.4.3 Identities in relation to groups .....	23
2.4.4 Professional commitment and identification .....	24
2.5 Theories about professions.....	25
2.5.1 Introduction.....	25
2.5.2 Professions and professionalism .....	25

2.5.2.1	Trait theory .....	26
2.5.2.2	Power theory.....	27
2.5.2.3	The new professionalism .....	29
2.5.3	Processes of becoming professional .....	30
2.5.3.1	Professionalisation.....	30
2.5.3.2	Professional socialisation.....	32
2.5.4	Professional roles .....	34
2.5.5	Summary and comments.....	35
2.6	Professional identity in pharmacy .....	35
2.6.1	Defining professional identity in pharmacy.....	35
2.6.2	Why professional identity in pharmacy is an important concept to study	36
2.6.3	Studying professional identity in pharmacy – three strands of enquiry ...	37
2.7	The empirical evidence relating to professional identity in pharmacy .....	38
2.7.1	Introduction.....	38
2.7.2	Dimension one – how pharmacists see themselves.....	38
2.7.3	Dimension two – how pharmacists think they are seen by others .....	39
2.7.4	Dimension three – how pharmacists are seen by others.....	45
2.7.5	Critique of the existing empirical literature .....	46
2.7.6	Aim and objectives of the study .....	48
2.8	Chapter summary .....	49
3	Study design and methods.....	50
3.1	Introduction.....	50
3.2	Overall approach to the study.....	50
3.2.1	Ontological and epistemological position .....	50
3.2.2	Grounded theory.....	50
3.2.3	Grounded theory and this study.....	51
3.3	Stage one .....	52
3.4	Stage two .....	54
3.4.1	Sampling strategy.....	55
3.4.2	The interviews .....	55
3.5	Ethical issues .....	56
3.6	Recruitment.....	57
3.7	Data analysis .....	57

3.8	Chapter summary.....	60
4	The study sample and presentation of the data in this thesis .....	61
4.1	The study sample .....	61
4.1.1	Stage one .....	61
4.1.2	Stage two .....	61
4.2	Presentation of the data in this thesis .....	62
5	Pharmacists as producers, dispensers and suppliers of medicines .....	64
5.1	Introduction.....	64
5.2	The medicines maker .....	64
5.2.1	Introduction.....	64
5.2.2	An old fashioned but recognisable role .....	64
5.2.3	Nostalgia for pharmacy of bygone days.....	66
5.2.4	Medicines makers today – a technical type?.....	67
5.2.5	Summary and comments.....	68
5.3	The dispenser and supplier of medicines .....	68
5.3.1	Introduction.....	68
5.3.2	The pill counter .....	70
5.3.3	Pharmacists are still dispensers .....	71
5.3.4	Supply work is uninteresting and technical .....	73
5.3.5	The timely supplier .....	77
5.3.6	The accurate supplier .....	79
5.3.7	The willing supplier .....	83
5.3.8	The reliable supplier .....	85
5.3.9	Summary and comments.....	86
5.4	Discussion.....	87
6	Pharmacists as scientists and medicines advisors .....	92
6.1	Introduction.....	92
6.2	The scientist .....	92
6.2.1	Introduction.....	92
6.2.2	The trained scientist .....	92
6.2.3	A scientific mindset.....	94
6.2.4	Summary and comments.....	95
6.3	The medicines advisor.....	95

6.3.1	Introduction.....	95
6.3.2	General medicines experts .....	96
6.3.3	The medicines information resource .....	99
6.3.4	The information professional.....	103
6.3.5	The checker.....	106
6.3.6	A good eye for detail and a medicines focus.....	109
6.3.7	Challenges in employing this for maximum benefit .....	111
6.3.8	Summary and comments.....	119
6.4	Discussion .....	120
7	Pharmacists as clinical practitioners, social carers and unremarkable characters	123
7.1	Introduction.....	123
7.2	The clinical practitioner.....	123
7.2.1	Introduction.....	123
7.2.2	Matching patient and medicine .....	123
7.2.3	The minor medical practitioner.....	128
7.2.4	A valued alternative to the GP .....	133
7.2.5	Summary and comments.....	135
7.3	The social carer .....	136
7.3.1	Introduction.....	136
7.3.2	The community figure .....	136
7.3.3	An approachable manner .....	140
7.3.4	Social issues .....	142
7.3.5	Summary and comments.....	144
7.4	The unremarkable character.....	144
7.4.1	Introduction.....	144
7.4.2	The anonymous pharmacist .....	145
7.4.3	Lack of visibility.....	148
7.4.4	Uninteresting, unfortunate or unpleasant characters.....	149
7.4.5	Summary and comments.....	152
7.5	Discussion .....	152
8	Pharmacists as business people and managers .....	155
8.1	Introduction.....	155
8.2	The business person .....	155

8.2.1	Introduction.....	155
8.2.2	The retailer .....	156
8.2.3	Providing services for money .....	160
8.2.4	Money-motivated community pharmacists .....	161
8.2.5	A generic, less personal service .....	163
8.2.6	Summary and comments.....	164
8.3	The manager .....	166
8.3.1	Introduction.....	166
8.3.2	The traditional pharmacy manager .....	166
8.3.3	Changing forms of management.....	167
8.3.4	The new pharmacy manager .....	170
8.3.5	Summary and comments.....	172
8.4	Discussion .....	172
9	Conclusions .....	175
9.1.1	Introduction.....	175
9.1.2	General discussion of the findings .....	175
9.1.3	Potential areas for future research.....	178
10	Appendices .....	186

Word count: 73,448

#### List of tables

Table 2.1: The empirical evidence on professional identity in pharmacy.....	41
Table 4.1: Group interview participants.....	61
Table 4.2: Individual interview participants.....	61

#### List of appendices

Appendix A:	Documents relating to Manchester University ethical approval
Appendix B:	Documents relating to Oldham NRES and also NHS R&D ethical approval
Appendix C:	Stage one interview schedule
Appendix D:	Stage two interview schedules
Appendix E:	Pharmacist pictures

## Abstract

The University of Manchester  
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Professional identity in pharmacy  
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This thesis uses the findings from a study of pharmacists and non-pharmacists to explore the concept of professional identity in pharmacy. Pharmacists are well-established as providers of healthcare in hospitals and community pharmacies and their position as dispensers of prescribed medicines, and advisors on medicines in general seem relatively secure, as does their clinical role in hospital and their extended role in community pharmacy. However, previous studies have suggested that there is still ambiguity over the identity of pharmacists. Government policy in particular can be oblique and there seemed to be a need to clarify who pharmacists are. Consequently, a study was designed to address this topic.

The concept of professional identity in pharmacy is made up of three dimensions: how pharmacists see themselves, how pharmacists believe others see them and how others do see pharmacists. This study investigated all three dimensions of professional identity in pharmacy.

The research adopted a grounded theory approach and a qualitative study was undertaken in two stages. The first stage involved 21 pharmacists taking part in group interviews. The second stage involved 85 pharmacists, pharmacy support staff, nurses, doctors and lay pharmacy users participating in individual interviews. The data were analysed using the framework method.

Analysis of the data generated for this study revealed nine identities for pharmacists: the medicines maker; the supplier; the scientist; the medicines advisor; the clinical practitioner; the minor medical practitioner; the unremarkable character; the business person and the manager. The pharmacists' identity as medicines advisor is considered the core identity which exists for pharmacists today and this manifests itself in different ways, depending on the setting or organisation worked in.

## **Declaration**

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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Special thanks go to my colleagues and friends in the Centre for Pharmacy Workforce Studies office, for putting up with me on a day-to-day basis and generally helping to keep me on track - Dr Sarah Willis, Dr Liz Seston, Jane Ferguson, Kelly Howells, Dr Helen Potter, Sam Jee and Andy Wagner. I have also been fortunate in the support, friendship and sometimes much-needed sense of perspective I have received from others in the group, in particular, Fay Bradley, Dr Penny Lewis and Dr Denham Phipps. Thanks also to Dr Devina Halsall, Jasmin Cairns and João Bissau Pereira for their ongoing encouragement which has helped me to get this far.

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## **Abbreviations**

BNF	British National Formulary
DGH	District general hospital
GP	General practitioner
GPhC	General Pharmaceutical Council
GSL	General sales list
MI	Medicines information
MUR	Medicine use review
NHS	National health service
OTC	Over the counter
P-med	Pharmacy medicine
POM	Prescription only medicine
UK	United Kingdom
USA	United States of America

## **The author**

The author has a social science background, having previously obtained a BA in politics from Lancaster University, and an MA (Econ) in applied social research from the University of Manchester.

In 2003, the author joined the Drugs usage and pharmacy practice research group at Manchester as a researcher. She worked on a number of community pharmacy evaluation studies and an interest in the varied ways in which pharmacists carry out their roles led her to take up this PhD in 2007.

## **1 Organisation of the thesis**

Chapter two presents the background literature which informed this study. It provides information about the history of pharmacy in Great Britain, and outlines the current policy context. Next the concepts of identity and of profession are introduced and defined, using theoretical literature drawn from the fields of sociology and social psychology. The key concepts from each of these three sections are then combined to provide the overall object of enquiry of this study – professional identity in pharmacy, before the empirical evidence base which exists on professional identity in pharmacy is reviewed and critiqued. The chapter ends by setting out the aim and research questions for this study.

Chapter three discusses the rationale for the design of the study. It describes the overall approach taken, and then goes on to describe the two stages of the study. It sets out the methodological approach to the study, describes the methods used and provides detail on the process of data analysis. Chapter four describes the study sample and introduces the main findings chapters which follow it.

This thesis contains four chapters which present the study findings. Chapter five presents the idea of pharmacists as people who work with the physical objects that are medicines, in terms of medicines formulation, assembly of medicines into prescriptions and supply of medicines to clients. Chapter six addresses pharmacists' identities as scientists and medicines advisors. Chapter seven covers the identities for pharmacists as clinical practitioners, social carers and also as unremarkable characters. Chapter eight presents the ideas of pharmacists as business people and as managers. Chapter nine concludes the study.

## **2 Background to the study and literature review**

### **2.1 Introduction**

This chapter presents the background literature which informed this study. Section 2.3 provides information about the history of pharmacy in Great Britain, and outlines the current policy context. Sections 2.4 and 2.5 introduce the concepts of identity and of profession respectively, using theoretical literature drawn from the fields of sociology and social psychology. The key concepts from each of these three sections are then combined to provide the overall object of enquiry of this study – professional identity in pharmacy – and this is explained in section 2.6. Section 2.7 then reviews and critiques the empirical evidence base which exists on professional identity in pharmacy and explains how this review led to formulation of the research questions for this study. Firstly, the approach taken and methods used in searching the literature are described below.

### **2.2 Literature review approach and methods**

This section describes the approach and methods adopted when reviewing the evidence base for this study.

#### *2.2.1 Overall approach towards and aim of the literature review*

Prior to commencement of the study a literature review was conducted. Professional identity is a complex subject and one that overlaps with many other areas. Therefore, the conceivably related objects of enquiry vary in nature, and are spread across several disciplines. If one imagines these objects as placed along a spectrum, at one end are tangible, physical entities such as the working environment, or technical tasks performed at work, which are directly observable and can be easily recorded or measured. At the other end of the spectrum are the least tangible, sometimes metaphysical, things such as thoughts and feelings about identity, which are usually accessed by way of using the spoken or written accounts of people. A traditional review of the literature was undertaken to inform this study, the details of which are described below. The ‘realist review model’ was developed by researchers involved in evaluating complex social interventions or programmes.<sup>1</sup> They propose that the researcher should make explicit the underlying (theoretical) assumptions about a phenomenon and look for empirical evidence about it, recommend taking an ‘inclusive’ approach to exploring the evidence base before embarking on a research study and state that:

*... there is no finite set of relevant papers which can be defined and then found [and] excluding all but a tiny minority of relevant studies on the grounds of rigour would reduce rather than increase the validity and generalisability of review findings since different studies contribute different elements to the rich picture that constitutes the overall synthesis of evidence.<sup>1</sup>*

Due to the complex nature of the subject matter of the current study, following a similar approach to the 'realist review' seemed appropriate. The aim of this literature review was to make explicit the theoretical assumptions about professional identity in pharmacy, and then to present the empirical evidence available in the area. The following section describes how the literature search was undertaken.

### *2.2.2 Search techniques and key sources of evidence*

A range of sources of information were searched for this literature review, and the following three paragraphs outline these, and the search techniques used.

The following bibliographic databases were searched online: Medline (1966-date); Embase Elsevier (1974-date); ISI web of knowledge (1981-date); Social Sciences Index (1983-date); International Pharmaceutical Abstracts (1970-date). Search terms, applied in various combinations and iterations included: professional, identity, pharmacy, roles, orientations, professionalism.

Specific journals were also searched, sometimes online, via search engines provided by the publisher, and also by perusing journal contents lists – this was done with both online and paper versions. The following journals were often sources of useful articles: The Pharmaceutical Journal; The International Journal of Pharmacy Practice; Research in Social and Administrative Pharmacy; Social Science and Medicine.

Relevant pharmacy and other healthcare-related websites were useful sources of information, both for 'keeping up to date' and for accessing specific policy documents. The websites of The Royal Pharmaceutical Society of Great Britain and The Department of Health were the most frequently used for these purposes.

I treated the literature review as an ongoing and iterative process, although, naturally, during the early stages of the study in particular, I spent a large proportion of my time reading material in different areas, and as time went on, gradually narrowed the focus and aim of the study. I attempted to keep up to date with relevant literature throughout the course of planning, undertaking and writing up this study. This is reflected by the publication dates of some of the sources cited in this thesis, which appeared within the last four years. Regular 'skimming' of new journal 'contents lists' as they were published, was a useful way of keeping up to date and I subscribed to emailed alerts from relevant publishers to prompt me to do this. I also received useful articles from colleagues, who passed on details of potentially useful sources they had 'spotted' during their own reading. The review was iterative in that 'snowballing', as in, checking

the bibliographies of articles that I read, proved to lead on to further useful articles, and also occasionally books.

In summary, using a range of search techniques resulted in this study being informed by a wide ranging literature including articles in academic and professional journals, grey literature and books. The following sections (2.3 to 2.7) set out the literature included in the review, starting with the history of pharmacy in Great Britain.

## **2.3 The pharmacy profession**

### *2.3.1 Introduction*

This study is about professional identity in pharmacy, which relates to the everyday work of pharmacists. The following subsections provide a brief history of how the profession of pharmacy came to exist, and how the role has evolved into the pharmacist we recognise today. The section ends with a review of the government and professional policy for pharmacy since the start of this century.

### *2.3.2 Historical context and the emergence of pharmacy as a profession*

In England, historically, 'medical work', that is - the work involved in providing consultations about illness, its diagnosis, its treatment, often with medicines, and the preparation and dispensing of these medicines - has been shared between a number of occupations.

In the 16th century, there were no 'pharmacists' or 'general practitioners (GPs)'. There were physicians (doctors), apothecaries and 'chemists and druggists' (grocers who prepared and distilled medicines).<sup>2</sup> Physicians focussed mainly on illness (consulting, diagnosing, prescribing treatments), while apothecaries undertook both medical practice and the selling of commodities. The 'spicer-apothecaries', had their own shops where they:

*...stored and sold spices, confectionery, perfumes, spiced wines, herbs and drugs which they compounded and dispensed to the public.*<sup>3</sup>

There were also 'dispensing chemists', who supplied medicines to physicians. There was considerable overlap between the work of various occupations in the field of 'medical work' and competition for control over different elements of this work. Apothecaries can be considered to have been 'in the middle', in conflict, on one hand, with the physicians, who did not want them to have a 'minor medical practitioner' role, and on the other, the 'chemists and druggists' over the monopoly to sell medicines.<sup>4</sup>

During the 19th century, medical work started to be separated more formally. The Apothecaries' Act of 1815 drew a boundary between the future medical and pharmacy professions by forbidding 'unqualified persons' i.e. chemists and druggists, from judging disease by external symptoms, while chemists and druggists got the right to 'buy, compound and dispense drugs and medicinal compounds.'<sup>2</sup> The 1858 Medical Act and formation of the General Medical Council, brought physicians and apothecaries (along with surgeons) together onto one medical register. By this time apothecaries had started to call themselves 'general practitioners of medicine', and their role evolved into that of the 'GP' we know today (although the Royal College of General Practitioners did not exist until 1952).<sup>5</sup> Meanwhile, in 1841, the Pharmaceutical Society was formed, and 'pharmacist' became a restricted title in 1868. In September 1841 the number of members and associates was 450; by the end of the year it was about 800 and by May 1842 it had risen to just under 2000.<sup>6</sup> However, despite the official separations by title and legislation, there continued to be overlaps in the work of apothecaries and pharmacists in practice. Apothecaries, and also chemists and druggists, both continued supplying medicines and recommending treatments for ailments in the community. At this time, medicines were made in community and hospital pharmacies, on the same premises from which they were dispensed. Pharmacists (and other pharmacy staff) compounded constituent ingredients to form medicinal products.

### *2.3.3 Pharmacists as dispensers of medical prescriptions*

An important factor in the development of doctors' and pharmacists' roles is the way in which 'medical care' has been paid for. Before the days of the NHS, doctors charged the individual client for their 'professional services' (consultations) and could also sell medicines, while pharmacists made a living by selling medicines. The point that, unlike doctors, pharmacists could be 'consulted' for advice without 'clients' having to pay a fee, is an important one to note here. In the 20th century, 'health insurance schemes' altered these arrangements - some of these schemes were organised through 'Friendly societies' and the 1911 insurance act extended this cover to help more people who could not afford to pay doctor's fees. The medical and pharmacy professions were both concerned by the extension of health insurance as they feared it could reduce their control over their areas of work, if doctors started to be employed by the 'Friendly societies' and paid less, or if the societies were to produce and dispense their own medicines (taking the pharmacists' role), and both professions lobbied to retain control of their areas of work. General practitioners wanted to retain their right to dispense under the scheme, but lost this 'battle', and all dispensing under the act had to be undertaken under supervision of a pharmacist. Thus, under the act, pharmacists were the only people permitted to dispense prescriptions, at the exclusion of general practitioners (apothecaries) or chemists and druggists although for private patients, general practitioners could still dispense.<sup>2</sup>



Once the NHS was founded in 1948, universal health insurance was introduced. For patients, the establishment of the NHS brought general practice consultations that were free at the point of access for all. For GPs it effectively removed their right to dispense for their patients, while pharmacists gained a virtual monopoly on the dispensing of prescriptions written by GPs - from 1948, 94% of the population obtained their medicines from registered pharmacies.<sup>7</sup> Today, 'dispensing doctor' GP practices still exist in rural areas but this is a very small proportion of general practice.

In terms of hospital pharmacy, from 1841 onwards, pharmacists began to be employed in hospitals in Great Britain. In 1938, the majority (71%) of large hospitals (100 beds or more) employed a full time pharmacist, but most smaller hospitals did not.<sup>8</sup> Where there was no full time pharmacist, the hospital would often call on the services of pharmacists in the community to assist with dispensing.<sup>8</sup>

#### *2.3.4 Other roles for pharmacists*

The section above described how, by the 1940s, the pharmacy profession was well-established, with pharmacists working in community pharmacies and hospital pharmacy departments. However, the potential for pharmacists to have a wider role, beyond the making and dispensing of medicines, had begun to receive attention during the previous decade. The future of the pharmacy profession, and what this could, or should, hold, became a topic of debate, and attention turned first to the hospital sector.<sup>8,9</sup>

During the 1930s, the Council of the Pharmaceutical Society set up a committee to enquire into all aspects of pharmacy and to make recommendations for the future. The committee published a report in 1939, which described the role of the hospital pharmacist as potentially including a range of activities such as: being responsible for the purchase, custody and dispensing of medicines; manufacturing galenical preparations (medicines or remedies); assisting medical staff in the selection of the most suitable medicines; being a general chemical adviser to the hospital and economic administration.<sup>10</sup> In 1941 the Council published a further report inquiring into pharmacy – its recommendations included: that the professional aspects of pharmacy should take precedence over commercial matters e.g. by developing a code of ethics and that the pharmacist's role as a dispenser of medical prescriptions should be further established – by extending the National Health Insurance scheme to all patients. As medical treatments were developing, more 'medicinal agents' were becoming available, which 'placed a strain on the legislation'. Additional requirements were being introduced, such as proprietary medicines needing to be labelled to show their composition and consequently the committee recommended that:

*...the course of events is determining that the pharmacist should become the expert in medicines...*<sup>9</sup>

The potential for hospital pharmacists to take on a wider role, beyond mainly making and dispensing medicines, continued to be discussed and investigated through the 1950s and was documented in the Linstead Report published in 1955.<sup>11</sup> The Linstead report recommended using 'less qualified' staff for routine work, and 'making the best use of available manpower' in hospital pharmacy, such as relieving pharmacists of routine work by using 'assistants in dispensing' (indeed, this was already happening).

Pharmacy work had traditionally consisted largely of making and supplying medicines, however, technological advances, such as the invention of the compressed tablet machine, changed the way that medicines were made. During the 1960s the pharmaceutical industry expanded rapidly and this affected the entire pharmacy profession, as medicines started to be made in factories, rather than pharmacy premises. Those with an interest in hospital pharmacy continued to express concern about whether the skills of pharmacists were being put to best use. By the 1960s there had been some developments in 'ward pharmacy', with pharmacists visiting wards to check prescriptions at the bedside, although progress was slow and confined mainly to large teaching hospitals. The Hall Report of 1970 stated that:

*...the pharmacist can no longer be regarded as only a dispenser of medicines...he has also to co-operate with medical and nursing staff in securing the most effective, safe and economical use of drugs'.*<sup>12</sup>

During the 1970s, the concept of 'clinical pharmacy' began to develop within the hospital sector and the pharmaceutical profession and the government began to question the role of pharmacists and debate what the future would and should hold for them.<sup>13</sup>

During the 1980s, interest in the future roles of pharmacists extended to the community pharmacy sector. The 'Nuffield Report'<sup>14</sup>, published in 1986, was the first major policy review of the pharmacy profession as a whole and its recommendations are credited with initiating a number of changes in pharmacy. In hospital, 'clinical pharmacy' was officially recognised; the Nuffield report recommended that this be practised in all hospitals<sup>14</sup> and the key government health circular on implementation of clinical pharmacy appeared in 1988<sup>15</sup>. For community pharmacy, the main influences of the report were in the areas of 'health promotion' and 'extended roles'.

Similar developments were taking place in the USA. Hepler and Strand used the term 'Pharmaceutical Care' to describe the potential expansion of the pharmacist's role, which they

saw as an opportunity for pharmacy to mature as a profession. For their vision to be realised, they stated that it was necessary to:

*...set new practice standards, establish cooperative relationships with other health-care professions, and determine strategies for marketing pharmaceutical care. Pharmacy's reprofessionalisation will be completed only when all pharmacists accept their social mandate to ensure the safe and effective drug therapy of the individual patient.*<sup>16</sup>

In Great Britain, the 1992 report 'Pharmaceutical Care' set out recommendations for future roles for community pharmacy. The main areas were: providing medicines, in a more flexible way (for substance misuse/addictions, repeat dispensing, emergency/out of hours supply); providing advice on medicines and on illnesses; ensuring that medicines are provided and used safely.<sup>17</sup>

### 2.3.5 The pharmacy profession today

In August 2010 there were 35,918 registered practising pharmacists in England.<sup>18, i</sup> Based on data drawn from the 2008 census and extrapolated to the 2008 register, it is estimated that 71% of practicing pharmacists work in the community pharmacy sector, 21% in hospital pharmacy and seven percent in primary care. Over half (55%) of pharmacists working in the community sector are employed in multiple or supermarket pharmacies.<sup>19 ii</sup>

In terms of employment tenure, within the community sector pharmacists work as business owners or salaried employees, in hospital and primary care trusts, pharmacists are generally salaried NHS employees, and in either sector they can work as self-employed locums. According to the 2008 pharmacy workforce census, in England, there were 5,370 locums, making up 38.2% of census respondents who worked in the community sector.<sup>19</sup>

There are 10,691 community pharmacies in England.<sup>21</sup> Traditionally, the majority of community pharmacies operated as independent pharmacies, run by owner-managers, but there has been a trend towards increased ownership by multiple contractors, (contractors who own six or more pharmacies). As of March 2010, 61% of pharmacies in England were owned by multiple contractors.<sup>21</sup>

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<sup>i</sup> Since this figure was calculated, the RPSGB has ceased to exist and pharmacists are now registered with the General Pharmaceutical Council (GPhC), but at the time that this thesis was submitted, no data from the GPhC register were available. There is no longer a non-practising part of the register.

<sup>ii</sup> The figures by sector are derived from data from the 2008 pharmacy census which is then extrapolated to the register, therefore the percentages do not match the 35,918 given as the overall figure. These are the most recent figures available.<sup>20</sup>

### 2.3.6 Pharmacy policy in the 21<sup>st</sup> century

Pharmacists register with their professional body, which sets standards for training, registration and continuing professional development, and their work involves providing services which are planned and funded by the government. Therefore, it was considered important, for the purposes of the current study, to understand the overall direction, and the significant areas of, professional and government policy which have contributed to shaping the way in which pharmacists practice today.

In 2000, the government published 'The NHS plan', its vision for the NHS in the 21<sup>st</sup> century.<sup>22</sup> The key documents in relation to pharmacy which followed the NHS plan were reviewed for this study. In 2001, the pharmacy 'response' to the NHS plan, 'Pharmacy in the future' was published.<sup>23</sup> Since then the main areas that policy has emphasised are:

- Pharmacy's role in the supply of medicines
- Pharmacists as a source of advice about medicines.<sup>24-27</sup>

The themes of developing the role of the pharmacist, beyond the supply of medicines through clinical pharmacy in hospital, and extended roles for pharmacists have continued to be emphasised in pharmacy policy directives. The 2008 pharmacy white paper stated that:

*Clinical pharmacy brings together the science of pharmacy and the skills of the practitioner to enable patients to receive – and to help other professionals deliver – safer care and more effective treatment.*<sup>28</sup>

Examples of the shift in proposed roles for pharmacists include:

- The introduction of a new contractual mechanism for community pharmacy
- The expansion of roles, particularly through more extended roles for community pharmacists
- Increased patient contact
- Increased integration of pharmacists with the rest of the health care team
- The introduction of pharmacist prescribing and pharmacists with a special interest
- The introduction of the role of accuracy checking technician.

Of course, in terms of public policy, the government has to focus on making the best use of resources within the pharmacy workforce and providing the best possible health care services. However, the government and pharmacy profession rarely, if ever, discuss the implications of the policies they set forth for the professional identity of pharmacists. Policy documents make many aspirational statements about what pharmacists could or should do, but the impact that

these might have on professional identity, in terms of shaping or changing what pharmacists perceive themselves as 'being' is difficult to discern.

These directives often describe tasks for the pharmacy workforce as a whole – (which includes pharmacists and support staff – as noted above) and a concern of this thesis is to say what pharmacists are like. The policy literature is sometimes oblique, in that policy directives often describe tasks for the pharmacy workforce, which includes both members of the pharmacy profession, and also a range of different types of support staff, who have not undergone the same training.

Pharmacists are professionals which implies that there are certain areas of work that only they are qualified to do – and sometimes the policy literature is oblique in the sense that it is difficult to see clearly which are the tasks that pharmacists alone can do.

### **2.3.7 *Summary and comments***

This section has provided an overview of the development of pharmacy in the UK, from the establishment of the profession, through to today. The next sections go on to address the theoretical concepts which are relevant to this study of professional identity in pharmacy.

Since the 1950s, there has been discussion within pharmacy professional, policy and academic circles, about pharmacists moving on from being people who undertake technical work with medicines, to having a wider role, and more contact with patients, where their knowledge about medicines and their effects on the body is utilised. This is referred to as 'clinical pharmacy' in hospital, and 'the extended role' in community pharmacy. Numerous government health policy and pharmacy professional policy publications have continued to put forward proposals and recommendations regarding pharmacists' work and roles.

## **2.4 Theories about identity**

### **2.4.1 *Introduction***

The overall topic of this section is the concept of identity, which has long been a focus of interest within the fields of both sociology and social psychology and it is from these fields that the literature presented here is drawn. Section 2.4.2 introduces the concepts of self and identity, and section 2.4.3 presents theories about identities in relation to groups.

### **2.4.2 *Selves and identities***

The concept of the self underpins ideas about identity. Therefore, this section introduces firstly the concept of the self, and then the concept of identity.

The early works which set down the ideas of the self-concept which are relevant to this study, date from the start of the 20<sup>th</sup> century and the theories of James<sup>29</sup>, Mead<sup>30</sup> and Cooley<sup>31</sup>. Stainton-Rogers uses James's work which referred to the concept of 'I' – the 'self as knower', and explains that this is an extremely difficult concept to define – it refers to 'the self' – which is not something that can be seen – and the self as a whole may include things that a person is not conscious of, although they may 'exist' – at the 'back of our minds'. Therefore, the 'self as knower' is not amenable to being studied.<sup>32</sup> Gecas provides the following explanation:

*The concept of self provides the philosophical underpinning for social-psychological inquiries into the self-concept but is itself not accessible to empirical investigation.*<sup>33</sup>

However, beyond the 'I', exists the 'Me', or the 'self as known', that is, the way people see and understand themselves – or in other words, 'who they are' - therefore this is a concept that people can be, and are, aware of.<sup>32</sup> Gecas refers to this as the 'self-concept', which he defines thus:

*The 'self-concept', on the other hand...is the concept the individual has of himself as a physical, social and spiritual or moral being.*<sup>33</sup>

James referred to one aspect of 'Me' as the 'social self' and conveyed the idea that there are multiple social selves, whereby people show different sides of themselves to different people. These ideas provide the underpinnings for the concept of identity. Identity is defined by Gecas as:

*...that vast domain of meanings attached to the self and comprising the content and organisation of self-concepts.*<sup>33</sup>

Unlike the 'self-as-knower', the self-concept can be known, and can be made known to others. One person's self-concept can have multiple identities, therefore, a person can see themselves as having more than one identity. This study is concerned with the reflexive and social aspects of identity. Reflexivity refers to being self-aware and having insight into one's own thinking and behaviour, while the social aspects of identity are those which exist in relation to other people. These ideas were emphasised by the early theorists - James and Mead both used the term 'social self' and emphasised the reflexive nature of this concept.<sup>32</sup> In 1982, Gecas wrote:

*The major outlines of the concept of self have remained largely unchanged since the formulations of James and Mead – i.e. the self is a reflexive phenomenon that develops in social interaction...*<sup>33</sup>

Thus, identities exist in relation to other people and 'who people are' is defined partly by who they are to other people. People are 'aware' that others 'see' them, and, to an extent, others'

perceptions are believed to influence and shape who people are. Such ideas are conceptualized through Cooley's term 'the looking glass self'. Or, as Gecas points out:

*That our self-concepts reflect the responses and appraisals of others is the dominant proposition in the sociology of the self.*<sup>33</sup>

This section has introduced four key ideas for this study: that each person is a self; that the self-concept can have multiple identities; that identities are socially constructed, in relation to and through interaction with other people and that identities can be investigated and understood by finding out and describing what constitutes them. The next section describes theories which consider identities in relation to groups.

### 2.4.3 Identities in relation to groups

The previous section explained that identity exists in relation to other people. This section focuses on groups of people, and how identities are derived from, and understood within and between groups. Two key theories are introduced: social identity theory, and the concept of stereotypes. Firstly, the self-concept, (who people are) is composed of a variety of social identities, such as national, gender or occupational identity.<sup>33,34</sup> Stainton-Rogers provides a useful explanation of how selves and identities fit together:

*Each of us experiences ourselves as being a 'self'. We are aware of being someone with a past, a present and a future, all of which affect who we are. We are also aware of the distinctive facets of our character...But as a 'self' we are not only aware of inhabiting a distinctive personal world, but also distinct social and cultural worlds. We are who we are because of our relationship to others – because we are a mother or a son...a student or a teacher. We are also who we are through belonging to different communities and our membership of other groups that reflect, construct and sustain our identity – as, for example, a social worker...a football fan...or whatever.*<sup>32</sup>

People can be grouped together in different ways, but the type of group that this study is concerned with, is what Stainton-Rogers terms an 'identity-reference group':

*Identity-reference groups are where belonging to the group involves identification with the group, and where affiliation acts as a reference frame for a person know 'who' they are – their social identity. Generally this is a long-term situation...and those who belong to the group will share common experiences, values and norms.*<sup>32</sup>

Social identity theory focuses on social groups, and the identity that people derive through being members of a group, and how people themselves compare themselves to and differentiate themselves from, those in other groups.

Several of the central ideas of social identity theory are of particular relevance to this study:

Social identification is a perception of oneness with a group of individuals, therefore, individuals attain an identity through identifying with other people who are part of their group (the 'in-

group'). Other groups ('out-groups') are very important because people are aware of them and compare their own group with other groups in order to establish a positively valued distinctiveness between the two. There is also often competition between groups. The strength of a person's affinity, or perception of oneness with their group can be affected by their beliefs about the distinctiveness of the group's values and practices in relation to those of comparable groups, and also the prestige of the group.<sup>35,36</sup>

Secondly, the concept of stereotypes is relevant to this study. According to social identity theory, people socially classify both themselves and others, and through doing this, they attribute prototypical attributes – to themselves and others. This is called stereotyping, when related to others, and usually self-stereotyping when related to oneself.<sup>36</sup> Stereotypes are 'social categorical judgement(s)...of people in terms of their group memberships'. Stereotyping is described as a natural human process which can have both positive and negative outcomes. Positively, individuals may use stereotypes to make sense of other groups. Generalised and often accurate views of a group can guide people in an appropriate manner when facing an individual from another group for the first time. However, stereotypes may also provide general false or negative expectations of another groups' attitudes or behaviours. It is possible that these negative expectations of a group create a reality through a self-fulfilling prophecy. For example, prior perceptions that doctors are arrogant may taint future interactions with this group. If other health professionals enter an interprofessional situation with these expectations in place, doctors may well begin to behave as expected. Further, if a professional group is faced with the stereotypes held of them by other groups, this may have an impact on their self image and output. Negative perceptions of the public stereotyping of nursing, for example, has been thought to influence the development of poor collective self esteem, job satisfaction and performance in nursing professionals.<sup>37</sup>

Other theorists (not from SIT) have also paid attention to identity in relation to groups, for example, Becker stated that:

*Individuals identify themselves – answer the question "Who am I?-in terms of the names and categories current in the groups in which they participate."<sup>38</sup>*

#### **2.4.4 Professional commitment and identification**

The last section set out ideas about identities in relation to groups – there are two further ideas which are worthy of brief mention here: the concepts of professional commitment and identification. Organisational commitment is:

*... the relative strength of an individual's identification with and involvement in a particular organization.<sup>36</sup>*



This is similar to the concept of affinity. This study is not concerned with measuring strength of commitment or affinity – but if professions have particular values, that its members should identify with – it is concerned with asking the question ‘what are these values?’ Mael and Ashcroft explain that a particular problem in this area is the frequent confusion between organizational identification and organizational commitment. In their view, commitment is characterized by a person's (a) belief in and acceptance of the organization's goals and values, (b) willingness to exert effort on behalf of the organization, and (c) desire to maintain membership. This formulation includes internalization, behavioural intentions, and affect, but not identification as presently defined. Commitment scales consistently feature generalized usage of the terms goals and values, as in the OCQ item, "I find that my values and the organization's values are similar".<sup>36</sup>

This section has introduced the ideas of the self concept, identities and identities in relation to groups. In the following section, attention turns to ideas about the professions.

## **2.5 Theories about professions**

### **2.5.1 Introduction**

This section introduces concepts relating to professions and professionals and explains how they have been understood for the purposes of this study.

People spend much of their lives working, so work is a large part of ‘social life’ and occupations are one of the main ways in which work is organised, and form a fundamental part of the ‘social structure’. Consequently, occupations have been of interest to sociologists for a long time. The material included in this review has been grouped into three areas: professions and professionalism (and how these are defined); processes of becoming professional and professional roles and their relationship to identity; Sections 2.5.2 to 2.5.4 focus on each of these areas in turn.

Theoretical work on pharmacy has been published within most of these areas, and reference is made to relevant papers within each section. This differs to the identity section (2.4) above, which did not reference papers about pharmacy, because pharmacy has not been theorised within that area.

### **2.5.2 Professions and professionalism**

The problem of defining a profession has been addressed from different theoretical perspectives. The literature reviewed for this study has been grouped into three main

approaches which also follow a chronological pattern, and these are presented below: trait theory, power theory and the new professionalism.

### **2.5.2.1 Trait theory**

Firstly, trait theory. Historically, a small number of occupations were generally considered the 'ancient' or established professions: the clergy, the army, law and medicine.<sup>39</sup> This idea works on an assumption that there is a hierarchy of occupations, at the top of which sit the professions. Initial sociological work (from the early 20<sup>th</sup> century) on the professions was concerned with listing 'traits' which defined a profession and set it apart from other occupations. Various lists of these traits were produced, and the trait approach proved very influential, with many subsequent publications adopting the approach of listing 'professional traits'. The traits commonly included in such lists were:

- theoretical knowledge in a particular field, obtained in a professional training school (a university)
- application of this theoretical knowledge in practice
- provision a skilled service or advice to others for a definite fee or salary (through their practical application of their theoretical knowledge)
- no marketing or advertising of services
- a corporate organisation, organised internally
- regulation by a code of ethics
- fulfilment of a necessary service for society
- members are motivated by a service-orientation – they gain intrinsic satisfaction from knowing that their work benefits society (and so extrinsic rewards are not very important to them)
- members are altruistic, as they are not motivated primarily by self-interest (but by wanting to work in the interest of others)
- the profession is accepted by the community because it is recognised that the profession works for the benefit of the community as a whole (derived from sources<sup>39-42</sup>).

Trait theory can be considered a 'functionalist' approach, as it generally accepted the existence of the professions as part of the social system, focussing on where they 'fit in', and what functions they fulfil for society. This implies a 'nice', functional, but oversimplistic and idealised view of the workings of the professions. Indeed, the functionalist approach was criticised for being too accepting of the professions' own definitions and in the 1970s, sociological work on the professions came to be dominated by theorists from the critical and interactionist traditions,

sometimes grouped together under the label 'power approaches' – the second area of theory about professions that is relevant to this study.

### 2.5.2.2 Power theory

Power theorists took a more political stance towards analysis of the professions, being concerned with power and control and how these are achieved, legitimised and maintained, the professions' relation to the state and autonomy, and whether or not professions always deserve the influence over public affairs that they possess.<sup>43,44</sup> Power theorists also pay attention to external forces such as technological change, market and organisational change and encroachment from other occupations. This section addresses the areas that power theorists concerned with the professions have focussed upon, and I have classified these as: an area of work which is distinct and which the profession controls; knowledge which is expert and esoteric; social distance which makes the profession 'untouchable' and autonomy.

Firstly, to address the issue of having control over an area of work. Johnson focussed on professions as groups which had to negotiate their position within a market.<sup>45</sup> As capitalist society developed, each profession had to seek state support to gain an 'exclusionary market shelter'. Freidson builds on Johnson's claim that these market shelters set each occupation apart from, and often in opposition to, the others, and writes that professions:

*...gain their distinction and position in the marketplace...from their training and identity as particular, corporately-organised occupations to which specialised knowledge, ethicality and importance to society are imputed, and for which privilege is claimed.*<sup>46</sup>

This implies that there is something particular about each profession that distinguishes it from other professions and that members of a profession have an identity that is associated with their particular area of work. The work of Larson<sup>47</sup> and Larkin<sup>48</sup> also focussed on gaining control of an area of the market, and an ongoing need for professions to be constantly negotiating this control.<sup>43</sup> This control over an area of work is also termed a 'monopoly of practice'.

Secondly, the issue of having a special area of knowledge, that goes with the area of work, and controlling this area of knowledge is important. In simple terms, this is about professionals 'being the experts' in their area of work, and being the only people qualified to carry out certain tasks. The notion of 'professional judgement' is important here. Professional judgement can be seen as 'knowing what to do' about a particular issue or problem. Although knowledge is important, this is about more than just knowing the answer to a question – it comes from a combination of a person having been trained in, and amassed knowledge in, a particular area, and then, through their experience of applying this knowledge and developing their skills, having

acquired an ability to make assessments or judgements. It is not simply a matter of having knowledge – it is the ability to use it to make a judgement. The knowledge itself might not be ‘exclusive’ to a particular profession, for example, a lay client could read many ‘facts’ about whatever matter it is they are consulting a professional about, but what sets the professional apart from others is being able to apply the knowledge in specific contexts. Jamous and Pelloile<sup>49</sup> argued that professional knowledge is of a certain type, that is:

*...esoteric or indeterminate knowledge – a professional competence and attitude which cannot be reduced to its constituent arts and routinised.*<sup>49</sup>

Thirdly, the concept of professional ‘social distance’ is relevant. Johnson writes of professional ‘mystification’. This is similar to Jamous and Pelloile’s argument that, to be successful, professions must promote their services as based on knowledge that is esoteric, that is, understood by only a small number of people. By promoting themselves as a specialist minority, professions set themselves apart from ‘everybody else’, and, by being the only ones able to perform certain functions, they make themselves invaluable. Their clients need them and depend on them, while never quite understanding exactly how they do what they do. This ‘social distance’ helps professionals to control and protect their area of work, by ensuring that no-one else is able to do it.<sup>43</sup>

‘Being needed’ and ‘exercising professional judgement’ can be seen as professional traits, but unlike institutional or organisational traits such as knowledge or a code of ethics, they involve a more complex ‘professional-client’ relationship, where their contribution is valued by their clients.<sup>50</sup> In terms of power, the public are unlikely to want to challenge the existence or legitimacy of a profession they see as necessary and, as others are prevented from practising in their area because they are not able to, professions effectively maintain control over their sphere of work. Therefore, these traits can be considered ‘ideological’ in nature.

Fourthly, the concept of ‘professional autonomy’ is relevant. Autonomy refers to self governance and self-regulation and has frequently been included in definitions of professions. Much of Freidson’s work is concerned with professional autonomy, which he considers the distinguishing characteristic of a profession.<sup>51</sup> A profession with autonomy has the freedom to practice self-regulation, and not to have its work controlled by others outside the profession. Freidson emphasises that this type of professional control is political in character, as it has to be negotiated with the state. Freidson defines functional autonomy as:

*...the degree to which work can be carried out independently of organizational or medical supervision and the degree to which it can be sustained by attracting its own clientele independently of organizational referral or referral by other occupations, including physicians. On the whole the more autonomous the occupation, and the*

*greater the overlap of its work with that of physicians, the greater is the potential for conflict, legal or otherwise.*<sup>51</sup>

As noted, historically, writings on the professions have implied a hierarchy of occupations, with professions at the top. Wilensky developed a model which presents a number of occupations as being in between 'non-professional' and 'fully-professional', using the term 'semi—profession'.<sup>52</sup> Freidson described the concept of the paramedical occupation, or paraprofession, as occupations centred around the work of healing which are ultimately controlled by physicians. Paraprofessions are organised around an established profession and partake of some but not all of the elements of professionalism, and, fundamentally, lack autonomy.<sup>53</sup>

Studies by McCormack<sup>54</sup>, Denzin & Mettlin<sup>55</sup>, Shuval<sup>56</sup> and Birenbaum<sup>57</sup> applied Wilensky's model<sup>52</sup> to pharmacy. From this perspective, pharmacy was described as a marginal, incomplete or quasi-profession. McCormack contended that pharmacy's marginality stems from the occupation's incorporation of the conflicting goals of business and profession. The 'dilemma' or 'difficulty' for the individual pharmacist is that they are constantly faced with decisions which require them to make a choice between business or professional goals.<sup>54</sup>

### **2.5.2.3 The new professionalism**

In addition to trait and power theories, which were driven by social scientists, latterly, many occupations themselves have produced their own definitions of professionalism – and the concept of the 'new professionalism' has emerged. Some of these definitions have arisen from those occupations which were not included in the short list of the 'ancient professions'. Of more relevance to this study is the interest within the health professions about defining or re-defining professionalism. With regards to pharmacy, numerous papers have been published in the USA and in Great Britain, which seek to define the elements which constitute 'pharmacy professionalism'. A full review of these is outside the scope of the current study, but the following two papers give a good indication of the ideas that have been put forward: In the USA, the White Paper on Pharmacy Student Professionalism (2000) defined a professional as a person who displays the following traits:

*knowledge and skills of a profession; commitment to self-improvement of skills and knowledge; service orientation; pride in the profession; covenantal relationship with the client; creativity and innovation; conscience and trustworthiness; accountability for his/her work; ethically sound decision making and leadership.*<sup>58</sup>

In 2007 a UK study identified four dimensions of pharmacy professionalism and related attributes:

*1. professionalism towards patients: (communication skills; empathy/compassion; dealing with patient diversity; ethical practice and confidentiality) 2. professionalism towards other professionals: treating others with respect 3. professionalism towards the*

*public: altruism and integrity 4. professionalism towards oneself: awareness of own limitations; life-long learning; dealing with uncertainty; self reliance and regulation; dress code; self-reflection; negotiating with others; keeping promises and appointments; providing and receiving feedback; dealing with errors.*<sup>59</sup>

These papers provide lists of positive, desirable attributes, which are found in codes of conduct or codes of professional ethics (including that for pharmacy) and tend to emphasise traits such as altruism, and 'ethical' practice. In the simplest terms, professionalism can therefore be understood as something 'good', while being unprofessional is something 'bad'.

This section has presented literature which helps to define what a profession is, drawing on areas which can be classified as trait theory, power theory and the new professionalism. In the following section, attention turns to the process(es) by which professional status is attained.

### *2.5.3 Processes of becoming professional*

This section presents theories about the processes through which professionalism is attained, both at the group and at the individual level – that is, how occupations become professions, and individual people become professionals. These processes are termed 'professionalisation' and 'professional socialisation' respectively, and sections 2.5.3.1 and 2.5.3.2 address each of these in turn.

#### **2.5.3.1 Professionalisation**

At the collective level, occupations have been viewed as going through processes by which they can become professions, through 'professionalisation', lose their professional status - 'de-professionalisation' and also regain professional status, through 're-professionalisation'.<sup>52</sup>

As noted in section 2.5.2.2, pharmacy has been treated in the sociological literature as an occupation which has 'failed' to achieve and maintain professional status. Sociologists writing during the 1950s to the 1970s set out what they saw as the 'problems' facing pharmacy. Structural, and economic factors are also considered relevant to pharmacy's 'problems'. Changes in the structure of the community pharmacy sector, with small retail businesses being replaced by larger chain stores, were seen as problematic. Shaw<sup>60</sup> and McCormack<sup>54</sup> both argued that an increase in chain businesses pressurised owners to emphasise their business role at the expense of their professional role, and that this was detrimental to pharmacy's image. Shaw linked this change to the issue of autonomy, focusing on pharmacy's lack of societal sanctioning, arguing that the public has a negative attitude towards pharmacy because of restrictions on the way community pharmacists work, and their reduced autonomy.<sup>60</sup> Denzin & Mettlin considered pharmacy to be an 'incomplete profession' – that never achieved professional status – on the grounds that it fails to meet some of the criteria : pharmacy has not

gained control over the social object which justifies its existence – the drug is an object which is sold for a profit, not a service sold for a fee or salary, although there have been attempts to shift attention to the filling of prescriptions, and the supply of information about drugs, as services (which in the case of prescription filling carry a fee).<sup>55</sup> Denzin and Mettlin's analysis was particularly influential and subsequent studies used this as a framework for examining pharmacy, as commentators<sup>50,61</sup> have pointed out.

During the 1980s, sociologists continued to analyse pharmacy and its 'problems' and to suggest strategies through which it could become a profession. Technological changes had impacted on the work of pharmacists – as noted in section 2.3.3 automated production of medicines meant that generally they no longer had to compound medicines. Pharmacists were seen as having lost their main function, and writers debated how pharmacy should proceed as a profession. As noted in section 2.3.4, new models of practice such as clinical pharmacy, pharmaceutical care, and extended roles were being proposed for pharmacists and some sociologists saw these in terms of a professional strategy, or study for pharmacy. Writing about pharmacy in the USA, Birenbaum perceived a profession threatened by the loss of its compounding function due to automation.<sup>57</sup> He contended that pharmacy needed to 'reprofessionalise' and saw clinical pharmacy as the way forward for the profession, citing the proposals of the Millis report e.g. the removal of the technical basis of the craft as a way of freeing the pharmacist to do more professional tasks.<sup>57</sup> In the UK, Holloway criticised Birenbaum's concept of reprofessionalisation, which he found too limiting and static, and argued that the issue is better understood in terms of Larkin's theory of occupational imperialism, which emphasises the need to constantly negotiate social or occupational control.<sup>7</sup>

In the 1990s, two sociological papers re-examined Denzin and Mettlin's claims and subsequent studies they seemed to have influenced. In 1995, Dingwall and Wilson challenged Denzin and Mettlin's analysis of pharmacy as an incomplete profession on two accounts: firstly, for claiming that pharmacy lacked some 'professional traits', but not substantiating such claims with evidence; and secondly for claiming that pharmacy had failed to gain control of the social object of its work. Dingwall and Wilson felt that a key problem with Denzin and Mettlin's analysis was its 'lack of original data on the everyday work of pharmacists'.<sup>61</sup>

Two years later, Harding and Taylor published their analysis of the pharmacy profession which also recognised that technological change had impacted on pharmacists' work and considered what the 'best way forward' for the profession would be. On the whole, they agreed with Dingwall and Wilson's critique of Denzin and Mettlin, however, they differed in emphasising their argument that:

*...the social object of pharmacy is the symbolic transformation of a drug into a medicine. Pharmacists have more than a legal license to dispense prescribed drugs, they also possess a publicly recognised authority to transform potent pharmacological entities into medicines.<sup>50</sup>*

Harding and Taylor re-examined the 'extended role' as a professionalising strategy and argued that activities which 'take the pharmacist away' from dispensing, take them away from medicines, so that the medicine 'no longer forms the focal point' for many of the new roles which had been suggested for pharmacists. While previous papers debated concerns about the 'lost compounding role', which was seen to have contributed to pharmacy's de-professionalisation, Harding and Taylor argued that the 'extended role' could also be damaging to the professional status of pharmacy:

*...strategies which displace the activities associated with dispensed medicines, and emphasise those associated with technology and routinised advice giving, may have a de-professionalising effect, when drugs lose their centrality to pharmacists' activities.<sup>50</sup>*

Therefore, Harding and Taylor seem to suggest that instead of spreading themselves more thinly across a wider range of services, pharmacists should consolidate their knowledge and skills on their area of expertise – drugs and medicines – and focus on these.

In 2001, Edmunds & Calnan continued the debate on 'reprofessionalisation' in pharmacy, but took a different view from Harding and Taylor, instead focussing on the trend towards extended roles for community pharmacists which they suggested could be a good opportunity to enhance the professional status of community pharmacy.<sup>62</sup>

Authors of the studies referenced in this section perceived a number of problems or difficulties for the pharmacy profession - these were – the conflict between pharmacy's business values and professional values, the corporatisation of pharmacy, technological change and a perceived loss of control over their area of work and suggested different strategies to take the pharmacy profession forward. The next section is about processes of becoming professional at the level of the individual.

### **2.5.3.2 Professional socialisation**

Theories of the self-concept and identity (as discussed in section 2.4.2) can broadly be classified as belonging to the 'interactionist' tradition. Gecas split interactionist theory into two main types – processual interactionist and structural interactionist.<sup>33</sup> Processual interactionist theory focuses on identity as negotiated within the social situation, while structural interactionist theory centres on identity as associated with particular roles, which form part of the social



structure – and this is discussed below in section 2.5.4. The focus of this section is processual interactionist theory which views the social situation as the context in which identities are negotiated and maintained through the process of negotiation. The processual interactionist perspective includes various ‘research streams’, including socialisation. The subject of this section is professional socialisation.

Professional socialisation is the process through which a person becomes a professional. In the 1950s, medical education became a subject of interest to medical sociologists, and several studies were undertaken which focussed on how medical students were prepared for their future role as doctors. A classic definition of professional socialisation is provided by Merton as:

*the processes by which people selectively acquire the values and attitudes, the interests, skills, and knowledge – in short, the culture – current in the groups of which they are, or seek to become, a member. It refers to the learning of social roles. In its application to the medical student, socialisation refers to the processes through which he develops his professional self, with its characteristic values, attitudes, knowledge and skills, fusing these into a more or less consistent set of dispositions which govern his behaviour in a wide variety of professional (and extraprofessional) situations.*<sup>63</sup>

Merton’s definition allows for a broad range of influences which contribute to the process of professional socialisation. While professional training will include ‘formal’ elements such as lectures (through which knowledge is acquired), Merton asserted that socialisation occurs primarily through interaction with other people who are significant for the individual such as faculty members, fellow students and patients. He also believed that students often choose to adopt a particular person as a ‘role model’, that is:

*a practitioner known personally or one known only by repute, as a model to imitate and an ideal with which to compare their own performance.*<sup>63</sup>

As well as considering influences which are present during professional education and training, other researchers cited the relevance of processes which occur on either side of this - Freidson contended that the process of professional socialisation may begin earlier in life than the point of entry to a professional school<sup>64</sup>, while Vollmer and Mills highlighted the importance of processes that take place after graduation, when individuals enter the workplace and establish relationships with colleagues<sup>65</sup>. In recent decades, much more research on professional socialisation has been undertaken, and the work of Merton<sup>63</sup>, Freidson<sup>64</sup>, and Vollmer & Mills<sup>65</sup> has been influential and continues to be cited by those studying the field.

Studies which applied these ideas to pharmacy came a little later. When they did, concern was expressed about ‘inconsistent socialisation’ in schools of pharmacy. In the USA, Shuval was concerned about inconsistent socialisation in schools of pharmacy, for example, that formal socialisers played up scientific and research aspects of pharmacy while avoiding the dilemmas

that question its professionalism and that fellow students and other staff seemed to reinforce negative images of pharmacy.<sup>66</sup> Chalmers et al were also concerned that a lack of clarity or mixed messages of what is expected of students can lead to 'disillusionment' or 'disenchantment'.<sup>67</sup>

More recent research undertaken in Great Britain has focussed on pharmacy education. Harding and Taylor express concern that students often receive ambiguous messages about what the professional practice of pharmacy consists of.<sup>68</sup> Similarly, recent work by Jesson et al highlights debate about the balance of science and practice within the pharmacy curriculum.<sup>69</sup> While academics seem to disagree about whether students are being appropriately trained as scientists, clinicians or both, students in Jesson's study also recognised dilemmas and contradictions associated with their education.<sup>69</sup> Research by Shann and Hassell highlighted the importance of education and training processes, including role models and the way in which these prepare individuals for their future roles as pharmacists.<sup>70</sup>

#### 2.5.4 *Professional roles*

The previous section presented the 'processual interactionist perspective' on professional identity formation. This section addresses what Gecas terms the 'structural interactionist' perspective.<sup>33</sup> Here, the important idea is not the social situation, but the concept of 'role'. The concept of role can be difficult to separate from that of identity, because it is so closely connected (and because of the existence of terms such as role-identity.) This links the way people see themselves to social structures, because people associate themselves (their self-concept and identity/ies) with a role – and a role is an element of social structure. For the purposes of this study, roles are considered to be 'what people do' and identities are 'how people see themselves' (and how they are viewed by others).

'Role theory' encompasses a fairly wide field of work (within the interactionist perspective) about social behaviours, identities, parts or roles and expectations.<sup>71</sup> Role theory is concerned with social behaviours (roles) that are associated with identified social positions which are generated by expectations. Role theory assumes a basic theatrical metaphor with parts (social positions) to be played and scripts (expectations) for behaviour. A key idea for this approach is that expectations generate behaviour.<sup>72</sup> This has been applied to studies of professional and organisational identities.

Guirguis reviewed the literature which has applied role theory to pharmacy practice.<sup>71</sup> In the 1960s, in the USA, Quinney operationalised the theoretical model by defining a set of tasks or functions, half of which represented professional work and half of which represented business work, and asked pharmacists to rate their 'orientation' (view on the importance of) each function.

He created a tool which he applied and then analysed his results to form a 'typology' of pharmacists in terms of their orientations e.g. the 'professional pharmacist' or the 'business pharmacist'. He also tested for relationships between different orientations and 'role stressors'.<sup>73</sup> His study was influential and his role orientation measurement tool (or modified versions of it), was applied in several subsequent studies. These studies investigated the relationship between the role orientations and work settings of pharmacists.<sup>74-76</sup> and the relationship between role orientation and values,<sup>75</sup> role conflict<sup>76</sup> and occupational inheritance<sup>77</sup>.

Later, in the 1990s in Canada, Hornosty also followed a similar approach, developing a measure of role orientation which required respondents to rate their orientation towards different pharmacy functions. Hornosty's analysis suggested three orientations in pharmacy: traditional, clinical and managerial, but found less evidence of role conflict or strain, and he argued that the distinction between the professional and commercial elements of pharmacy emphasised in previous work had been overdrawn.<sup>78</sup>

### *2.5.5 Summary and comments*

The section has covered professions and professionalism (and how these are defined); processes of becoming professional and professional roles and their relationship to identity. Sections 2.4 and 2.3 had already introduced the concept of identity, and provided information about pharmacy. The next section addresses professional identity in pharmacy.

## **2.6 Professional identity in pharmacy**

The preceding three sections have set out the historical and theoretical literature in relation to pharmacy, identity and professions. This section defines the concept of professional identity in pharmacy, explains why this is an important area to study, and introduces the three strands of enquiry through which a study may be undertaken.

### *2.6.1 Defining professional identity in pharmacy*

For the purposes of this study, professional identity is defined as 'who pharmacists are as professionals'. This allows for the inclusion of a broad range of phenomena or constructs that have been suggested in previous studies to contribute to professional identity, for example: knowledge, skills, values, motivations, goals, orientations (preferences, attitudes), attributes, qualities, characteristics interests and working relationships in terms of which people define themselves as professionals.<sup>79,80</sup>

### 2.6.2 *Why professional identity in pharmacy is an important concept to study*

In studies of professions and organisations, identity change and ambiguity have been thought to increase during times of change. Because new roles require new skills, behaviours, attitudes and patterns of interaction, they may produce fundamental changes in an individual's self-definition(s).<sup>80</sup> Studies of the health professions have highlighted problems of an inconsistent and conflict-ridden sense of identity among persons undergoing a shift in roles, as Lum [cited in Pendergast] states:

*professional socialisation proceeds at a more uneven pace and results in a less integrated professional self image in those...professions undergoing a transition in role definition.*<sup>81</sup>

Structural changes such as regulatory changes or competitive moves can cause the organisation's collective identity to surface. The collective identity also becomes more salient when members believe that the organisation's actions are inconsistent with its collective identity. In these cases, individuals may be prompted to ask 'what is this organisation really all about?'.<sup>34</sup>

On one hand, pharmacists are well-established as providers of healthcare in hospitals and community pharmacies. Their position as dispensers of prescribed medicines, and advisors on medicines in general seem relatively secure, as does their clinical role in hospital and their extended role in community pharmacy. However, on the other hand, there is still debate and ambiguity over the identity of pharmacists, Government policy in particular can be oblique (as noted in section 2.3.6), and there seemed to be a need to clarify who pharmacists are.

In 1995, Dingwall referred to pharmacy practice research as 'piecemeal' in nature<sup>61</sup> and called for further research that looked at the profession as a whole, in terms of trying to understand what type of profession pharmacy is. Six years later, Hassell et al<sup>82</sup> argued that the 'raison d'être' of the pharmacy profession, and its place in and contribution to the NHS was ambiguous and unpredictable; subsequently, Shann & Hassell have suggested that there was a need to consider the different 'types' of pharmacist that might exist and to validate these and to clearly identifying the characteristics that define and distinguish them.<sup>70</sup>

In terms of how professions should be studied, Freidson argues that theorists should attempt to create a definition which does not reflect the interests of a particular occupation but should be more detached in its perspective.<sup>51</sup> Instead of generalising about professions, researchers should document the nature and explain the character of particular professions, that a profession should be studied as an empirical case, that we should seek knowledge of the special characteristics of a profession, and find out what is particular about it. Dingwall pursues

this argument and suggests that we should focus attention on 'finding out just what kind of occupation pharmacy is'.

### *2.6.3 Studying professional identity in pharmacy – three strands of enquiry*

The sociological and social psychological theories outlined in sections 2.4 and 2.5, address how professions, as groups of individuals, operate within wider society. Although these theories have different objects of focus, several make claims which suggest a three-fold focus for a research study on professional identity.

Trait theory (section 2.5.2.1) posits that professions are accepted by the community. Power approaches (section 2.5.2.2), being more interactionist, have more to contribute, suggesting that each occupation must carve out a niche in the market, and that doing this involves an awareness on the part of those within the profession, of other occupations, and in turn, on the part of those others, of the occupation in question, and its work. Freidson emphasises the point that any occupation needs a client base in order to survive, and in the healthcare market place, there are sometimes choices about where to seek healthcare from.<sup>83</sup> Therefore, it is worthwhile for a profession to understand how other professions, as well as its clients, see it. In addition, social psychological theories provide us with interactionist, and/or constructionist approaches, which posit that identities exist in relation to, and are negotiated with, others. The literature review noted Freidson's argument that professional identity is negotiated, and only really comes to mean something, through interaction with 'others'.<sup>53</sup> Following this argument, it seemed worthwhile to investigate the views of 'others' about how they see pharmacists.

Taken together, these ideas suggest that the concept of professional identity is made up of three dimensions, which are: how a person sees themselves, how they think others see them and how others do see them. These dimensions have been alluded to in the foregoing literature review, although the terminology has varied across different studies, for example:

- Dimension one – how people see themselves – identity and in terms of theories about stereotypes – these views are autostereotypes<sup>35</sup>
- Dimension two – how people believe they are seen by others – this is referred to as construed external image<sup>34,36,84</sup> image<sup>80,85</sup> and in terms of theories about stereotypes – these views are perceived autostereotypes<sup>35</sup>
- Dimension three – how others see a person – sometimes called reputation - and in terms of theories about stereotypes – these views are heterostereotypes<sup>35</sup>

Therefore, it was important to establish what evidence already exists on professional identity, within each of these three dimensions. Section 2.7 presents the evidence which is relevant to each of these in turn – how pharmacists see themselves as professionals, how they think others see them, and how others do see pharmacists.

## **2.7 The empirical evidence relating to professional identity in pharmacy**

### **2.7.1 Introduction**

This section presents the empirical research which informed this study. It is presented in order of the three 'dimensions' of identity described in section 2.6.3. Pharmacists' views of their own identity; pharmacists' beliefs about others' perceptions of them; others' views of pharmacists. Further detail on some of the studies is provided in table 2.1 below. Section 2.7.5 provides a critique of this literature, highlighting some of the methodological issues, as well as gaps in the knowledge, and explains how these led to formation of the aim and objectives of this study, which are described in section 2.7.6.

### **2.7.2 Dimension one – how pharmacists see themselves**

Five qualitative studies and six quantitative studies were identified, which investigated pharmacists' own perceptions of their professional identity. The qualitative studies were undertaken in different countries, but all took as a point of departure a concern with changes to pharmacists' roles and aimed to bring more clarity to the question of their identity.

Sorensen investigated pharmacists' professional self-perception (identity) and developed a model with four 'types' of pharmacist: technical; business; conforming and holistic.<sup>86</sup> In a similar study, Norgaard identified four main perceptions of the pharmacists' role: provider of technical, standardised advice; drug expert; pharmacy leader and provider of individualised advice.<sup>87</sup> A study by Lasselain, published in 1991, investigated the views of community pharmacists in France and found that they perceived two main roles: a social role and a technical role.<sup>88</sup>

Leufkens carried out a study with various stakeholders involved in clinical pharmacy in Europe and used scenario analysis to develop three future scenarios for clinical pharmacy. Scenario analysis identifies major trends and forces (the driving forces) behind a phenomenon – in this case clinical pharmacy – and then constructs plausible scenarios. From the driving forces, critical uncertainties are identified, which can be simplified into one or two axis, 'scenario drivers', or dimensions. Leufkens identified three visions for the future of clinical pharmacy, wherein pharmacists were described as clerks, controllers or care managers.<sup>89</sup> A recent study in Canada investigated pharmacists' identity development during their integration into family practice teams. The findings signalled an emerging pharmacist family practice identity.<sup>90</sup>

In terms of the quantitative studies, Collins and Kritikos investigated pharmacy students' views of their own profession compared to other professions, using a tool originally developed by Furnham.<sup>91</sup> Collins's analysis revealed two primary factors: 'receptivity' comprising ratings of approachability, sympathy and accessibility, and 'potency', comprising levels of training, skills, power, essentialness and pay.<sup>92</sup> Kritikos's analysis found three dimensions: empathy, potency and expertise. Pharmacists were seen as generally more empathetic but less powerful than medical specialists, while community pharmacists were seen as more empathetic than hospital pharmacists.<sup>93</sup>

Hind<sup>94</sup> also measured 'group identity' and also used an adapted version of Carpenter's professional stereotypes scale<sup>95</sup>. Hean<sup>37</sup> used a scale originally developed by Barnes<sup>35</sup> to examine stereotypes among the groups of students. Stereotype profiles were constructed for professional groups that either differed greatly or appeared to be very similar. Doctors and pharmacists were rated similarly on several characteristics, including academic ability, which was high, and interpersonal skills, which was low. The biggest perceived difference between doctors and pharmacists can be seen in the domain of leadership skills, a characteristic for which pharmacists were given particularly low ratings. Pharmacists were also rated significantly lower than doctors on the characteristics of decision making and confidence.

In terms of professional identity in relation to strength of identification with the professional group, Adams<sup>96</sup> and Hind<sup>94</sup> applied a scale originally developed by Brown<sup>97</sup> and also tested for associations between professional identity and a number of independent variables. Profession, previous work experience, understanding of team working, knowledge of profession and cognitive flexibility were found to be significant predictors of professional identity.<sup>96</sup> Additionally, O'Neill measured the strength of pharmacists' organisational identification (using Mael's scale) and found that 76% were very interested in what others thought about their company.<sup>98</sup>

### *2.7.3 Dimension two – how pharmacists think they are seen by others*

Just one study was identified which investigated the concept of construed external image in pharmacy; this study found that 90% of pharmacists thought their company was either considered good or respected by others.<sup>98</sup> Lasselain found that community pharmacists felt undervalued by other health care workers, for example, that GPs thought they did not know anything about disease.<sup>88</sup> Hughes and McCann's 2003 study found that pharmacists thought that GPs often had a negative image of them as 'shopkeepers', and as a threat.<sup>99</sup> A recent Canadian study suggested an emerging 'family practice identity' for pharmacists, however, the same study found that pharmacists thought that doctors sometimes found pharmacists

frustrating to communicate with, particularly when they were presented with cumbersome paperwork by the pharmacist.<sup>90</sup>

Magirr looked at autonomy in pharmacy practice in the UK in the 1990s. The public see the pharmacist as lower sometimes or invisible, but respect problem solving, trust them more and think they have more time for them than doctors.<sup>100</sup>

Hornosty found that many pharmacists felt that the public did not have a good understanding of the work of the pharmacist or the knowledge and training required to become a pharmacist; rather, they felt that despite public relations campaigns the image of the pharmacist was still largely that of a 'pill counter' and 'bottle labeller'.<sup>78</sup>



**Table 2.1: The empirical evidence on professional identity in pharmacy**

Author	Date	Country	Research question(s)/ objective(s)	Sample	Method	Scale items
Adams <sup>96</sup>	2006	UK	Strength of professional identity	Cohort of first year health and social care students at two universities	Questionnaire – adapted version of Brown's scale	<b>I am a person who:</b> considers the group important; identifies with the group; feels strong ties with the group; is glad to belong to the group; sees myself as belonging to the group; makes excuses for belonging to the group; tries to hide belonging to the group; feels held back by the group; is annoyed to say I'm a member of the group; criticizes the group.
Collins <sup>92</sup>	1999	Australia and UK	What are the perceptions of pharmacy students of their own and other professions?	Pharmacy students	Questionnaire. Exploratory factor analysis. Used 8 of Furnham's bipolar scales	Analysis revealed two dimensions: <b>Receptivity:</b> approachable-unapproachable, sympathetic-non-sympathetic, accessible-non-accessible. <b>Potency:</b> highly trained-little trained, skilled-non-skilled, powerful-non powerful, essential-non essential, highly paid-badly paid.
Hean <sup>37</sup>	2006	UK	Stereotypical perceptions of healthcare professions.	Students of 10 healthcare professions, including pharmacy.	Questionnaire using rating attributes on a five-point scale.	How would you rate pharmacists on: academic ability; professional competence; interpersonal skills (e.g. warmth, sympathy, communication); leadership abilities; the ability to work independently; the ability to be a team player; the ability to make decisions; practical skills' confidence
Hind <sup>94</sup>	2003	UK	Testing hypothesised relationships between stereotypes and professional identity.	Students in nursing, pharmacy, physiotherapy, dietetics and medicine	Questionnaire using Carpenter's stereotype attribute scale and Brown's scale of professional identity.	Carpenter's stereotype attribute scale: Positive - caring, dedicated, communication skills, confident, decisive, Negative - dithering, detached, arrogant.

Hornosty <sup>78</sup>	1990	Canada	What is the subjective role orientation of practising pharmacists?	Pharmacists	Questionnaire.	<p>Analysis revealed 3 factors: <b>Traditional:</b> Dispensing prescriptions and selling OTC medicines. <b>Managerial:</b> Managing personnel, cash, front of store stock and dispensary stock. <b>Clinical:</b> accumulating relevant literature, providing information and advice about drugs to other health care professionals and counselling patients on drugs. <b>Perception items:</b> Pharmacy is considered a worthy profession and has prestige and high standing in the community; pharmacy is an occupation that is both a profession and a commercial business; pharmacy is a practice that is very useful and important to society in general and one that directly benefits one's fellow man; the practice of pharmacy requires a good knowledge of science and scientific method; community pharmacy, as it is practiced today, is highly competitive; a pharmacist spends a lot of time meeting the public and dealing directly with people; the single most important function of the pharmacy is to counsel patients regarding prescription-related matter and over the counter medications; there is little doubt that clinical pharmacy is the wave of the future and will significantly change the practice of the profession; the average pharmacist in practice today is more competent to counsel patients regarding prescription medications than is the average doctor; it is possible to be both a very good professional and a highly successful businessman (or woman) in community pharmacy today; pharmacy involves an awful lot more than filling prescriptions and looking after the store; the public would be very willing to seek information and advice from a pharmacy if it just knew how much the pharmacist really knows about drugs and related matters; there is too much emphasis placed on the clinical aspects of pharmacy in pharmacy school; the faculty should give more recognition to the business aspects of pharmacy practice and offer more business oriented courses; pharmacy's professional status in the community is increasing and will continue to increase in the future.</p>
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Hornosty <sup>101</sup>	1992	Canada	What do students think, does this change over time?	Pharmacists	Questionnaire	Some items from previous questionnaire plus new items: the average pharmacist in practice today does a good job counselling patients regarding prescription medicines and OTC; to be a good pharmacist it is more important to be able to communicate effectively with patients than to possess extensive knowledge about the latest developments in pharmaceutical sciences; I think that I would rather counsel patients than be a drug consultant to the doctor; more and more doctors are becoming aware that the pharmacist is a highly qualified expert in the field of drug therapy and are more and more willing to consult them for advice; the public has a good understanding of the work a pharmacist does and the knowledge and training required to become a pharmacist; despite the public relations campaigns the public image of the pharmacist is still largely that of a 'pill counter' and 'bottle labeller'; drug counselling is really not feasible as a general practice in most community pharmacies; most owners and managers of community pharmacies expect new graduates to be more oriented to the commercial aspects of pharmacy practice and to spend less time counselling patients; most pharmacists in community practice today are more concerned with making a profile than with providing a professional service; practising pharmacists tend to think that too much emphasis is being placed in pharmacy school on the clinical aspects of the profession; most pharmacy professors believe that the future of the profession lies in the area of clinical pharmacy; university professors helped me a lot to understand what the profession of pharmacy is all about; practising pharmacists have helped me a lot to understand what the profession of pharmacy is all about.
Kritikos <sup>93</sup>	2003	Australia	1. to investigate pharmacy students' perceptions of 10 medical and allied professions. 2. to explore students' perceptions of community and hospital pharmacists	Pharmacy students	Questionnaire Used nine of Furnham's scale items	Analysis across the non-pharmacy professions yielded three factors: empathy, potency and expertise. <b>Empathy:</b> unapproachable-approachable, non accessible-accessible, non-sympathetic-sympathetic. <b>Potency:</b> non-powerful-powerful, badly paid-highly paid, low status-high status. <b>Expertise:</b> little trained-highly trained, non-skilled - skilled.
Leufkens <sup>89</sup>	1997	Europe	What are the major trends and forces behind pharmacy today? What future roles could pharmacists have in optimizing pharmacotherapy?	Various delegates at a clinical pharmacy conference	Scenario analysis	Two dimensions were identified: professional autonomy and drug-patient orientation. From these were constructed a framework with three visions of the future of clinical pharmacy: <b>Clerk:</b> Low professional status, passive attitude, focus on logistics, dependent relationship with doctor, limited role in optimizing pharmacotherapy, whistle blower-for doctor, limited opportunity for outsourcing services - need inside supervising. <b>Controller:</b> Moderate professional status, reactive attitude, focus on protocol, 'watch dog' relationship to doctors, budget control and disease management role, good opportunity for outsourcing services, external accounting model. <b>Care manager:</b> high professional status, proactive attitude, patient-focussed, partner relationship with doctors, partnership role, dual commitment with doctors. No opportunity for outsourcing services - is based on long-standing relationship.

Norgaard <sup>87</sup>	2001	Denmark	What is the current and future role of the community pharmacist?	Community pharmacists and support staff, pharmacy educators.	Semi-structured interviews.	Identified four main 'roles' for pharmacists: <b>Provider of technical advice:</b> has no specific responsibility in the pharmacy. <b>Drug expert:</b> provides individual counselling on medicines, with the help of IT databases; secures/finds new working tasks, educates pharmacy technicians, promotes co-operation with other healthcare professionals, has specialised knowledge of drugs. <b>Leader:</b> Manages the pharmacy; performs professional health services; works to develop the pharmacy; acts as a role model for the rest of the pharmacy staff. <b>Provider of individualised advice:</b> provides pharmaceutical care, manages the pharmacy, provides individual counselling on drug use based on special expertise, is an academic, is a professional resource in the pharmacy, co-ordinates local interdisciplinary initiatives.
O'Neill <sup>98</sup>	2007	USA	Organisational identification and construed external image	Pharmacists	Questionnaire with agreement with statements measured on five and seven point scales respectively.	Organisational identity:: When someone criticizes my company/organization it feels like a person insult; I am very interested in what others think about my company/organization; When I talk about my company/organization, I usually say 'we' rather than 'they'. Construed external image: Overall, my company/organization is considered good by others; In general, others respect my company/organization; In general, others think that my company/organization is unworthy; Most people consider my company/organization, on the average , to be more ineffective than other pharmacy companies/organizations.
Quinney <sup>73</sup>	1963	USA	To what degree are pharmacists oriented to professional or business roles?	Community pharmacists	Scale with 10 orientation items	Analysis revealed a 2-dimensional 4-fold typology of role organisation: professional; professional-business; business and indifferent <b>Professional role items:</b> reading the professional literature; being part of the public health team; using and encouraging the use of official drugs; attending professional meetings; compounding and dispensing prescriptions. <b>Business role items:</b> maintaining a business establishment; being a successful businessman; arranging window and counter displays; being a good salesman; handling a variety of sundry goods
Sorensen <sup>86</sup>	1986	Denmark	Pharmacists' self - perception	Community pharmacists	Qualitative interviews	Identified four 'types' of pharmacist: technical, business, conforming and holistic

Two opinion pieces were published in the *Pharmaceutical Journal* concerned with pharmacy's problematic public image, and suggesting ways in which this could be addressed. Matowe claimed that the public image of pharmacists has declined and that pharmacists should work to increase public awareness of their roles beyond dispensing e.g. with health promotion leaflets and press releases.<sup>102</sup> Norris expressed similar concerns to Matowe, and believed that pharmacy's image has been damaged by the fact that pharmacists sell drugs for a profit. She recommended work to find out why pharmacists do not provide extended services and to develop interventions to address this.<sup>103</sup> In the 1980s, Poirier set up a humanities course for health professionals in an American university focussing on the representation of health care in the media. Poirier was concerned that pharmacy students still frequently encountered future colleagues who characterised the pharmacist as a 'pill counter'. The faculty involved in the course were concerned with changes taking place in the health professions and felt that understanding and accepting such changes were important for health professionals and also the general public. They saw the media as a force in forming public opinion and suspected a complex dynamic relationship between public images and interprofessional relationships, and noted that media portrayal of pharmacy had seldom been studied. A speaker on this course gave a lecture on pharmacy and television news which questioned why medical 'authorities' such as doctors, research scientists or pharmaceutical company spokespeople rather than pharmacists were often chosen as television spokespersons on drug-related issues. Pharmacy students on the course expressed their frustration as they encountered the 'invisibility' of pharmacists in all media.<sup>104</sup>

#### *2.7.4 Dimension three – how pharmacists are seen by others*

This section presents empirical data on how pharmacists are seen by others: pharmacy support staff, doctors, nurses and the lay public.

In 1996, Adamcik et al reviewed the literature on perceptions of the role of the pharmacist since the 1960s, and found that overall, doctors had held negative attitudes towards most clinical roles for pharmacists. Adamcik's review found that doctors were least supportive of tasks that allowed pharmacists to make independent decisions such as choice of drug, and most favourable toward 'traditional clerical tasks'. Adamcik's own empirical work measured support for clinical roles for pharmacists in hospital and community settings among pharmacists, doctors and nurses and found that doctors and nurses were more antagonistic toward clinical activities in the community than hospital practice setting.<sup>105</sup> An Australian study published three years later showed that doctors were more accepting of community pharmacists giving advice on non-prescription medicines than prescribed medicines and that doctors wanted pharmacists to be available to provide information – but had more reservations about them providing therapeutic

information.<sup>106</sup> Two more recent studies of hospital doctors' views suggest a similar theme, that doctors were comfortable with pharmacists detecting and preventing prescription errors, but less comfortable with pharmacists suggesting use of prescription medicines to patients.<sup>107,108</sup> Edmunds and Calnan explored GPs' attitudes towards extended roles for community pharmacists in the UK and found support for some extended roles, such as managing repeat prescribing, but wariness about pharmacists having too much involvement in decisions about what prescribed medicines were appropriate for patients.<sup>62</sup> GPs in Hughes and McCann's study thought that there was a conflict of interest between pharmacists being shopkeepers and providing health care.<sup>99</sup>

In terms of the lay public's view of pharmacists, there is a well-established evidence base on the lay public's use of community pharmacy as a healthcare resource. Hassell et al's review of the literature in 1999 showed some lay use of the community pharmacy as a 'first port of call' for minor ailments; evidence that lay users perceive less social distance between themselves and community pharmacists than they do with GPs; and also that the pharmacist is perceived as easier to talk to and willing to spend more time doing so.<sup>109</sup> An empirical study by Hassell suggested that the lay public did not see the community pharmacist as a general health advisor, but tended to predominantly use the pharmacist as a source of advice about products.<sup>110</sup>

Varnish investigated pharmacy users' views of the pharmacy profession and argued that the theoretical conflict between business and professional values may be overdrawn – his data provide examples of lay pharmacy users thinking that pharmacists put health before profits.<sup>111</sup> Cavaco's study of community pharmacy users in Portugal revealed contradictory ideas about the functions of the pharmacist. Primary health care roles were seen to result from counterbalancing perceived deficiencies from other health care providers such as doctors and the 'commercialism image' of community pharmacies.<sup>112</sup> A small-scale study from the USA in 1989 suggested that pharmacists were seen by the public as having a less interesting and challenging occupation than other professions.<sup>113</sup> Findings from a questionnaire study in Nigeria on the public perceptions of pharmacists suggested a lack of a distinct 'identity' for pharmacists, for example over 40 percent of respondents said they could not distinguish a pharmacist from a pharmacy attendant.<sup>114</sup>

### *2.7.5 Critique of the existing empirical literature*

Section 2.6.3 identified the three dimensions of which profession identity in pharmacy is constructed, which are the objects of enquiry of this study. The existing literature contributes to the understanding of these three dimensions, but there are several gaps. Firstly, in terms of the first dimension of identity, studies of how pharmacists see themselves, the focus has mainly

been confined to students and community pharmacists. In terms of the second dimension, how pharmacists think other see them, the published evidence on this is limited and the concept does not seem to have been fully explored. Thirdly, in terms of how non-pharmacists view pharmacists, there seems to have been more focus on the views of doctors, and a lack of work on nurses and pharmacy support staff or hospital pharmacy users.

In terms of the populations included within the samples of the studies reviewed, there is very little published evidence on the views of nurses or pharmacy support staff towards pharmacists; Norgaard's study included the head of The Association of Danish Pharmacy Technicians in its sample<sup>115</sup>, but this was the only example found within the studies reviewed here where a member of support staff was included in an empirical study. Neither was there any evidence in the literature of lay users' views of hospital pharmacists. The majority of studies reviewed here were not conducted in the UK, therefore, any application of the tools used would require testing before they could be considered a valid measure of the professional identity of pharmacists working within the British healthcare system. Those studies that were undertaken in the UK are all quantitative in nature, and were undertaken with student populations. It is also notable that the majority of literature covered in this review relates to community pharmacists.

In terms of the methods employed in the studies in this review, of the quantitative studies, Hind<sup>94</sup> measured the professional identity of pharmacists and O'Neill<sup>98</sup> measured pharmacists' organizational identification. Both of these studies applied existing scales, neither of which were developed within the field of healthcare research, and while their validity has been verified through previous applications neither were validated any further before being applied in the studies referenced here. Hean's study<sup>37</sup> used a scale originally developed by Barnes et al<sup>35</sup> and adapted it, and undertook a validation exercise with experts representing the different professions to which the scale was originally applied, however, these did not include pharmacy. Adams<sup>96</sup> adapted Brown's<sup>97</sup> scale to suit the health and social care student population through validation using a panel of judges and a pilot of the questionnaire with a similar student sample, and also ran factor analysis on the questionnaire.

Furnham's<sup>91</sup> scale was informed by salient previous studies and from the results of an exercise where doctors, social workers and occupational therapists answered an open question describing a number of medical occupations, which were not specified, so we do not know if pharmacy was included. Collins<sup>92</sup> and Kritikos<sup>93</sup> applied Furnham's tool, which was 18 years old at the time of Collin's study, but neither undertook any validation of the tool for application with pharmacy students.

Questions over validity aside, the studies do provide useful information relevant to this study, for example, on the strength of professional identity in pharmacy relative to other health professional groups (in Hind's study it was the lowest of all health professions included in the study). However, what studies such as those by Adams<sup>96</sup>, Hind<sup>94</sup> or O'Neill<sup>98</sup> do not tell us, is anything about the perceived nature of the pharmacy profession (or organisation), that is, what it actually is that members are identifying with. In this respect, they can be said to have a limited scope. Furthermore, and importantly for the current study, which seeks to address professional identity from the perspectives of the profession's clients as well as its members, they are not applicable for use with lay clients.

The qualitative studies, which do provide a more holistic pictures of the 'character' of the profession and the people in it – such as those by Leufkens<sup>89</sup>, Norgaard<sup>87</sup>, Lasselain<sup>88</sup> and Sorenson<sup>86</sup>, were undertaken outside the UK, and the most recent of these (Norgaard) was published 10 years ago. Lasselain's study covered the views of only seven pharmacists.<sup>88</sup>

Hornosty's work, published in two papers at the start of the 1990s in Canada, was interesting methodologically, as it extended Quinney's work on role orientation, but included a range of methods including observation, group discussion, interviews and written comments. Pharmacy students were encouraged to freely express their views about their experiences in pharmacy school and their thoughts about the profession and incorporated statements from these discussions and their other research into a questionnaire. This original qualitative work is likely to have increased the validity of the questionnaire.

Therefore, Hornosty's approach would have been the 'method of choice' if any one of the existing studies had been selected for application in the current study. However, firstly, Hornosty's questionnaire would not have been considered suitable for application in the UK today, due to its age and the fact that it was developed in the Canadian pharmacy practice setting. Secondly, the study design did not allow for the inclusion of non-pharmacist views.

Overall, none of the existing studies appeared to provide a suitable method to adopt for a study of professional identity from both a pharmacist point of view and a non-pharmacist point of view.

#### *2.7.6 Aim and objectives of the study*

The previous section outlined existing work and identified notable gaps in the knowledge. This study aimed to further understanding of professional identity in pharmacy and address some of these knowledge gaps.



The overall aim of this study was to investigate the topic of professional identity in pharmacy.

As explained in section 2.6, the concept of professional identity in pharmacy has three dimensions – how pharmacists see themselves, how they think others see them and how others do see them. The objectives of this study were to investigate each of these dimensions. The objectives are expressed as a set of research questions, which are:

- How do pharmacists see themselves?
- How do pharmacists believe that others see them?
- How do non-pharmacists see pharmacists?

These questions will be addressed through a qualitative study, which will seek the views of pharmacists from the main sectors of pharmacy practice – community, hospital and primary care pharmacy, as well as non-pharmacists - pharmacy support staff, nurses, doctors and lay users of pharmacy services.

## **2.8 Chapter summary**

This chapter has presented the background literature, and located this study of pharmacy within the existing literature on the professions and identity. It has presented and critiqued the relevant empirical evidence and explained how reviewing this evidence base led to the development of the aim and objectives of the current study. The next chapter describes the study that was designed to meet these objectives.

### **3 Study design and methods**

#### **3.1 Introduction**

This chapter discusses the rationale for the design of the study. It describes the overall approach taken, and then goes on to describe the two stages of the study. Firstly, the chapter sets out the ontological and epistemological positions that were adopted.

#### **3.2 Overall approach to the study**

##### *3.2.1 Ontological and epistemological position*

From an ontological perspective, the 'social reality' (to use Mason's term<sup>116</sup>) that is the object of enquiry of this study is professional identity in pharmacy. Section 2.6 explained that this has three dimensions: how pharmacists see themselves, how they think others see them, and how others do see them. Identity is an abstract concept that cannot itself be observed, or measured in its entirety, although it is regularly used and understood in everyday life. Therefore, to research identity, it is first of all necessary to find ways to operationalise the concept – to transform it into something concrete that can be studied empirically.

The concept of identity is usually accessed through spoken accounts of thoughts and feelings. Therefore, epistemologically, this study uses people's spoken accounts as evidence, which allow us to know and to investigate the concept of professional identity.

##### *3.2.2 Grounded theory*

Grounded theory was developed by Glaser and Strauss during the 1960s.<sup>117</sup> The authors originally proposed grounded theory approach as an alternative to what they saw as a tendency for academic social research at the time to focus mostly on theory, and to use research data to either verify or critique existing theories. Grounded theory studies are concerned with generating new theory, that is grounded in empirical data. Instead of concentrating on theory 'testing', following the grounded theory approach involves focussing on the prior step of discovering what concepts and hypotheses are relevant for the area that one wishes to research. Grounded theory is therefore an inductive approach, meaning that concepts, hypotheses and generalisations are derived from the data, as opposed to a deductive approach, which would start with a predetermined theory or 'hypothesis' and use the data to test (prove or disprove) this.

Grounded theory is an approach; therefore it does not specify one single research technique. However, grounded theory does advocate certain principles which should be followed in terms

of sampling, data collection and data analysis. Firstly, grounded theory studies use theoretical sampling. This is based on the saturation of categories and is utilised to discover categories and their properties, and to suggest the interrelationships into a theory, (as opposed to statistical sampling, which aims to obtain accurate evidence on distributions of people among categories to be used in descriptions or verifications).<sup>117</sup> Theoretical sampling is defined as:

*the process of data collection for generating theory whereby the analyst jointly collects codes and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges.*<sup>117</sup>

In designing the research, and ensuring its credibility, I was looking for the 'adequate theoretical sample'.<sup>117</sup> Theoretical sampling is designed to generate different kinds of data and therefore give the analyst different views or vantage points from which to understand a category. In grounded theory studies, data collection and analysis may overlap with one another. Previous researchers have proposed that theory generation should be an 'iterative process' or a process of progressive focussing, whereby questions and methods are modified in light of the emergent data, and that the researcher should alternate data collection periods with preliminary analysis of the data.<sup>118</sup>

In terms of data analysis, grounded theory is part of a more general research method called 'comparative analysis', which refers to a way of understanding data and explaining ideas about it, by assigning the data to categories and looking for 'patterns'. Comparative analyses are used to generate concepts, from accurate evidence, and also to specify concepts. Specifying a concept involves specifying the unit of analysis for a study - and identifying the distinctive empirical elements distinguishing the units of comparison. Explicating concepts and their elements should allow the reader of a study to understand what is being written about.<sup>117</sup>

### 3.2.3 Grounded theory and this study

Glaser and Strauss asserted that by categorising data and understanding what the categories are, so social life can come to be known, and understood.<sup>117</sup> Professional identity in pharmacy is the 'social reality' with which this study is concerned. In order to know what professional identity in pharmacy is, and to understand it, this study sought to generate data which could then be categorised. The interpretation in the thesis then seeks to explain these categories, with the aim of allowing professional identity in pharmacy to be better articulated, defined and understood.

Grounded theory was deemed to be a suitable approach for this study because professional identity is a complex area, there were many gaps in the evidence base, and because existing research tools were not considered suitable for being reapplied. As section 2.7.5 explained, I

had not identified one particular existing theory that lent itself sufficiently well to being applied and tested for this study, or one ready-made research tool that could be administered. If this had been the case, particularly if an existing quantitative tool had been used, the precise nature of the elements or constructs of identity that were being measured would have been known at the point that the tool was administered to the respondents (and the tool could have measured for example their agreement with statements). However, because I wanted to find out how professional identity was understood, the investigation was exploratory in nature, and at the point that the interview schedule was 'administered', I did not know what constructs or elements the participants were going to provide. Accordingly, an initial study was undertaken, with the aim of it being something akin to a pilot study, in that the sample size was relatively small, and that more data collection would follow it. This study was undertaken to provide some insight into how the issue of professional identity was viewed by pharmacists, and to allow me to analyse the data to see what themes emerged and let these inform the study in terms of where the investigation should go next.

To gain an understanding of how people experience professional identity in pharmacy, a qualitative approach was deemed appropriate. The following sections describe the two stages of the study.

### **3.3 Stage one**

In the qualitative research paradigm, a variety of data generation methods are commonly used. Potential techniques for generating data for this study included observation, group interviews and individual interviews. Focus groups have been found to be especially effective in studying professional practices as they allow the researcher to access the process through which collective meaning is negotiated and through which group identities are elaborated.<sup>119</sup> Barbour states that the group interview convenor:

*...should have, as a basis for comparison, groups made up of individuals selected on the basis of some shared characteristic or attribute, but which differentiates them from other groups.*<sup>119</sup>

Therefore, a series of sector-specific group interviewss was undertaken with practising pharmacists from the community, hospital and primary sectors.

The concept of professional identity refers to who people are as professionals, and the identity that is gained through membership of the professional group. Section 2.4.3 introduced the concept of stereotypes, which are generalised descriptions of groups of people – descriptions which include prototypical attributes, which people can assign to themselves and/or to others.

When designing the empirical data collection stage of this study, I sought a method that would allow me to explore the concept of professional identity in pharmacy, that is, what pharmacists are like and what characterises them. The development of personas has been used by product developers who want to understand the users of their products. A persona is a representation of a real group of people, usually synthesized from data collected via interviews. Personas may be exaggerated to some extent, but are understood as 'abstractions or caricatures' of people's perceptions of their own work roles, or the roles of others around them, with a few fictional personal details to make the persona a realistic character. In doing so, personas are said to be cognitively compelling because they put a personal human face on otherwise abstract data.<sup>120,121</sup>

The persona technique seemed to offer a potential method of enquiry into researching identity for the current study. No previous studies had been found which made use of the persona method in pharmacy practice research, therefore study one was in some respects a pilot study in that it was trying out a new technique in this area.

The group interviews discussions were structured around devising pharmacist 'personas', that is, imaginary characters who may be found in the pharmacy profession. Personas are usually captured in one to two page descriptions that capture the characteristics (goals, values, preferences, working relationships, behaviours) and also environment of a real group of people. In preparation for the group interviews, I devised some 'example personas'. At the start of each session I described the method to the group and showed them the example personas. To avoid influencing responses, I used 'cross-sector' examples, so community pharmacists were shown hospital pharmacist personas and vice versa. Participants were also asked about their perceptions of the pharmacy profession in general, whether they thought there was one overall type of person who characterised 'the pharmacist', or whether they discerned particular types of pharmacist. The sessions were designed to proceed by the group devising one or more personas which represented the main types of pharmacist the participants thought existed within their sector. The personas were 'drawn up' on large sheets of paper, using headings such as 'goals' and 'preferred types of work', to prompt elaboration of the attributes of the characters being described.

As mentioned in section 3.2.3, this study was exploratory in nature, due to the area being under-theorised previously. In order to gain a valid understanding of the topic in question, I wanted participants to express themselves in their own words, therefore, I used 'open-ended' questions and tried to minimise my input into the discussions, beyond sometimes probing for further detail or clarification where relevant and managing the discussion in terms of time.

The sessions were audio recorded. Eight interviews were conducted, involving 21 pharmacists in total, one group contained just one pharmacist and the remaining were group interviews with between two and five participants in each. The interviews were between half an hour and two hours in length (9.25 hours in total).

Participants in the groups all agreed that there was no one 'typical' pharmacist that characterised an entire sector of the profession – all of the groups perceived several types. Participants applied themselves to the task of devising the personas with enthusiasm, and all group sessions resulted in several personas as well as a large amount of discussion. The personas drawn up were all fictitious, although pharmacists also gave 'real' examples of personalities, traits and stories from their experiences with current and previous pharmacist colleagues. Participants also spontaneously discussed their own working practices and personal experiences and views about their work. (See appendix C for the group interviews schedule.)

The group interviews generated 32 personas, captured on paper. I transcribed the audio recordings verbatim and carried out a thematic analysis on the transcripts (which followed the framework approach, which is described in detail in section 3.7 below) which also allowed me to add more detail to the personas. The analysis allowed me to compare the personas and their various attributes and through this process I was able to group together similar characteristics and reduce the personas down to eight 'characters' which I considered to represent the personas described in the groups.

Methodologically, carrying out this initial study showed that technique of devising personas can work well in the pharmacy practice research context, in that it seemed 'meaningful' to the participants in the study, and generated a considerable amount of data. In terms of the findings, it seemed that participants perceived several different 'identities' for pharmacists. The main limitation of this stage was that the sample consisted of participants who were employed by the university (in teaching practitioner, teaching fellow or research posts), or were undertaking post-graduate studies (the clinical diploma or a PhD) although they also all spent time practicing in practice settings (in community pharmacies, in hospitals or in primary care trusts), they were considered less 'grass roots' than would be a sample of pharmacists who were not employed in academia.

### **3.4 Stage two**

As noted in section 2.6, professional identity has three dimensions, and this study had three objectives, which relate to investigating each of these. The data generated through stage one related to objective one, finding out how pharmacists view themselves and others within their

profession. More research was necessary to address objectives two and three – how pharmacists think they are perceived by non-pharmacists, and how non-pharmacists see pharmacists.

#### *3.4.1 Sampling strategy*

Analysis of the data generated in stage one suggested considerable diversity within the pharmacy profession in terms of pharmacists' professional identity. Therefore, in stage two I aimed to extend the sample to include a range of pharmacists who were more 'grass-roots' than those in stage one who were all connected to the university. To address objective three, it was necessary to recruit non-pharmacists to the study. While potentially virtually anyone could have contact with a pharmacist, either as a service user or colleague, deciding on a sampling strategy involved balancing an ideal with realistic practical constraints, in terms of time and logistics. After consideration, four groups of non-pharmacists were chosen for recruitment to the study. Firstly, pharmacy support staff, who work alongside pharmacists on a daily basis, secondly, doctors, who have traditionally been (and remain the main) prescribers of medicines, thirdly, nurses, who often administer medicines, and fourthly lay users of pharmacy services. In terms of the professional and support staff, the sample included participants from all three sectors of pharmacy practice, while the lay users were people who had used either a community pharmacy or a hospital pharmacy.

#### *3.4.2 The interviews*

This stage of the study was designed to further explore the concept of professional identity in pharmacy using individual interviews with pharmacists and non-pharmacists. Interview schedules were prepared for each participant group. Pharmacist interviewees were asked questions in relation to their own work and about other pharmacists they had come across, and how they thought their profession was perceived by non-pharmacists. Non-pharmacists interviewees were asked about their experiences and encounters with pharmacists. The schedules were designed to elicit the opinions of all groups of interviewees on their general impressions of pharmacists, their experiences of pharmacists and what they thought made a good or bad pharmacist, what pharmacists do and what else they could or should do. The literature review helped to inform question design, for example section 2.5.3.2 explains the concept of role models, and pharmacist interviewees were asked for examples of these.

Stage two did not repeat the persona-generation exercise carried out in stage one. As mentioned, analysis of the data generated had led to the development of eight personas. After consideration about the best way to present these personas to participants, I decided to develop a visual aid which could be used as a discussion prompt during interviews. I searched for

photographs and put together eight pictures to represent the eight personas. These pictures, and also the interview schedules were refined following discussion with the study supervisors (KH and JH). They were then piloted by showing them to pharmacists within the pharmacy practice research group, who suggested a few minor changes. (Copies of all interview schedules can be found in appendix D and the pictures are appendix E.)

As noted, grounded theory proposes that the data collection and analysis should take place simultaneously, and that the researcher should analyse data and then decide what data to collect next. I endeavoured to bear this in mind during the field work stages of this study, for example, the first version of the interview schedule used did not include any questions about clinical work. However, during one interview, a practice nurse raised the issue of being aware of potential drug interactions when prescribing and dispensing medicines, and she referred to her own 'clinical knowledge', which she seemed to differentiate from the knowledge that she perceived the pharmacist to have, and this led to an interesting discussion about her perception of the nature of clinical work and whether she considered pharmacists to be clinical or not. Consequently, I added a question about clinical work to the interview schedule.

The interviews were all digitally sound-recorded, apart from one where the participant declined to be recorded, but was content for me to take as many written notes as I could during the interview. Field notes were generally taken during the other interviews, often on the interview schedule sheets as I would make notes by the relevant question. I kept a research diary throughout the study, and made further notes in this after each interview was finished.

### **3.5 Ethical issues**

The main ethical considerations for a study using interviews as the research method, such as this one, are ensuring that potential participants are provided with sufficient information about the study when they are invited to take part, ensuring that participants understand the general purpose of the study, what participation will entail and that they are happy to take part (that informed consent is obtained), and management of the data in terms of maintaining confidentiality and anonymity.

All participants were provided with written information about the study via the 'information sheet', were encouraged to ask me any questions, and gave written consent to participate. To ensure the anonymity of participants, all identifying features of the participants were excluded from the data during transcription and reporting. The only people who had access to the raw data were my supervisors and I. These data, which consisted of audio files, interview



transcripts, contact details and consent forms are stored in password protected electronic files and paper documents are kept in locked filing cabinets.

Both stages of the study were reviewed and given approval by ethics committees. Stage one was reviewed by the university ethics committee and approval was confirmed on 31/10/2007. Stage two was reviewed by Oldham NHS research ethics committee and approval was confirmed on 14<sup>th</sup> March 2009. Research and development approval was obtained from NHS trusts and primary care trusts which covered the areas where participants were recruited from. Copies of the documentation can be found in appendix B.

### **3.6 Recruitment**

For professional participants, invitation to take part in the research was emailed to potential participants. Those who agreed to take part were contacted and arrangements made to conduct the interview at a time and location convenient for them, which was usually at the participants' place of work.

A snowballing strategy was employed, whereby interview participants were asked whether they knew of any colleagues who could be invited to take part in the study. This proved to be an effective strategy, as several participants helped me recruit other participants for interviews, for example:

- Hospital pharmacists and administration staff forwarded email invitations to colleagues in their departments and were also provided with paper copies of invitation letters to distribute.
- A primary care pharmacist arranged for me to give a brief presentation about the study at a training event and invite attendees to take part.

For recruitment of lay pharmacy users, access to three community pharmacies and a hospital outpatients' pharmacy was obtained via two of the pharmacy interview participants. Pharmacy users were approached in person and the study was explained to them. For both stages of the study, all participants were provided with information sheets about the study and written consent was obtained from all participants. Copies of the information sheets and consent forms provided to participants can be found in appendix B.

### **3.7 Data analysis**

I noted above that grounded theory is part of a more general research approach called 'comparative analysis', and also that grounded theory does not specify one single technique for data analysis. Constant comparative analysis is a method of analysing data which involves a

process of examining the dataset, looking for themes and 'coding' it to these themes. Glaser and Strauss emphasise the importance of thorough data analysis, so that the researcher gains awareness of everything in the set of data and is then in a position to draw out the important points, as opposed to conducting analysis in a piecemeal fashion, which would give a 'false' representation of the data, as important points would not be represented.<sup>117</sup>

Several reference sources were consulted which deal with the practical tasks involved in handling and analysing qualitative data.<sup>117,119,122</sup> After consideration, the 'framework' method was selected because it seemed to indicate a rigorous analysis process, which would lead to the findings presented from the study being grounded on the experiences of the participants. Also, the developers offer a guide to their method which is clearly expressed, and offers detailed instructions on how to go about each stage of the analysis. The authors define framework as:

*an analytical process with five distinct though highly interconnected stages. [Which are] familiarisation, identifying a thematic framework, indexing, charting, mapping and interpretation.*<sup>122</sup>

Once I had prepared my interview transcripts, I set out to work through each of the five stages, and the following paragraphs set out Ritchie and Spencer's guidance on each stage, followed by an account of what I did.

#### **Stage one - familiarisation.**

Ritchie and Spencer state that the aim of this first stage of framework analysis is:

*to become familiar with the range and diversity of the data, and gain an overview of the material gathered, and involves immersion in the data: listening to tapes, reading transcripts, studying observational notes....the analyst is...gaining an overview of the richness, depth and diversity of the data [and] beginning the process of abstraction and conceptualization. While reviewing the material, the analyst will be making notes, recording the range of responses to questions...jotting down recurrent themes and issues...*<sup>122</sup>

As I undertook all of the interviews myself, I was close to the data from the beginning of the first interview. As noted, notes were taken during and after interviews, and at this stage early emergent themes were already being noted. I also transcribed all of the interviews, thereby listening to each participant's account a second time. Each interview transcript was printed out and read. For the individual interviews, a single page summary was produced for each interview. These summaries were considered alongside the transcripts, on which I also highlighted salient portions of text, and wrote further notes, and also the research diary and field notes from the interviews.

#### **Stage two – identifying a thematic framework and stage three – indexing.**

In terms of identifying a thematic framework, Ritchie and Spencer state that once the dataset has been reviewed, during the familiarisation stage, the analyst:

*... returns to these research notes, and attempts to identify the key issues, concepts and themes according to which the data can be examined and referenced. That is, she or he sets up a thematic framework within which the material can be sifted and sorted... The first version of an index is often largely descriptive and heavily rooted in a priori issues. It is then applied to a few transcripts when categories will be refined and become more responsive to emergent and analytical themes.*<sup>122</sup>

The framework stage, indexing, is defined as:

*...the process whereby the thematic framework or index is systematically applied to the data in its textual form.*<sup>122</sup>

Richie and Spencer note that the framework stages are interconnected and may overlap, and I found that stages two and three were the most intertwined in this study. While reading the transcripts, I carried out a process of listing themes and assigning codes to parts of the data. All the interview data were entered into qualitative analysis software programme Nvivo and the programme was used to assign codes to the transcripts. As Ritchie and Spencer imply will happen, many of the early 'codes' and themes were 'a priori', sometimes following questions from the interview schedule, for example 'what makes a good pharmacist?' was a 'theme' while particular elements, such as 'having good attention to detail' or 'being approachable' were 'subthemes'. Once initial codes had been applied to the transcripts, this allowed me to view the data 'by code' and re-read it by theme, across different transcripts. While doing this I noted further relevant issues and concepts, some of which then also became themes or subthemes within the index.

Some of the themes which emerged through reading the transcript were issues which I had already come across when reviewing the previous research, for example, pharmacists in this study mentioned that they thought others perceived them as 'shopkeepers', although none of the interview questions contained any suggestion of this theme, so this can be considered an 'emergent' theme, that was 'grounded' in the data, albeit not one that was a 'new' idea to me. Other themes were less expected, for example, analysis revealed a considerable amount of data relating to the issue of pharmacists being physically hidden from sight. Overall, the coding scheme developed both deductively, being informed both by pre-existing concerns, questions and hypotheses, and inductively, from the data themselves.

#### **Stage four - charting**

Ritchie and Spencer states that through charting, the fourth stage of analysis, the researcher should:

*...build up a picture of the data as a whole, by considering the range of attitudes and experience for each issue or theme. Data are 'lifted' from their original context and rearranged according to the appropriate thematic reference.<sup>122</sup>*

Ritchie and Spencer propose that charts should be laid out either by theme or by case, depending on how the analysis is being conducted. My analysis was thematic, in that I was looking for the main themes in the dataset. However, I was also comparing the views of different groups. Therefore, I entered summarised versions of the data into charts which had themes as column headings, and respondent groups as row headings, so a cell on the chart would show the range of data about, for example, what doctors thought made a good pharmacist. Ritchie and Spencer recommend entering a 'distilled summary' of the respondent's views onto the chart. The amount of information that I entered into my charts was very short, consisting of a few words at the most for each idea, and sometimes just one word. The data were referenced to show which interview they were from.

### **Stage five – mapping and interpretation**

The final stage of framework analysis is when the analyst:

*...begins to pull together key characteristics of the data, and to map and interpret the data set as a whole.<sup>122</sup>*

Ritchie and Spencer outline a number of objectives and features of qualitative analysis, three of which are particularly relevant for this study: defining concepts, mapping range and nature of phenomena and creating typologies.

The aim of this study was to explore the concept of professional identity in pharmacy, and in doing so I was looking to define the elements of which identity is constructed, and also to determine the range of and nature of these elements. During the later analysis and writing up stages of this study, I was able to group together various elements drawn from the data set, to create various identities in pharmacy.

## **3.8 Chapter summary**

This chapter has outlined the rationale for taking a grounded theory approach to this study. It has also described the data collection and analysis for both stages of the study. The next chapter describes the sample of participants and explains how the data are presented in the findings chapters.

## 4 The study sample and presentation of the data in this thesis

### 4.1 The study sample

This section describes the samples for each element of the study.

#### 4.1.1 Stage one

Twenty-one pharmacists took part in the group interviews. Table 4.1 shows the numbers employed in each sector of practice.

**Table 4.1: Group interview participants**

Number of interviews by sector of practice		
Community pharmacy	Hospital pharmacy	Primary care
6	13	2

All pharmacists were connected to the university, either as teaching or research staff or postgraduate students. The community pharmacists were employed by two chain pharmacies (and worked in four different pharmacies between them) and also included two locums, the hospital pharmacists were employed at three different hospitals, and the primary care pharmacists worked for two different trusts.

#### 4.1.2 Stage two

Eighty five people participated in the individual interviews. Table 4.2 shows the numbers from each participant group.

**Table 4.2: Individual interview participants**

Participant type	Sector of practice		
	Community	Hospital	Primary care
Pharmacist	13	7	2
Pharmacy support staff	6	2	1
Doctor	5	6	n/a
Nurse	3	5	n/a
Pharmacy user	27	8	n/a

The pharmacists who participated in interviews were based in:

- Two large national pharmacy chains (four different pharmacies)
- Three local pharmacy chains (five different pharmacies)
- A supermarket pharmacy

- Two independent pharmacies
- Three large teaching hospitals
- Three primary care trusts

The GPs were based at four GP practices (two in inner city areas, one in a suburban area and one dispensing practice in a rural area).

The community nurses were based at one of the GP practices, a health centre (this was a district nurse who spends much of her time visiting people at home).

Also interviewed were a school nurse, and three locum pharmacists who worked in a variety of community pharmacies and also a specialist (cancer) hospital.

The hospital specialities which interviewees were currently working in are listed below, although several interviewees had experience of previous work in other areas.

- Cardiology
- Thoracic surgery
- Intensive care
- Critical care – anaesthesia
- Acute medicine – admissions unit
- Surgical units – acute admissions and high dependency
- Medicines information

## **4.2 Presentation of the data in this thesis**

The four chapters which follow this one present the data generated during the two stages of the study. My analysis of these data revealed the existence of nine identities for pharmacists. The findings chapters are arranged thematically, with each having an overall theme, which then breaks down into the separate identities for pharmacists which have been defined within each theme. Data from stages one and two have been combined, so each findings chapter contains data from both. Within each findings chapter, each main section begins by highlighting relevant areas in the government policy literature, before going on to present the empirical data.

Section 2.6.1 defined professional identity in pharmacy as ‘who pharmacists are as professionals’ and explained that this allows for the inclusion of a broad range of phenomena or constructs that have been suggested in previous studies to contribute to professional identity, for example: knowledge, skills, values, motivations, goals, orientations (preferences, attitudes),

attributes, qualities, characteristics interests and working relationships in terms of which people define themselves as professionals.<sup>79,80</sup> The concept of identity has three dimensions: how a person sees themselves, how they think others see them and how others do see them.

As stated, the overall aim of this study was to investigate the topic of professional identity in pharmacy and the specific research questions to address were:

- How do pharmacists see themselves?
- How do pharmacists believe that others see them?
- How do non-pharmacists see pharmacists?

Each findings chapter draws on all three dimensions of identity, grouping together the participants' views on pharmacists' attributes, characteristics and other elements of identity within the main categories which form the headings and subheadings used to present the identities.

I found a recent paper on the topic of defining professionalism within general practice<sup>123</sup> particularly useful when working to conceptualise and shape the findings of the current study. This paper highlighted the importance of looking for areas of consensus about a concept, and also referred to the idea of 'valued attributes' and 'accepted attributes'. Through the findings chapters in this study, I presented the identities, and endeavoured to show the areas of consensus, and also those where opinions varied. I also paid attention to which attributes of pharmacists were 'accepted' that is, generally agreed to exist, and which were 'valued', that is, viewed positively.

The nine identities for pharmacists are presented in the findings chapters below, beginning with chapter five, which addresses the ideas of pharmacists as makers and suppliers of medicines.

## **5 Pharmacists as producers, dispensers and suppliers of medicines**

### **5.1 Introduction**

This chapter is about pharmacists as people who work with the physical objects that are medicines, in terms of medicines formulation, assembly of medicines into prescriptions and supply of medicines to clients. Section 2.3.6 noted that the policy direction has been for pharmacists to move away from the technical work involved in the supply of medicines, to enable them to devote most of their time to direct patient care, although policy does emphasise that pharmacists retain overall responsibility for the accuracy of dispensing. The interviews undertaken for this study generated a considerable amount of discussion on pharmacists as makers, dispensers and suppliers of medicines; hence this chapter. Analysis of the data suggested two identities for pharmacists within this theme: pharmacists as makers of medicines, and pharmacists as dispensers and suppliers of medicines. Sections 5.2 and 5.3 examine each of these in turn.

### **5.2 The medicines maker**

#### *5.2.1 Introduction*

As noted above, (in section 2.3.3) medicines manufacture shifted to the pharmaceutical industry during the 1960s. The making of medicines receives little mention within the contemporary pharmacy policy literature. The only direct references in the documents included in my review were: The RPSGB framework's third 'role' for *pharmacists* includes the function 'produce drug preparations and products' which includes the tasks of 'preparing and packaging pharmaceutical products'.<sup>26</sup> 'The best medicine' includes aseptic dispensing as a *hospital pharmacy* role<sup>27</sup>

Therefore, before I started my data collection I did not anticipate much, if any, discussion on the topic. However, during the course of carrying out the interviews, I noted a considerable amount of talk about the making of medicines. During the early stages of analysis (during the data collection and familiarisation stages), I noticed that although 'making medicines' was often seen as an 'old-fashioned' pharmacy role, it did not seem to have been left entirely in the past and forgotten; also, participants' views on this subject varied. Consequently, I decided that the issue was worth examining more closely.

#### *5.2.2 An old fashioned but recognisable role*

During the stage one interviews, there was very little mention of medicines making in community pharmacy. However, during stage two, picture 01 generated several responses about



pharmacists as makers of medicines. Some interviewees commented that this was an outdated picture, referring to a role from the past, that no longer exists in pharmacy practice:

*...that's probably about 30 years ago. I'd say 1970s...you wouldn't find anything like that going on now. (Community pharmacist O)*

However, the role of making medicines was within 'living memory' for pharmacists. Some community pharmacists recalled their own previous working practices:

*...it makes the technicians laugh actually when I tell them about what my jobs were when I was a pre-reg, about making up the methadone mixtures, and compounding the things, which of course they don't need to do now, nobody does anything, I think they make up one ointment a month, a dilution...that was a big part of my job, was making up the ointments and mixtures and things...(Community pharmacist R)*

Hospital pharmacists remembered seeing colleagues making up medicines in the dispensary, although they had not actually done this themselves:

*...that is kind of one of the things that is dying out...there was a technician, she's retired now but...that was one of her main roles, just making creams up...formulations...(Hospital pharmacist S)*

The pharmacist quoted above had observed a technician making medicinal products in the hospital dispensary; a community pharmacy technician described how this had been part of her job in the past:

*Respondent: ... when I first started [in the 1970s]...the ointments were mixed, on a weekly basis.*

*Interviewer: So were you doing that, or the pharmacist?*

*Respondent: Both. You know like say for the kaolin and morphine, we'd start off with the powder, mix it up, everything'd be checked, Friday afternoon you'd do what they classed as a baby clinic, so all the ointments that came in you made from scratch, you actually made, Friday afternoons basically spent making ointments up...(Community pharmacy support staff D)*

A GP also recognised picture number one as a familiar pharmacist:

*I mean that looks a bit old fashioned but it's definitely recognisable...a more kind of old-fashioned style chemist... (GP A)*

This pharmacy user seemed to perceive pharmacists to still be makers of medicines:

*Well they obviously mix erm powders and liquids, and things to make ointments, er follow a prescription and presumably they'd have, if you're cooking, a recipe, so presumably they'd follow a recipe and just mix the set amount according to the prescription...(Community pharmacy 1, user J)*

A hospital pharmacist and a lay pharmacy user mentioned that previously, pharmacists would have needed more knowledge about how to make medicines, and their quotes suggest that this was a 'special' area of knowledge for pharmacists:

*...they probably were written down...but she probably was the only person who was able to do all these formulations...(Hospital pharmacist S)*

*At one time, er, [pharmacists] had more knowledge in one sense because they had to take individual chemical parts, and put them together in bottles and so they were much more formulators than they are at present. (Community pharmacy 1 user A)*

### 5.2.3 Nostalgia for pharmacy of bygone days

Medicines making was not just remembered by participants in this study, it was also missed; investigation of the data exposed a discernable sense of regret from some pharmacists that making medicines was no longer part of their work:

*...you used to make up a lot more than you do now...You very rarely make anything, which is a bit of a shame really. I spent a lot of my career making stuff. (Community pharmacist O)*

*... there are a few things that we still kind of [make] but I guess it's dying out...it's a shame in some ways, kind of history and traditions are changing...they probably will die out unfortunately. (Hospital pharmacist S)*

Other pharmacists expressed a general nostalgia for 'community pharmacy of the past', both in terms of the pharmacist themselves, as well as the pharmacy premises. The following quotes recall community pharmacists of the past, working in old-fashioned shops (these participants were again commenting on picture 01):

*That was a long, long time ago, back in the day...a bit like the pharmacist I used to work for...they did have some of those great old dispensing jars and things, and he used to make up rose water tinctures and things for people who came in...he was lovely though (laugh)...(Hospital pharmacist P)*

*I suppose this one is...a more old-fashioned view of a...pill counting and compounding pharmacist (laugh)...the traditional pharmacist... Although actually there did used to be a lovely old pharmacy near where I live that had all those lovely old wooden shelves and things, and the old bottles in the window. (Community pharmacist R)*

As well as nostalgia for the 'lovely' pharmacists and pharmacies of the past expressed above, other participants identified receiving a personalised service as an aspect of community pharmacy that was particularly valued by pharmacy clients. One way this was fulfilled was via community pharmacists providing products that were made on the premises, which could be tailor-made for the individual client:

*I've worked in shops where we used to make gallons of our own cough medicine and it used to fly out, customers used to come specially for it, you can't do that anymore. The customers felt they were getting value for money, they thought they were being treated specially, you could tailor it to their needs...(Community pharmacist Q)*

*...harping back to the days when pharmacists could prepare individual medicines for patients who just come for advice and want something not off-the-shelf but something that pharmacists could conjure up in the back. (PCT pharmacy technician A)*

#### 5.2.4 Medicines makers today – a technical type?

As well as describing former medicines-makers in pharmacy, interviewees also referred to people who undertake this work today, and this did emerge in stage one. Hospital pharmacists (in two separate group interviews) described pharmacists working in aseptic dispensing. These were differentiated from the majority of hospital pharmacists, including the group interviews participants, none of whom worked in aseptics themselves, indeed, people employed in this area seemed to be a source of some amusement to the first group quoted here:

*HP Respondent:...there's a difference between people who work in...technical services as opposed to...(general laughter)...the bulk... if you're if you're in...technical services often they're very focussed around production of...drugs... whether it be aseptics or [other drugs]... (Hospital pharmacist group interview 2)*

Similarly, these group interviews participants drew a distinction between 'aseptic/technical' and 'clinical' pharmacists, and suggested that it was an area of work some pharmacists would rather avoid:

*HP M: ...aseptics, it's one of those [jobs] you either love or you hate...*

*HP L: ...I think they're less clinically based and quite often for us, a lot of the people who've been technicians and then become a pharmacist tend to go into aseptics.*

*HP K: But they're very detail orientated, very sort of serious, focussed, sort of individuals, with, everything's got to be black and white, it's very procedure-led...with clinical pharmacists it's always a grey area, so there's never a right or a wrong answer, with things like aseptics there is. (Hospital pharmacist group interview 4)*

We did not draw up detailed personas for pharmacists working in aseptics in the group interviews, however, the quotes above imply a particular 'mindset', associated with a technically-focussed role, where one follows pre-defined procedures.

A pharmacy technician, who had previously worked in hospital aseptics, raised the more practical issue that this area of work is physically demanding:

*I just thought, 'I'm getting older, what do I see myself doing over the next 15-20 years? Can I see myself climbing over this?' 'Cause there's a barrier to get into the aseptic suite, [would I want to be] climbing over here at 50, 60 still going in doing aseptics? (Primary care technician A)*

And the same issue was also acknowledged by this pharmacist:

*Interviewer: So physically making up [aseptic preparations] is more the technician's job?*

*Respondent: Yeah it is actually and that's probably the toughest bit of it. (Hospital pharmacist S)*

### 5.2.5 Summary and comments

This section has presented the idea of the pharmacist as a maker of medicines. This is supposed to be a thing of the past, but was discussed by several participants in this study, and existed in all three dimensions of pharmacists' identity. Pharmacists seem to have an emotional attachment to this previous identity, which, although no longer commonly undertaken, lives on in their memories. They also think lay clients valued the old fashioned medicines maker, for the personal service and tailor made goods they provided, using their 'mysterious' esoteric knowledge. Also, this identity was indeed perceived by non-pharmacists, in fact the only professional group not to mention it at all were nurses. Negatively, today's medicines making pharmacists, those that work in aseptic dispensing, are associated with technical/manual work, which is seen as physically hard, non-clinical, and unappealing to some pharmacists.

## 5.3 The dispenser and supplier of medicines

### 5.3.1 Introduction

In this section, the focus moves from the making of medicines to the supply of ready-made items to clients – through the dispensing and supply of medicines. The supply of medicines is mentioned throughout the pharmacy policy literature; in 2003, the government set out its vision for a time where pharmacists moved away from the technical tasks involved in supplying medicines, and took on a wider role, where they were more directly involved with patients, stating that:

*The traditional pharmacy role continues to be important but changes in meeting patient needs and technological and scientific advances mean that pharmacists will need to broaden their contribution.<sup>24</sup>*

However, a key professional policy directive published six years later retains dispensing as an 'essential' and 'important' function of pharmacy and pharmacies.<sup>26</sup> It is difficult to gauge from these documents to what extent pharmacists are supposed to be 'dispensers'. Also, the words 'pharmacy' and 'pharmacists' are used interchangeably, so it is difficult to discern clearly which of the tasks involved in dispensing should be undertaken by pharmacists and which by other pharmacy staff.

Secondly, policy on the supply of medicines in relation to hospital pharmacists has been inconsistent. In 2003, the government stated that:

*In hospital, automation and robotics will remove the burdens of mundane and repetitive tasks and release time for more direct patient care*<sup>24</sup>

And in 2005 that 'the distribution and disposal of medicines is a role for hospital pharmacy in particular'.<sup>25</sup> This seemed to be confirmed in a report on hospital pharmacy in 2007:

*clinical pharmacy involves managing the supply of medicines to ensure that there are sufficient stocks on the wards and appropriate planning for discharge.*<sup>27</sup>

However, just one year later, the government stated that:

*Hospital pharmacy has completed the transition from a service with a product and supply focus to one that is focused on patients and underpinned by clinical practice.*<sup>28</sup>

As well as the inconsistency, the last quote begs the question of where responsibility for the supply of medicines within hospital lies if not with pharmacy?

The manner in which medicines are supplied has also been a key theme of pharmacy policy, which has emphasised that this must be convenient or timely and safe or accurate. The first of the 2003 '10 key roles for pharmacy' is:

*to provide convenient access to prescription and other medicines.*<sup>24</sup>

And the 2008 white paper continued to emphasise access to:

*'the right medicines at the right time'.*<sup>28</sup>

Pharmacy policy literature has a recurrent focus on the avoidance of medication errors, and key functions for pharmacy are to reduce, prevent, detect and report medication errors and adverse drug reactions,<sup>24,25,28</sup> and that this should be achieved by:

*Developing safe and effective systems [and] accurately dispensing prescriptions*<sup>26</sup>

The government's vision 2008 for a future pharmaceutical service, was 'accurate' in terms of:

*the correct medicine, dosage and patient.*<sup>28</sup>

Pharmacy professional policy puts pharmacists in a position of responsibility for dispensing:

*supervision of the supply and the accurate dispensing of medicines are core functions in the provision of pharmacy services...Although the technical aspects of dispensing are increasingly delivered by support staff, a pharmacist has responsibility for the clinical assessment of the prescription and retains overall responsibility for dispensing.*<sup>26</sup>

Although my interview schedules did not contain questions specifically about dispensing or supplying medicines,(although when participants raised it spontaneously I did question them on

their views about it), during the early stages of analysis, I noted a considerable amount of talk about these areas, and different views on them. To clarify the situation, I defined some specific questions and interrogated the data to find answers to them. These questions included: Are pharmacists dispensers? Do they see themselves as such? Do others think this? The following sections present the data relating to these questions.

### 5.3.2 *The pill counter*

When medicines were first manufactured industrially, tablets were often supplied to pharmacies in bulk packages and had to be counted out for each individual prescription. Today, the majority of medicines are supplied as 28-day supplies and are supplied to the pharmacy pre-packed in boxes. A participant, who had worked in community pharmacy since the 1970s, described how her work had changed accordingly:

*[previously, we made up medicines in the pharmacy]...whereas now everything's just, stick a label on the box and that's it...(Community support staff D)*

However, generally during the interviews there was little mention of boxes of tablets, instead, data analysis revealed an enduring image of the pharmacist a counter of pills or tablets, which was mentioned by both pharmacist and non-pharmacist interviewees. This pharmacist made such a comment, which seems to have been made at least partly in jest, and which she immediately rebuked herself for:

*Interviewer: Describe a pharmacist in five words*

*Respondent: Er, somebody who counts tablets (laugh). Ooh God, what a bad answer! (Community pharmacist O)*

This is interesting, as she seems to associate tablet-counting with her profession, despite feeling that this is not desirable. Similarly, 'tablets' seemed to be what came immediately to mind for this nurse, when pharmacists were mentioned. Like the pharmacist, he too seems to say this part-jokingly, and also quickly offers qualification that he is aware that pharmacists do in fact fulfil a wider role:

*Interviewer: Describe a pharmacist in five words.*

*Respondent: Erm, tablets, that's an easy one (laugh)...that's all you've got, no...[describes other tasks] (Hospital nurse D)*

A different nurse thought that lay pharmacy users often saw pharmacists as pill counters:

*...I think a lot of the perception of the general public is that...all the pharmacist does is count the number of tablets and gives them out to them...(Community nurse B)*

Indeed, some lay pharmacy users did associate tablets with pharmacists:

*...the pharmacist, working out the tablets and so on. (Community pharmacy 1 user F)*

*[pharmacists are]...counting out their tablets, or putting it on their scales and that.  
(Community pharmacy 2 user G)*

Pharmacists also perceived a pill-counter image for their profession in the media:

*...[there are] recalls on a national level so then pharmacists have to come under the spotlight [on television news reports] and there's usually some pharmacist counting his tablets in a triangle...(Community pharmacist R)*

*...quite often [on television]...you've got a reporter stood in somebody's pharmacy saying 'the latest scare about this medicine' and then you've got some pharmacist in the background counting a few pills out, that's the only sort of thing you get really. (Primary care pharmacist D)*

As with mixing medicines, pharmacists no longer spend much time actually counting tablets, however, the figurative image of them as 'tablet counters' still seems to prevail.

### 5.3.3 Pharmacists are still dispensers

There was a strong association of pharmacists with dispensing across all groups of participants in this study. Fifteen lay pharmacy interviewees (out of 35) mentioned 'dispensing' and/or 'medicines'/'drugs' in their responses to the first interview task 'describe a pharmacist in five words' alone, as well as frequently mentioning the concept, throughout the interviews. Doctors and nurses from both hospital and community settings (four out of five GPs, and four out of six hospital doctors), mentioned dispensing when asked to describe pharmacists:

*...somebody working in a chemist, who dispenses medicines, erm, from prescriptions...(GP A)*

*Somebody...primarily concerned with dispensing medicines. (Hospital doctor D)*

*[pharmacists]...have the place of dispensing the medicines...(Hospital nurse D)*

*The main part of the role is understanding the...medication, erm, and dispensing it...(Community nurse A)*

Two hospital doctors (from different hospitals) commented particularly on picture 01 that they 'recognised' the person as a 'dispensing pharmacist' – although it is notable that in both quotes they say that this is something they imagine, not that they do actually observe in practice:

*...this one...measuring out some sort of drug...that's entirely what I relate pharmacists to do, in their day to day life...quite diverse...they're involved in primary care...attached to GP surgeries...[or] independent pharmacies like Boots and pharmacists in Tesco's or*

*whatever...they all have a common function in terms of dispensing medication. (Hospital doctor C)*

*...certainly the picture there of somebody dispensing drugs, again is a role of the pharmacist that I can easily imagine, but don't see very often...(Hospital doctor A)*

These data suggest that doctors and nurses strongly associate pharmacists with dispensing. Some pharmacy interviewees expressed a similar notion:

*A pharmacist is someone who dispenses medicines really, that's my first thought...(PCT support staff A)*

*...prescriptions, maybe dispensing...(Primary care pharmacist C)*

*Respondent: I think most [community pharmacists] would still see dispensing [as the main part of their work]... (Community pharmacist Q)*

The three participants quoted above all had roles which gave them an overview across many different pharmacists (through their roles for PCTs or the LPC), and only the last one undertook hands on pharmacy work. Most pharmacists interviewed for this study did have hands on jobs, but just one of these referred to dispensing as a core part of his work:

*Obviously the main part of the job I would say is still dispensing so I do dispense quite a bit myself...(Community pharmacist T)*

Other pharmacists reported varying levels of involvement with the actual assembling of prescriptions they did themselves. For community pharmacists, this sometimes depends on how many support staff are available, or how busy the pharmacy is. Several pharmacists mentioned that the 'dispensing' work, as in assembling the prescription, tended to be done by support staff, and that they would then just do the clinical check:

*...they [the support staff] do the physical assembly of the tablets, what I tend to do is I do the labelling and I tend to check as I label. I mean if I'm on my own I have to do all of it but if they're here I just do the labelling and checking...(Community pharmacist S)*

*...quite often you haven't got any dispensary staff to support you, so I'm actually having to do the tablet counting... (Community pharmacist O)*

All of the hospital pharmacists I interviewed spent some time in the dispensary, but generally this was a small proportion of their working hours, with the minimum being one hour a week. Some of the discussion of dispensing with hospital pharmacists was as a result of me asking them directly whether they had dispensary duties and what they felt about this. None mentioned dispensing spontaneously when talking about pharmacists generally:



#### 5.3.4 Supply work is uninteresting and technical

The data presented above showed that pharmacists are still seen as dispensers and suppliers of medicines, and that they are in fact still involved in the manual tasks involved in dispensing and supply of medicines to patients. During analysis of the data, several issues emerged which are related to dispensing and supply work, which were seen as problematic: that supply work is boring; that pharmacists undertaking it is a waste of their training; that its technical and manual nature means that it can be undertaken by machines, tends to take place out of sight, and has lower status than more 'professional' work. These issues are explored in the following paragraphs.

Several pharmacists reported that they found dispensing and supply work monotonous:

*Dispensing is a mundane job to me. (Community pharmacist S)*

*...not particularly exciting you know, I could probably do without doing that... the actual assembly bit is not that interesting. (Community pharmacist O)*

*[dispensary work is] boring, it's repetitive...(Hospital pharmacist T)*

*...it's not that interesting so you get boxes off shelves and stick labels on them and transport them around. (Hospital pharmacist P)*

This notion also emerged in pharmacists' responses to the question about media portrayal of their profession:

*...the types of programme they're in, Casualty and ER and all these types of things, it's not the dishing out of drugs that people want to see and it's quite difficult to put that kind of role in an exciting television thing. (Hospital pharmacist R)*

The following quotes, from hospital pharmacists convey the notion that the community pharmacy sector is particularly boring:

*That lady (looking at picture 01) wasn't why I went into hospital pharmacy, to be her, sat in the dispensary just having prescriptions come down every day and dispensing and checking. That's why I wouldn't do community pharmacy. (Hospital pharmacist Q)*

*...community pharmacy is an easy way of living...but then you are shutting yourself off and it's like any other job, you get paid for what is quite a mundane, monotonous job...(Hospital pharmacist O)*

The quotes presented so far in this section refer to the work activities undertaken by community pharmacists. This hospital nurse commented directly on community pharmacists themselves, and perceived them as being different to the hospital pharmacists she has daily contact with:

*Respondent: I mean our pharmacist [in the hospital] is quite cool...but... I suppose it depends what sort of pharmacy you do and where you work...the ones...in the...chemists' out in the high street, seem a bit, nerdy...your sort of typical idea when you think of pharmacists, someone wearing the white coat and dispensing tablets in a little corner shop somewhere (laughs)*

*Interviewer: So how's your one different?*

*Respondent: I suppose cos I've got to know him as a person, and he...likes to go out for a drink, likes good music, you know, doesn't look nerdy. (Hospital nurse A)*

As well dispensing and supply work being unattractive and uninteresting to many pharmacists, several interviewees saw this as a waste of pharmacists' training:

*...we're wasted as dispensers, anybody can dispense for god's sake. Doctors are doing it (laugh) for god's sake, in rural areas, you don't need a pharmacist. (Community pharmacist S)*

*... there's no need to have pharmacists in the dispensary...(Hospital pharmacist T)*

This notion was not confined to pharmacists - community nurses raised a similar point:

*I just don't like the thought of them stood behind the counter, they're there for more than just putting out pills aren't they? (Community nurse C)*

*...they've such a vast training...a vast amount of knowledge that is just being so underutilised really. (Community nurse B)*

This nurse had worked in hospital in the 1970s, and even then had thought the pharmacist was wasted when undertaking 'supply' tasks:

*...to tell you the truth, I saw him as a stock-taker...he was just checking our stock, and you used to think, 'well you could get someone else to do that'. (Community nurse A)*

As well as suggesting that it was a waste of resources for pharmacists to be dispensing, and that it would be better for other staff to undertake this work, some interviewees pointed out that nowadays, dispensing tasks can be undertaken by machines. Automated dispensing, using robots, is now in place in many hospitals, as observed by this nurse:

*Interviewer: Describe a pharmacist in five words*

*Respondent: ...robot, I like that robot (laugh). (Hospital nurse D)*

This nurse mentions both other staff and also machines performing dispensing tasks.

*...you've got other people who dispense...you've got the machine now that pulls the drugs out...(Hospital nurse B)*

Two pharmacists raised the issue of dispensing being undertaken 'mechanically'. Both quotes here seem to reflect some degree of concern that the dispensing pharmacist could be in danger of being displaced:

*I do scare some of them sometimes...by saying 'look you've got to come out and interact with patients because otherwise you'll have no job at all, because if you're going to do dispensing...we can get a computer and a robot to do that, so you're out of a job, so you've got to be maximising your input. (Primary care pharmacist D)*

*...is there something unique about pharmacy? I worry that there's not, the dispensing side you can do from a factory in the centre of Wales, quite efficiently for 80 percent of the population. (Community pharmacist O)*

However, an additional point was raised by the lay pharmacy user quoted below. He described his use of his local pharmacy, which he valued as part of his 'routine'. Although his wife uses the internet for prescriptions, he chooses to use this aspect of healthcare differently to her, and provides a reason why the personal service provided by community pharmacists is sometimes chosen by users, even though the technology is available which removes the 'need' to visit the pharmacy in person in some cases:

*I live in the village, so I quite like having a little walk out at lunchtime when working at home...I'm a little bit old-fashioned, my wife actually uses the internet for prescriptions. I tend to take mine in, paper one into the surgery just across the road...(Community pharmacy 1 user G)*

The quotes above suggest that pharmacists are 'overqualified' to be dispensers, and that the work is very technical in nature. The next two quotes imply a link between pharmacists supplying medicines, and pharmacists having a low status in the eyes of some clients:

*I don't think they're deemed as high profile, and I think it's because a lot of the general public don't actually realise what they do, they think they're glorified shop assistants that give out pills... (Community nurse B)*

*...sometimes nurses have views of pharmacists...as purely suppliers of medication... (Hospital pharmacist S)*

Both the pharmacist quoted above, and the one below, seem dissatisfied with their 'image' as dispensers:

*[nurses] do often ask me to order things, but I'm still in the process of trying to teach them that's not my job, that's why we have a technician, any ordering refer to her (laugh)...even now...a lot of patients think my role is to sort out their...prescription...(Hospital pharmacist R)*

Much of pharmacists' work has traditionally taken place out of public view; data from this study show that in community pharmacy, the pharmacist was typically hidden in the back of the shop:

*People used to come and say 'Can I speak to the man in the back?' and I'd say 'Well actually that's me.'* (Community pharmacist O - female)

*Going back a few years it used to be 'that bloke in the back'...(Primary care pharmacist D)*

Data from this study suggest that this is often still the case:

*If it's a quiet time of day...I'll probably be out, more visible on the counter area, if it's the time when we're really in the thick of the prescriptions coming in, I'm more likely to be out of sight and they'd have to ask to speak to me if they wanted to.* (Community pharmacist R)

*...[pharmacists] tend to be further to the back of the shop...(GP A)*

The pharmacist as a person hidden from view in some way, was a common theme among community pharmacy users in this study (being raised by 13 of them):

*Like the very small ones you'll see just a person at the back putting it all together...(Community pharmacy 2 user G)*

*The lady busy in the back I should think.* (Community pharmacy 2 user D)

*...they're always stood behind this, a barrier...sort of separate area... slightly shielded from the public... (Community pharmacy 1 user F)*

Interestingly, this GP, while talking in a positive way about the potential for pharmacists to have greater involvement in patient care, and how she thought it could be beneficial to have a pharmacist working on her surgery premises, still saw the place for that pharmacist as being 'in the basement':

*...when we moved here what we wanted to do was have a pharmacist in the basement or something...(GP D)*

In the hospital sector, not just the individual pharmacist, but the pharmacy department as a whole was traditionally out of sight:

*...until five years ago...pharmacy was like some black hole that was down there and sent up the drugs...(Hospital pharmacist Q)*

This view is validated by this quote from a pharmacist recalling her previous experience in hospital pharmacy during the 1970s:

*...You were just stuck in a pharmacy basically... most of the time...I was just doing ward boxes, sending them to the wards... really, it was just supply. (Community pharmacist Q)*

Lay users saw hospital pharmacists as still shut away:

*Interviewer: Describe a pharmacist in five words*

*Respondent: Erm medical, hole in the wall...(Hospital pharmacy user G)*

*...either the guy or the lady that's working behind the scenes, pretty much just doing their pharmacy duties generally...(Hospital pharmacy user A)*

This section raised several negative issues about dispensing work and presented data which suggest that pharmacists do not appreciate being seen as 'mere' suppliers. However, analysis of the data generated for this study also showed that pharmacists who are seen as 'good suppliers' of medicines are highly valued. Four supply-related attributes were identified – the good supplier was seen as timely, accurate, willing and reliable; sections 5.3.5 to 5.3.8 address each of these in turn.

#### *5.3.5 The timely supplier*

Users of pharmacy services mentioned 'fast' or 'efficient' dispensing when responding to questions about what made a good pharmacist. Explicitly negative views about pharmacists were rare amongst lay pharmacy users participating in this study, but one area where they did criticise pharmacists was not supplying their medicines as quickly as they would like them to: This out-patient user of the hospital pharmacy described his wish to have his prescription filled and be able to leave the hospital as soon as possible.

*Respondent: ... well a few times I've spoken to the pharmacist, but you'd just rather get your pills and get out of here (laugh)*

*Interviewer: Are there any other ways they can help you?*

*Respondent: Not really no, I just think, less chat and just get on with it...to get to this stage, you've sat in a consultant's room for 45 minutes...and then you've gone and got the bloods done, so that's another wait, so by the time you get to here to get drugs, to get whatever you were gonna get, you've had enough (laugh) and you wanna get out. (Hospital pharmacy user C)*

This pharmacist expressed the same point:

*A lot of [patients] are looking to have their prescription dispensed quickly, in all honesty, erm, they want their prescription quickly and efficiently. (Primary care pharmacist C)*

Waiting for pharmacists to supply medicines when they are using the pharmacy as lay users was also mentioned by a GP and a practice nurse.

*...I just recently have been to a pharmacist or two for various reasons for the first [for personal use] for a while and it is interesting because you get a very different view from that perspective...there was a wait, I mean I was a bit surprised at how long the wait was I must say...I was waiting 20 minutes...(GP A)*

*I've experienced being in a pharmacy...I went for a prescription for a neighbour, and I ended up waiting half an hour, because they couldn't issue it without the pharmacist, because he was in with this other person, doing a consultation...you're thinking, 'oh, no...this is not fair, I'm having to wait forever for this!' (Community nurse A)*

The prompt supply of medicines was an important issue in hospital pharmacy too, and 'out of hours' (evenings and weekends) periods were mentioned in particular as times when waiting to obtain medicines was a source of some frustration, as described in the following quotes from a doctor and a nurse (from different hospitals):

*...this may be the way that the hospital works itself, but often, particularly with drugs that are occasionally used [not 'regularly' used]...out of hours...getting access to pharmacy to get hold of replacements can sometimes be a little difficult, a little fraught...we don't always get as rapid a response from on call pharmacists as we would like. (Hospital doctor A)*

*... from our point of view, it's timing which is the problem for us...a hospital works 24 hours a day, pharmacy doesn't, and I think certainly here is very backward, they open at nine, they close at six thirty, you have an on call pharmacist but they're not on site and...at half twelve on a Saturday...if we want to send anyone home, we can waste hours trying to get everything sorted out for them...if we could have anything from pharmacy, it would be more flexibility in the way that they operate... it's more of an organisational, attitude, working thing that needs to change which would make the hospital run a lot more smoothly. (Hospital Nurse D)*

Both interviewees above reflected that the issue may not be particularly that pharmacists themselves are 'slow' or 'unresponsive' as individuals, but suggested a number of possible reasons, including organisational factors that could prolong the medicines supply process. Nonetheless, their quotes do still portray pharmacy as 'less responsive' than other areas of the hospital.

The pharmacist as a timely supplier of medicines was a desirable quality from the point of view of those waiting to receive medicines, but can be a source of stress for pharmacists. For hospital pharmacists, working in the dispensary was pressurised:

*... dispensary, it can be stressful at times, erm it's ok for short periods of time, I wouldn't like to be there all day...there's no kind of a respite...(Hospital pharmacist S)*

*Respondent: generally the hospital locums work in the dispensary doing all the dispensing...generally they're used in the engine room...doing all the dirty work really*  
*Interviewer: How do you feel about that, do you enjoy working there?*  
*Respondent: No... it's extremely busy, erm it's disorganised (pause) it's hard work actually...(Hospital pharmacist T)*

This pressure on pharmacists to provide medicines quickly also extended out of the dispensary, to the hospital wards:

*...I've been in situations in the past where patients have been very aggressive and verbally...not very nice and they think it's your fault that their prescription isn't on the ward...(Hospital pharmacist R)*

This issue was also recognised by a nurse:

*...filling take-home prescriptions and get the patient out as quickly as possible....the pressure feeds down from above, you know, to get the patient home. (Community nurse B – previously spent years working in hospital.)*

The ability to cope with the pressure of a demanding dispensing workload, calmly, was raised as important for pharmacists in both sectors of practice.

*...a good pharmacist is one that stays calm under pressure...even though we're busy and the work begins to pile up, can get through it in a nice steady manner...some of them do get a bit giddy...you see the pressure getting to them...I can see the difference...someone comes in and I think 'that person's going to be fine' and then another one comes in and I think 'It's not going to be fine'... you have to be a certain character anyway to survive in pharmacy and I think it's quite high pressured, hard work...(Hospital support A)*

*...a good pharmacist is you need to be able to work under pressure, for example when there are 10 people waiting for prescriptions, or there are many things to do. (Community pharmacist P)*

### 5.3.6 The accurate supplier

The importance of pharmacists being accurate in their work and not making mistakes were mentioned frequently by participants in this study. The dictionary defines the word 'accurate' as 'correct in all details'.<sup>124</sup> Accurate is an adjective, and in this case the noun it describes is the medicine supplied to the patient. Accuracy was both an accepted and a desired attribute of pharmacists – it was used in descriptions of how pharmacists are and how they should be:

*[Describing a pharmacist in five words.]...Er probably safe, accurate... (Hospital pharmacist P)*

*[a good pharmacist is]...accurate, try and not make many mistakes...(Community pharmacist T)*

Lay pharmacy users also mentioned the importance of pharmacists dispensing accurately:

*Interviewer: ...in terms of... pharmacists...what would you say is the main part of their job?*

*Respondent: Ensuring the proper drugs are given out, proper measurements, proper amount of tablets... (Community pharmacy 2 user G)*

Pharmacists and support staff from both sectors of pharmacy expressed a sense that an important responsibility for pharmacists was ensuring that patients received the 'right' medicines:

*...make sure they're giving the correct medicine out to the correct people...(Community support staff E)*

*Obviously making sure the medication [the patient is] getting is correct...(Hospital support A)*

Accuracy checking, that is, making sure that the medicines and their label match what is written on the prescription, is one part of the dispensing process.<sup>26,125,126</sup> Accuracy checking technicians (ACTs) work in some pharmacies and undertake the accuracy check. The presence of ACTs was variable amongst the pharmacies that the pharmacists who participated in this study worked in – some had ACTs and some did not. Consequently, some pharmacists reported that they carried out the accuracy check:

*...one of the dispensers would probably dispense it and then I'd do the final check...(Community pharmacist Q)*

Even when ACTs were there, it did not mean that the pharmacist would stop accuracy checking altogether:

*... [patients] present to a counter assistant usually...who will deal with the prescription and then it gets passed back and is then dealt with by the technician who will dispense it and sometimes label, then the pharmacist would check. That would be the usual, in the busy ones, it is a bit of a conveyor belt type of situation...at least two people always see the prescription, sometimes three people. We do have accuracy checking technicians as well. So they will look after some of the repeat medicines that have already had a clinical check, so that can happen...they might do some of the repeat medication that's waiting to be delivered or sent out and I'll just look after the acute stuff... (Community pharmacist P)*

There was variation amongst community pharmacists in this study over who actually carried out this check, and views on who should do this:

*...I don't think we're gonna get away from checking prescriptions, 'cause they are bringing in ACTs to do that, but I don't think we're gonna end up moving away from that*



*role, I think we're gonna be doing that for quite a while...we are providing more services and we are talking to patients more, rather than standing behind and checking, from when I started...but from when I speak to my friends...you're constantly behind there, if there's a busy pharmacy you're constantly checking, and that's where ACTs do help cos they can carry on checking and you can talk to patients, so I suppose it is changing a little. (Community pharmacist T)*

*Oh I was a big fan. When [the introduction of ACTs] came about, the staff and I said, 'that's the way forward', cos it takes pressure off me, and gives [the support staff] more of a role, more sort of a clinical role. (Community pharmacist S)*

*... we've got accuracy checking technicians who will check prescriptions and there's no need for pharmacists to do that when they could be out on the wards a lot more preventing problems from happening rather than sorting them out once they've happened. (Hospital pharmacist T)*

Doctors seemed to see pharmacists as having a methodical and careful approach to their work:

*Respondent: ...pharmacists too, are very directly accountable, you know, if a pharmacist puts methatrexate in a penicillin bottle, that's his career on the line isn't it?*

*Interviewer: So they do have responsibility?*

*Respondent: Absolutely, and it's their neck on the line too isn't it? And I think that's what makes them meticulous and careful. (GP D)*

*...they're all a very similar breed of person really, they're very methodical...will work through things in a very systematic fashion, is my impression...(Hospital doctor C)*

Some respondents spontaneously combined an acknowledgement that it is important that the pharmacist dispenses prescriptions safely and accurately, with a desire for them to do so as quickly as possible:

*Speed, want you do it quickly...when I go to the pharmacy I want them to be safe with me, erm, I want them to do the right thing with me prescription and me medicines, and to do it reasonably quickly. (Community pharmacist O)*

*Interviewer: And with patients coming in, what do you think they look for in a pharmacist?...what would they see as a good pharmacist?*

*Respondent: ...we've always prided ourselves on speedy dispensing, we don't dispense with accuracy but we accurately dispense and in a timely manner, that they like...(Community pharmacist Q)*

So did this lay pharmacy user:

*...they're all pretty slow as well, I've never seen anyone so slow at doing things, like dishing out prescriptions, it must be part of their training, make sure they do it slowly. I know they have to be very precise in what they're actually handing out, but really they do tend to be very slow (laugh) (Hospital pharmacy user F)*

Several pharmacists expressed concern about making dispensing mistakes. The first pharmacist quoted here seems to refer to a general fear about this:

Interviewer: Is there anything that makes your job difficult, or any bad sides to it?  
Respondent: I think it's just, erm, when you're worried about making mistakes.  
(Community pharmacist T)

This pharmacist seemed reluctant about the idea of delegating accuracy checking to support staff (ACTs) because of worry about their potential to make mistakes:

*...[if technicians carry out the checking] the pharmacist is still liable, if they mess it up you're still gonna be the one that gets in trouble, which doesn't seem right either.*  
(Community pharmacist T)

This pharmacist expressed a sense of generally increased pressure on pharmacists not to make errors:

*...dispensing errors...the power seems to have shifted more to the patient, away from the pharmacist, so there's more pressure on pharmacists not to make mistakes, or...be seen to have done something wrong...(Community pharmacist S)*

And these pharmacists seemed to express a fear of 'punishment' for making mistakes that seemed to pervade much of their practice:

*...the society's waiting to jump on you. They can jump at you at any moment...(Community pharmacist Q)*

*Everyone's down on pharmacists for making mistakes, even our governing body is out to get us, I think I fear them more. There's a culture of blame and claim. Patients say, 'If it's wrong I can sue you!' And they're joking, but you have to have a million pounds insurance in place....pharmacists get scape-goated. (Hospital pharmacist N)*

This doctor cited getting things 'wrong' in describing his idea of what would make a bad pharmacist:

*Well I suppose it would be making bad mistakes...(Hospital doctor D)*

While the quote from the doctor above was theoretical, the pharmacist below had several years of experience working with a range of pharmacies across a whole PCT area. She mentioned the importance of having a well organised dispensary with good systems in place in terms of safety, and described the variation that she had observed in this respect:

*...[a good pharmacist is] organised...as soon as you walk in through the door, I kinda know, what I'm facing...you walk into the dispensary...I mean I've walked into some pharmacies and you're like, 'oohhh – disaster!' You know, cos stuff's everywhere and there's stuff all over the place, and you think, 'this is a disaster waiting to happen, this is where mistakes are made'. (Primary care pharmacist C)*

This pharmacy user recalled an incident where the wrong tablets had been dispensed for a prescription she collected. Participants in this study were not asked directly about pharmacy

'mistakes', but they were asked for examples of any 'bad experiences' they had had with pharmacists, and about how they would define a 'bad' pharmacist. It is notable that this is the only example of a pharmacist giving the wrong drug to a patient in a community pharmacy that was raised during the entire set of interviews conducted for this study:

*... they can get the prescription wrong, so you've got to be careful. I mean, there has been occasion where [I picked up a prescription] for my mother, and they got it a bit wrong, you've got to watch that they're giving you the tablet that's on it...(Community pharmacy 2 user C)*

Whilst direct personal accounts of experiencing pharmacists' mistakes were very rare amongst the data generated for this study, participants did provide several examples of pharmacist 'errors' that have featured in the media. These quotes describe real-life cases that the participants recalled seeing reported:

*I think the only things you see it's like on TV or anything is if they've done an error somewhere...maybe in the local papers...if something's happened...(Community support staff D)*

*... in the paper actually, what's her name? The poor pharmacist who got the criminal record for making a dispensing error...I think it did go into the main press so that's not a good light really...(Hospital pharmacist P)*

These pharmacists recalled seeing fictional examples of pharmacists making dispensing errors:

*I think the worst thing about kind of media type pharmacy things...television dramas, films, anything, they always portray the pharmacist to be either a failed medical person...or somebody who's made a terrible mistake, and that really annoys me...(Hospital pharmacist R)*

Although this pharmacist did recall an instance where an initially negative portrayal of a pharmacist was changed after pressure from within the profession:

*...there was a famous pharmacist in one of those programmes, [Peak Practice]...apparently there was a big furore because he was portrayed as a buffoon and made a dispensing error and then everybody in the pharmacy profession complained and then they changed the story line and he became a hero and saved a patient's life...(Community pharmacist R)*

#### 5.3.7 The willing supplier

Thirdly the pharmacist being a willing supplier of medicines was important to community pharmacy users. The man quoted below seemed to value the pharmacy as a place where he could obtain medicines, even when the GP had not prescribed anything for him.

*...if you go the doctors for a cold or flu they don't usually give you anything but at least if you come to the chemist they'll give you something that helps you out...only powders and stuff but it helped. (Community pharmacy 2 user K)*

Some community pharmacists thought that, often, when a lay pharmacy user consulted them, obtaining a medicinal product was foremost in their mind:

*I find that generally patients do expect to be able to buy something from the pharmacist so they want that reassurance anyway, a lot of them won't be satisfied if you tell them to see the doctor, they expect you to be able to sell them something and to go away with something, so it's sort of meeting the patient's expectation as well. (Community pharmacist S)*

Participants in this study reported that pharmacists sometimes prevent the supply of medicines to clients. This can be done for example by refusing to provide an 'emergency supply' of prescribed medicines, to provide medicines available via 'patient group direction' or by preventing the supply of an over the counter product, which may be requested by a 'proxy' pharmacy user, or because they feel it is unsafe for the patient and their condition. This community nurse described the frustration she had felt when she had visited a pharmacy for her own personal use, and the pharmacist had been unwilling to provide her with the product she wanted:

*I had an experience myself, where I went to a pharmacist...I had conjunctivitis... it was the beginning of my holiday... so I'd been through all the same kind of processes I would do with a patient, and I thought, 'no, I'm going to go and buy it', cos you can buy it over the counter, and this pharmacist was just not going to give it to me. He was adamant, I said, 'well I've made this decision, to buy this,' in the end I said to him, 'if I was a doctor, would you still have the same argument with me?' And he was very embarrassed about that, and allowed me to buy it. (Community nurse A)*

Pharmacists are allowed to make 'emergency supplies' of prescription only medicines to patients without a prescription, in certain circumstances. This community pharmacist described a scenario where she had refused to supply a patient's medicine:

*...last Saturday... This lady's husband had died...earlier that week, and she'd come in and she had run out of her Metformin tablets for diabetes.. and she wanted to do an emergency supply...which you can do, but she hadn't had them from us for a year. And she couldn't remember her dose. And you think 'well if I give her the wrong thing, that's gonna damage her, but she's obviously upset'...she kept telling me she'd just come from the churchyard...I said, 'well you're gonna have to either bring me the box in, or like a repeat slip, some evidence of the dose you're on, so we don't do you any harm', And she came back with this repeat slip...slapped it on the table...said, 'I told you I wasn't lying,' and...she's bereaved and she's very emotional...you could have done it without that, and that would have made me deeply uncomfortable and I think it's a dangerous situation, so I had kinda put pressure on her when she wasn't really in a state to cope with it, so for her it was kind of a bad outcome I suppose, cos she got what she wanted but she'd been hassled and stressed about it and had to trawl back to her home and come back...But from my point of view I think that was the best job I*

*could have done in that situation...So that was kind of a difficult one...(Community pharmacist O)*

The emergency supply scenario described above had been an uncomfortable experience for the pharmacist, in terms of the dilemma of weighing up risking the patients' physical safety if she supplied the medicine used to control her diabetes, against the psychological distress she was concerned about causing in a patient who she could see was already emotionally traumatised. In the quote below, a different community pharmacist describes her experience of refusing to supply medicines to clients, first to a patient wishing to obtain a medicine for herself, and secondly for a patient using the pharmacy on a proxy basis for a family member:

*I had a lady yesterday who came in...she'd had a spray from the doctor for a sore throat, so that hadn't worked, and she was now having problems with her ears [and wanted another product from the pharmacy] and I felt...it did need more intervention from the doctor, so I said the best thing to do was to go and see the GP. So she said 'are you refusing to serve me?' So immediately there's this barrier, you know? 'You are refusing to give me what I want.'... Or somebody comes in 'my daughter has a rash, can you give me something for it?' 'Well, it's difficult without seeing the rash.' 'Oh just give me something, she told me to go out and get a cream, so I have to go home with something.' I said, 'well exactly what sort of something would you like?' 'Well, something for a rash.' You know I'll, 'It could be eczema, it could be acne, it could be scabies, it could be absolutely anything.' And I wasn't prepared to sell it, without seeing the rash. (Community pharmacist O)*

In this scenario, the pharmacist could be described as an 'anti-supplier'. This seems to be an area of tension between the priorities of pharmacists and their users.

### 5.3.8 The reliable supplier

Lastly, both lay and professional clients valued a pharmacist who was a reliable supplier, who always had their medicines available in stock:

*...it's more the running of the chemist, where things aren't being delivered...they've got no delivery or people's tablets aren't being delivered...the running of the shop really. (Community nurse C)*

*...one of the [local] pharmacies...there's somebody who owns their own business, and he seems to be able to get lots of medicines that [another] pharmacist can't get hold of...(GP A)*

Failure to have stock available was one of the main sources of dissatisfaction with pharmacists. This nurse recounted her own experiences of using the pharmacy as a lay client:

*...another pharmacist, where I used to go as a patient for my inhalers...never ever has the full amount of medication. And I always have to go back. I've stopped going to him now, I go to another one round the corner. (Community nurse A)*

*... what I don't like, when they've not got...they've run out and they give you an IOU note and you've to come back again to get drugs like that, that's annoying. Because ...they know what they need, so they shouldn't run out of drugs. (Community pharmacy 2 user A).*

Reliable stock availability was predominantly a community pharmacy issue, but was mentioned by one hospital pharmacy client, (although this could also have included their experience of community pharmacies):

*Interviewer: What makes a good pharmacist?*

*Respondent: Well-stocked...yeah from history really in terms of like you assume that you'll be able to go and collect any medicines that you were prescribed...so I would say a preference for me would be, knowledgeable and well-stocked.*

*Interviewer: Any bad experiences or can you say what makes a bad pharmacist?*

*Respondent: Yeah not having stock really I would have thought. (Hospital pharmacy user A)*

### 5.3.9 Summary and comments

This section has presented the data relating to the identity of the pharmacist as a dispenser and supplier of medicines. Pharmacists' identity as dispensers is still a strong one, in the sense that it was perceived by participants across all groups. However, it is not neutrally accepted, and is seen as problematic because it is associated with work that is uninteresting, wasteful of pharmacists' training and is technical in nature, which means that the people who undertake it can potentially be replaced by machines, often work out of sight of others, and may have a lower professional status. In terms of identity dimension one (how pharmacists see themselves), pharmacists expressed some discomfort with this identity due to finding it boring and wasteful of their skills. Nurses shared pharmacists' concern about the latter point, but other non-pharmacist groups did not express such concerns. Pharmacists working at a strategic level expressed concern about 'dispensing pharmacists' being replaced by machinery and/or technology. Some pharmacists were frustrated by others still perceiving them as 'technical' workers – this issue was raised by hospital pharmacists in relation to their perception of how nurses saw them. It is, however, notable that the views of some community nurses corresponded with pharmacists on this topic as they too thought that pharmacists were 'wasted' as dispensers. The idea of pharmacists often being hidden from view, due to the nature of dispensing work taking place out of sight of others was noted by pharmacists and lay pharmacy users, and the lack of pharmacy coverage in the media also frustrated pharmacists. Doctors' views concurred with pharmacists' in terms of pharmacists often being 'out of sight' but their feelings about this were more neutral.

However, as well as the negative views, analysis of the data revealed four elements which contributed to an overarching concept of the pharmacist as a 'good supplier' of medicines, an important concept relating to pharmacists' professional identity and one associated with four

attributes which were highly valued, which were: timely, accurate, willing and reliable. Pharmacists think lay users want them to be dispense the correct medicine quickly. These points correspond closely to what lay users said they wanted from pharmacists. Of the four factors mentioned, the first three were all important to identity dimensions two and three (how pharmacists think others see them and how others do see pharmacists), however, being a reliable supplier was not mentioned by any pharmacy interviewees, so it may be the case that pharmacists are not aware how important this aspect of the supply service is to their clients. In terms of identity dimension one - being accurate – was the dimension that pharmacists seemed to identify with most closely themselves – although they thought clients wanted them to dispense quickly, they never described themselves as ‘naturally’ fast-acting people, whereas being accurate was emphasised strongly within all three dimensions. Fulfilling all aspects of the ‘good supplier’ role simultaneously is sometimes challenging for pharmacists for example, dispensing many prescriptions accurately within a short space of time may include an element of tension between being a speedy supplier and an accurate supplier, and this can lead to pharmacists feeling pressurised.

The next section discusses these findings further, together with the data from section 5.2 about pharmacists as makers of medicines.

## **5.4 Discussion**

This chapter has suggested the existence of two identities for pharmacists which relate to the physical objects which are medicines – the maker of medicines and the dispenser and supplier of medicines.

The first of these can be divided into the ‘traditional medicines maker’ and the ‘contemporary medicines maker’. The traditional medicine makers – the pharmacists who compounded constituent ingredients, by hand, in the dispensary before supplying them to clients, have been viewed retrospectively as ‘craftspeople’, defined by their role as compounders of medicines, by Birenbaum.<sup>57</sup> In terms of empirical research of pharmacists’ role orientations, Quinney’s scale originally included ‘compounding’ as a task which pharmacist could express their orientation towards. As noted in section 2.3.3, nowadays, medicines tend to be made in factories, Birenbaum viewed the loss of pharmacists’ compounding role as a threat to their professional status.<sup>57</sup> Sociological theory on the professions claims that occupations have a specialist area of work which claim and which others cannot undertake.<sup>46</sup> Birenbaum follows ideas such as this in arguing that pharmacists have lost their niche area of work. By losing their compounding function, Birenbaum was concerned that they had lost their professional status. Birenbaum

suggested that pharmacists should move forward and 're-professionalise' by embracing clinical roles and redefining pharmacy as a clinical profession.<sup>57</sup>

While the issue of the pharmacist as a maker of medicines has been absent from much of the pharmacy practice research literature, the empirical studies that followed Quinney<sup>73</sup>, (e.g.<sup>75,78</sup> reviewed in section 2.7.2) make no mention of it. However, as data generated for this study have shown, the identity of the traditional pharmacist as a maker of medicines still exists, albeit mainly in the memories of study participants. This somewhat unexpected finding prompted me to search specifically for more recent literature which might address the issue of extemporaneous dispensing. This search revealed that the subject has in fact received attention in recent years, both from within the pharmacy profession, in terms of an 'improve versus abandon' debate<sup>127</sup> and from sociologists studying pharmacy education.<sup>127-129</sup> Harding and Taylor in particular have paid attention to this topic. Unlike Birenbaum, they do not assume that the role is entirely a thing of the past, but suggest a number of potential benefits of pharmacists continuing to formulate medicines today, three of which in particular match with findings from this study. Firstly, Harding and Taylor claim that patients could benefit from:

*the receipt of a bespoke medicinal product, which has been hand-crafted by a specialist "just for me", and not mass-produced by a faceless industry.*<sup>130</sup>

Pharmacists in this study (in section 5.2.3) also thought that pharmacy users had appreciated the individualised service they received when medicines were prepared especially for them in the past. The 'personal service' aspect of traditional pharmacy where medicines could be made, is interesting considering that government pharmacy policy has emphasised that pharmacists must provide 'patient centred care'.<sup>23,28</sup>

Secondly, Harding and Taylor perceive benefits to the pharmacists' own sense of identity, in terms of a connection to not just knowledge about the constituent ingredients that make up a medicine, but direct experience of working with these to formulate medicines. They argued in 1999 that continuing to carry out extemporaneous dispensing was an opportunity to consolidate pharmacy's identity, as extemporaneous dispensing is a 'physical manifestation of the pharmacist's skills and training'.<sup>130</sup> They conducted research with pharmacy students and staff on a university course teaching extemporaneous dispensing and their papers on this published in 2004 and 2005 showed that pharmacy students appreciated being taught extemporaneous dispensing and enjoyed the extemporaneous dispensing practical classes. One student commented that:

*It made me feel like a pharmacist not just a science student*<sup>128</sup>



Teaching staff also felt that the way that the skills required for extemporaneous dispensing are applied was 'a creative process and as such akin to an art'.<sup>129</sup> Formulation was further described as an art that involved 'experience and just feeling, rather than firm science'.<sup>128,129</sup> The ideas conveyed here seem to link to two areas of focus of the power theorists' views about professionals having esoteric knowledge and a sense of mystification (described in section 2.5.2.2).<sup>46,50,131</sup> A pharmacy technician in this study described the traditional pharmacist as 'conjuring up' (section 5.2.3) medicines in the back of the shop - the word conjure means 'to bring as if by magic' which relates to the idea of mystique and esoteric knowledge.<sup>131</sup> Other data presented suggest that pharmacists' work traditionally had an element of mystery, probably more so than is associated with handing the client a box of pre-packed tablets.

Thirdly, as well as being associated with a sense of mystery, or esoteric knowledge, which is by nature intangible, Harding and Taylor have also argued that the fact that medicines are tangible, material objects, could contribute to a more 'solid' identity for pharmacists and that extemporaneous dispensing is 'a potent symbol of the pharmacist's status and value to the community'.<sup>130</sup> They argue for the value of retaining 'the practice of formulating and manufacturing' which they describe as being at the 'very heart of pharmacists' identity...encapsulated by the archetypal symbol of pharmacy – the pestle and mortar – an iconic image...' <sup>129</sup> The data presented in section 5.2.2 show that the pharmacist as a maker of goods was indeed a clear, easily recognisable identity, for several participants in this study.

Harding and Taylor also argue that the more tangible benefits of cost-savings for the NHS and time-saving or convenience for patients would result, as a product made within a pharmacy could be more cost-effective for the national health service.<sup>130</sup>

Data presented in section 5.2.4 also highlighted that medicines are still routinely made in hospitals, in aseptic dispensing areas. While this type of work has received little attention within the research literature, one article, published in 2004, claimed that even though pharmacists would be unlikely to physically carry out much aseptic dispensing themselves in practice, it was beneficial to invest time in thorough teaching about aseptic dispensing procedures at university. This, it was argued, should ensure that pharmacists would enter practice with a high level of understanding of the principles of this type of work, which would help them to supervise it from a position of authority.<sup>132</sup> A similar argument could be made with respect to extemporaneous dispensing and pharmacists' ability to judge the quality of pre-made medicinal products that they handle in practice – that even if they are not called upon to make medicines, having experience and understanding of their makeup could be beneficial.

In terms of pharmacists as suppliers of pre-made medicinal products, in a similar way to the traditional compounding role, the idea of the pharmacist as dispenser or supplier of medicines is rarely discussed in any detail in the contemporary policy literature. As noted (in section 2.3.6), government and professional policy direction has been for pharmacists to move towards supervising dispensing, while support staff undertake the actual physical tasks. When the government does mention pharmacists in relation to the supply of medicines, it is with reference to them as managers of the process, especially in hospital pharmacy.

Hornosty's work, published in Canada at the start of the 1990s, conveyed concern amongst pharmacists that their profession was still seen by the public as that of the 'pill counter' and bottle 'labeller'.<sup>78</sup> Later in the same decade, Varnish (in a UK publication) wrote that technology was 'rapidly making the tablet counter redundant'.<sup>133</sup> This was with reference to 'original pack dispensing' and computer generated labels, reducing the counting and label writing/typing tasks. Today, in the UK, computer generated labels are common practice within pharmacy, dispensing robots have been installed in some hospital pharmacies, and some medicines can be ordered over the internet, and participants in this study associated pharmacists with such technology. However, pharmacists do still undertake dispensing work, particularly in the community sector, and the image of the pharmacist as a supplier of medicines and even as a 'pill' counter was still relevant for participants in this study.

Pharmacists' function as suppliers of medicines is still appreciated, and this chapter identified four attributes of supply work which were valued – being quick, being accurate, being willing and being reliable. Of these, being accurate was the most important. For a prescription to be dispensed accurately means that the products supplied match what is written on their label, which in turn matches what was prescribed (written on the prescription). The potential consequences of this not being done accurately could be tragic, for example in an extreme case, where a lethal dose of a medicine could be supplied, taken by the recipient and kill them. The accuracy check itself does not take long, does not require knowledge, just an ability to read the prescription and medicines' labels so can be considered small but very significant. Indeed, interviewees in this study evoked both the vital importance of accuracy when medicines are being dispensed and also the responsibility entailed in doing so. Overall, pharmacists were seen as people who worked with a high degree of accuracy, however, there was some expression by pharmacists of a fear of the potential consequences of making a mistake that may overshadow their work.

Analysis of the empirical data generated for this study revealed five negative issues in relation to pharmacists' identity as suppliers in terms of it being seen as boring, wasteful of pharmacists' skills, technical in nature which therefore means it can be undertaken by machines, making the

pharmacist replaceable and also potentially lowering their professional status, and also tends to take place out of sight, meaning pharmacists are often hidden from view. Lay clients and doctors seem to 'accept' the pharmacist as a dispenser 'neutrally', whereas pharmacists and community nurses expressed more concern and frustration with what they saw as pharmacists being stuck with work that was wasteful of resources (which is not beneficial to society) replaceable/not esoteric (bad for professional status) boring to do (bad for the individual) and in terms of wider image - seemed uninteresting to others, had low status and low visibility (bad for the profession). A nurse in section 5.3.4 referred to pharmacists in general as 'nerdy', an adjective which describes the characteristics of a nerd, that is, a type of person defined by the dictionary as:

*An insignificant, foolish, or socially inept person; a person who is boringly conventional or studious [also] who pursues an unfashionable or highly technical interest with obsessive or exclusive dedication.*<sup>124</sup>

The low visibility of pharmacists was also perceived by participants in this study to extend to pharmacist's lack of coverage in the media. This has been noted by a previous study of pharmacists in the media undertaken in the USA.<sup>104</sup>

This chapter has explored the concept of pharmacists as makers and suppliers of medicines. Next, chapter six presents the ideas of pharmacists as scientists and medicines advisors.

## 6 Pharmacists as scientists and medicines advisors

### 6.1 Introduction

This chapter is about pharmacists as people who know about the 'science' of medicines and how they work, and who apply this knowledge in practice. Section 2.3.6 noted that pharmacy policy in the 21<sup>st</sup> century has positioned pharmacists as advisors on medicines. The interviews undertaken for this study generated a considerable amount of talk about pharmacists knowing about medicines. This was not surprising, as of course pharmacists work with medicines, and knowledge underpins the activities of all professions. However, the recurrent spontaneous mentioning of knowledge, information and advice, suggested that it would be worthwhile to unpack exactly what it is that pharmacists know about, in what way(s) this knowledge is applied in practice and how this might contribute to their professional identity. Analysis of the data generated for this study suggested the existence of two identities within this area: the pharmacist as scientist and the pharmacist as medicines advisor. Sections 6.2 and 6.3 present each of these in turn.

### 6.2 The scientist

#### 6.2.1 Introduction

The most recent white paper for pharmacy refers to the 'science of pharmacy' as being 'one part of clinical pharmacy'.<sup>28</sup> Other than this, no further discussion of science in relation to pharmacy or pharmacists, was found within the policy documents reviewed for this study. However, during the early stages of data analysis for this study, pharmacists' 'scientific' knowledge was noted as a recurring theme and this is the topic of the following section.

#### 6.2.2 The trained scientist

Several pharmacists who participated in this study referred to members of their profession as 'scientists', sometimes mentioning their education and training:

*Interviewer: Describe a pharmacist in five words*

*Respondent: ...scientific, expert in their field... (Hospital pharmacist O)*

*Pharmacists are probably more scientists than clinicians...I think that's an underlying similarity...Well by their training they are scientists...(Primary care pharmacist D)*

Four pharmacists interviewed individually mentioned that they had enjoyed or been good at science during their schooldays, and participants in a stage one group interview described a middle aged, female pharmacist thus:

*CP F: Probably wanted to be a pharmacist for a long time*

*CP D: She was probably clever at school, into her science, did chemistry. (Community pharmacist group interview 2)*

Non-pharmacist interviewees also viewed pharmacists as people who were highly educated in scientific subjects:

*Well if it's about physics and chemistry I don't want to know...I should imagine it's quite technical and hard and quite academic (laugh) (Community nurse C)*

*...I'm sure it's a very lengthy process... (Hospital pharmacy user C)*

Community pharmacy premises are often colloquially referred to as a 'chemist's shop', or simply a 'chemist', and the pharmacist themselves is often termed a 'chemist'. Also, chemistry, as in the area of science was mentioned with relation to pharmacists' knowledge. Participants in this study used all of these terms. They were used interchangeably during the interviews – a 'text query' run in NVivo showed that the word 'chemist' was used by 36 of the 85 participants interviewed individually for this study – sometimes referring to a shop, sometimes a person:

*Interviewer: Describe a pharmacist in five words.*

*Respondent: A chemist, erm, medication. (Community pharmacy 2, user J)*

*...chemistry knowledge somewhere along the line must come into it. (Hospital pharmacy user C)*

While in-depth analysis was not undertaken on every instance of the word 'chemist' in the data set, it is notable that running the same NVivo text query on the stage one data revealed that the word was used only once during the entire set of group interviews – to refer to a 'local chemist shop' – this absence suggests that this group of pharmacists do not identify with being 'chemists' in either the shop-keeper or the scientist sense of the word. This hospital pharmacist spontaneously mentioned the word, but then seemed unsure as to where it fitted within her self-concept:

*there'd be chemist in there somewhere, but I don't think I'd class myself as a chemist. (Hospital pharmacist O)*

This hospital nurse seemed to view pharmacists working in the community as very different from hospital pharmacists and referred to 'chemists' in her explanation of this:

*Respondent: I suppose when I think of pharmacists I think of the pharmacists I work with...I don't think of them necessarily being, you know, the people that when you take your prescriptions to you know, places like Boots and Superdrug, it doesn't necessarily think of that in my head really.*

*Interviewer: Of them as pharmacists?*

*Respondent: Yeah. I don't...I just think of them as chemists.*

When asked for examples of famous pharmacists, no hospital doctors were able to recall any, but instead offered names of well-known scientists. The first doctor quoted below mentions a chemist:

*The only thing that I can think of...are historical figures like Louis Pasteur, but I don't know if he was a pharmacist, he might have been a chemist, and Alexander Fleming. (Hospital doctor C)*

*...well I suppose William Withering could have been described as a pharmacist, he discovered digoxin from a foxglove...but I think he was a doctor...and of course all the big great drug developers like Fleury...but they were all trained in medicine. (Hospital doctor D)*

Nurses' responses were similar, with Marie Curie the only 'pharmacy-related' figure suggested. Not one pharmacy user could name a famous pharmacist, although the scientists Alexander Fleming, Marie Curie and Louis Pasteur were mentioned twice each.

The section quotes above refer to pharmacists being educated in 'basic science' subjects. Non-pharmacists also referred to pharmacists and areas of more 'applied' science related to the actions of medicines:

*...they do pharmacodynamics, kinetics...I imagine they know all that...they've probably got a deeper theoretical knowledge...(Hospital nurse B)*

*...understanding the pharmacology and pharmacokinetics...of medication...(Community nurse A)*

*...most doctors won't have anything like the background in the science, you know, pharmacokinetics, pharmacodynamics, the genetics and all that kind of thing that pharmacists have...(Hospital doctor D)*

*... very specialised...isn't it? A very specialised branch of science. It's applied science, and so it'd demand a lot of a pharmacist in training... (Community pharmacy 1 user D)*

When this doctor sees people in his hospital wearing white coats he assumes them to be either pharmacists or people who work in laboratories:

*... if they're wearing a white coat, that increases their chance of being a pharmacist, but does not guarantee it, because...the lab areas of hospital will wear white coats...(Hospital doctor C)*

### 6.2.3 A scientific mindset

Pharmacists seemed to be generally perceived as having a scientific background by participants in this study. Conceivably, anyone could obtain scientific knowledge, however, the data suggested that there might be a certain type of person who is drawn to science:

*... I wouldn't say that every pharmacist is exactly the same, [but I think they are probably]...people [who] are drawn more to probably sciences, possibly more of an analytical, logical mind, possibly not. (Hospital pharmacist S)*

The following pharmacist also perceives members of her profession to have a scientific orientation, and links this to a 'geek' personality:

*...I think they're all fairly geeky, I think they're all science-conscious people. (Hospital pharmacist Q)*

A hospital pharmacist suggested that some pharmacists might be suited to working in laboratories, because they were not sociable, implying an association between science and a lack of social skills:

*...you can't be socially inept...if you're not an approachable person...you're not going to be a good pharmacist...it's quite frustrating sometimes when you see pharmacists that are that way inclined...you need to share knowledge...if you want to shut yourself away then...go and work in a lab. (Hospital pharmacist O)*

#### **6.2.4 Summary and comments**

This section has presented the concept of the pharmacist as scientist, trained in the sciences of chemistry and pharmacology. For one doctor, a white coat can signify either a laboratory scientist or a pharmacist, which implies a further, symbolic connection of pharmacists with science. Data from some of the interviews suggested a particular scientific mindset or attitude as an element that contributes to making up 'who pharmacists are'. This was mentioned predominantly by pharmacists and doctors in the hospital setting. Non-pharmacists do not experience the pharmacist as a basic scientist in a literal sense – they do not see them working in laboratories, or 'being' chemists, yet a strong figurative image of them as such emerged from the data. Pharmacists' identity as scientists exists in all three identity dimensions, suggesting that it is strong. There was also suggestion from hospital pharmacists of a scientific attitude or mindset that may contribute to pharmacists' professional identity and some associate this with a lack of social skills.

The following section explores how pharmacists' scientific knowledge is applied in practice through pharmacists providing information about medicines to others.

### **6.3 The medicines advisor**

#### **6.3.1 Introduction**

Section 6.2 presented the idea of the pharmacist as someone who understands the science of medicines and how they work. This section addresses the issue of pharmacists putting their

knowledge into practice by providing information about medicines to others. Throughout the last decade, pharmacy policy has consistently positioned pharmacists as providers of information and advice about medicines. In 2003, the government stated that a key role for pharmacists was:

*to advise patients and other health professionals on the safe and effective use of medicines*<sup>24</sup>

And that hospital pharmacy includes:

*counselling patients on their medicines [and] advising and training medical and nursing colleagues on pharmaceutical care issues.*<sup>27</sup>

The strategy for pharmaceutical public health set out '10 key roles for pharmacy in public health', one of which is:

*Protecting health through promoting the safe, effective, informed and responsible use of medicines.*<sup>25</sup>

And that hospital pharmacists should be:

*custodians of all medicines-related policies, processes and procedures, ensuring that the organisation complies with legal requirements on the control and use of medicines...*<sup>25</sup>

During the course of undertaking the interviews for this study, I noted a considerable amount of talk about pharmacists being asked for, and providing, information and advice about medicines, across all participant groups. When asked to describe a pharmacist in five words, eight of the 11 doctors interviewed spontaneously mentioned 'knowledge or advice about medicines', while five of the eight nurses interviewed mentioned 'information or advice about drugs'. Six pharmacy users mentioned 'information' or 'knowledge', and five mentioned 'advice'. Pharmacists were seen as advisors on the 'correct' supply of medicines, in terms of them being clinically appropriate and also complying with guidelines and/or the law.

### 6.3.2 General medicines experts

Pharmacists were seen as the professional group with more knowledge about medicines than any other. This was expressed by these non-pharmacist participants from the community setting:

*They certainly do have an in-depth knowledge of drug...usages and dynamics and all those kinds of things, that I don't think doctors have...(GP B)*

*Well I think they know more than the doctors half the time...I think their extended knowledge on medicines is better...(Community pharmacy 2 user A)*

Being knowledgeable about medicines was cited as a defining aspect of a good community pharmacist:



*[a good pharmacist]...they know the ins and outs of their store or how their products work...(GP E)*

*[a good pharmacist is]...one who's full of information about the product, and who knows about the product...(Community pharmacy 1 user E)*

This pharmacy user referred to the pharmacist as having 'expertise':

*... the doctor presumably cannot have the full expertise in terms of the drugs knowledge. And the up to date knowledge...that a pharmacist has. (Community pharmacy 1 user G)*

Participants from the hospital sector described pharmacists as having 'specialist' knowledge of medicines:.

*...we're the only profession that specialises just in drugs...I guess we're the specialist on medicines (Hospital pharmacist P)*

*...they're highly specialised in er the use of drugs and medicines...their knowledge is, far deeper in certain areas than most doctors. (Hospital doctor D)*

*...we're the only profession that specialises just in drugs...I guess we're the specialist on medicines (Hospital pharmacist P)*

In specialist settings within hospitals, pharmacists work with medical consultants who are experts in their fields, and therefore tend to have a full knowledge of the medicines used within their field. However, because patients in hospital often have more than one medical condition, they may be faced with other medicines outside their area with which they are less familiar, and this is an area where the pharmacist's knowledge can be useful, as noted by pharmacists as also a hospital doctor:

*The critical care consultants will know everything there is to know about the drugs that are specific to critical care, right, but because the patients that we get are from any conceivable disease state or surgical procedure that you could imagine, they will be on other things for their co-morbid conditions, that the consultants in critical care won't generally come across...and I think that's the same across the board, if you go into a...cardiology ward, you will have patients with...cardiological conditions but because of their co-morbid states there will be loads of other types of drugs that [the doctors] don't generally come across and I think that's where the pharmacist plugs the gap, they're very good generalists, pharmacists. (Hospital pharmacist T)*

*...[oncologists] tend to know only about cancer drugs, so they come to the pharmacists for advice on other stuff, for example if the patient's got heart problems or diabetes. (Hospital pharmacist N)*

*...as I've been more senior I've found the essence of a pharmacist more and more essential because your therapeutic armamentarium has got bigger, and your own personal ability to retain all that information has got less...although I'm obviously up to date and abreast of my own field, I'm not...in other fields, so if we have a patient who comes in from cardiology on different cardiac medications, I will use the pharmacist to*

*educate me and update me...from the point of view of different regimes and specific agents that are being used, particularly those I am less familiar with. (Hospital doctor A)*

This member of community pharmacy support staff thought that pharmacy staff were generally trusted by the general public to provide 'correct' information:

*Well I think public do trust us...the majority of them...I don't think I've ever heard anybody saying otherwise...the right advice and everything...(Community support staff B)*

Keeping their knowledge up to date was also seen as important:

*[a good pharmacist is]...somebody who is kind of keen to keep up to date... (Hospital pharmacist R)*

*...knowledgeable about the latest research into different drug types. (Hospital nurse D)*

*...they'll be doing their reading won't they?...there's new [drugs] coming on the market all the time...there must be an awful lot of homework to do to keep up to date...(Community pharmacy 1 user D)*

There was very little negative data in relation to pharmacists' ability to advise about medicines. However, a nurse highlighted the area of advice about the administration of medicines and recounted an incident which occurred while she was in a community pharmacy as a 'lay user' herself, but had ended up 'stepping in' in a professional capacity when she was alarmed by the pharmacist 'misinforming' a patient about the use of an asthma inhaler. This is a complex area – as the nurse explains, there are at least three people who could instruct this person on how to use the inhaler correctly, however, if she had not been in the pharmacy to observe this, then the pharmacist probably would not have been told on that particular day that the advice was wrong:

*...a few months ago I was in [a pharmacy] and there was this lady who had come in, her GP had given her a prescription for, salbutamol, her inhaler, for her daughter, and she'd come in for the device, the spacer, erm, to put in it...the GP obviously hadn't given her any advice on how to use this...and she took it out of the box and asked the pharmacist, 'well what do I do with this?'...and the pharmacist said, 'Oh I have no idea, I don't know how to use that.' And she started giving her advice, and was giving her the wrong advice, and because I'm a paediatric nurse, at that point I felt I had to intervene, but the pharmacist...said, 'well we don't get any training on this at all.' And I'm seeing that from the acute side, erm, my new role as well, the number of inhalers and devices that children are actually being dispensed...I think the GP's thinking the pharmacist's doing the training, and the pharmacist's thinking that the GP's done the training, and this child's being sent home...with a tiny little leaflet, no-one's actually showing them how to use it, and...we're getting a lot of children into hospital, in what could be a life-threatening condition really, because there are children that die from asthma every year, still do, because that advice has not been given. (Community nurse B)*

This hospital pharmacist felt uncomfortable about being asked to advise on or deal with the finer points of the administration of medicines:

*...even though pharmacy's changed quite a lot, and I think they're trying to define pharmacy more...and provide a direction for us to go down, but in doing so I think, the sort of size of the definition, is becoming sort of grey in areas...you're expected to know everything a nurse does...everything about administration...I'll be asked about ventolin sometimes and that's not my area, that's the needle they put in, there's different sizes...which is fine, but where is that line drawn?...I'm not qualified as a nurse, I don't do administration, yet we're expected to know everything about the administration of a drug...(Hospital pharmacist O)*

### 6.3.3 The medicines information resource

The idea of the pharmacist as a person who was generally available to respond to questions about medicines was raised several times. The hospital pharmacist quoted below thought that non-pharmacist colleagues appreciated this:

*I think they now also see us as a really useful resource on the ward, so that especially the younger doctors who've got less experience with the medicines, they're regularly, quite happy to have you there to come up and ask questions. (Hospital pharmacist P)*

Non-pharmacist interviewees' views concurred with this, and they reported making use of the pharmacist for various queries:

*...if there's an issue that can wait, I'll just wait until I next bump into them, cos I'm pretty sure that I'd bump into them two or three times a day, if I need to know there and then, then I will pick up the phone and find them. (Hospital doctor C)*

Hospital nurses reported finding the pharmacist a useful source of information, and specifically mentioned medicine dosages:

*... it's also just knowing that you've got that extra resource, in the middle of the night if you're tired and you're worried about a drug calculation you can always ring them and they'll check it themselves so it's a support network in many ways about medicines. (Hospital nurse E)*

*...particularly working with children, with doses and drug licenses...you have to be so much more careful...the adult doses are more routine. But we base children's doses on weight and age, so we're working out doses specifically to that individual really, per weight. So we did liaise very, very closely with the pharmacists on the paediatric side in the hospital. (Community nurse B – referring to her recent past role in hospital)*

In the community setting, this nurse, who spends a large proportion of her working day visiting patients in their own homes to administer medicines, reported that for herself and her colleagues, both community and hospital pharmacists were sources of advice on drug dosages and administration timings:

*...it could be someone's coming home from hospital and we're not sure of the dosage or when it should be given, so we will phone our local pharmacist up and get advice there...we speak to a lot of them, or...if the patient has come out of the hospital with something and we've got a query we might speak to [a pharmacist] in the hospital...(Community nurse C)*

This school nurse had checked on potential interactions with a pharmacist before giving medicines to a child:

*... I did contact a pharmacist yesterday...I had a query from school, one of the teachers had been asked to give some medication to one of the children...so, we were querying whether the co-codamol and codeine could be taken together...So...phoned the pharmacist [at a hospital] and was given advice...so they are used as a resource there too. (Community nurse B)*

Doctors and nurses appreciated the function of the pharmacist as a ready source of information about medicines. The importance of pharmacists also providing information to lay pharmacy users was also expressed. The hospital pharmacist quoted below gave the following response when she was asked what she thought patients wanted from pharmacists:

*I think information, I mean...when I go and see my GP and he gives me medicines, I get no advice whatsoever...and the same thing I have found when I go on the ward rounds, I see...good doctors...that I respect, but they just physically do not have...the time necessarily to sit down with patients and tell them about their medicines, so I think when we sit down and tell patients, 'this is what you've been put on now, I'm now going to explain to you what it is and what it's for, what the side effects are,' they're so grateful to know and to have that information, so I think that's the main thing that they want from the pharmacist, is information about their medicines. (Hospital pharmacist P)*

A hospital doctor who worked in the same department as the pharmacist quoted above also thought that patients wanted to have someone knowledgeable spend time explaining their medicines to them – he cited this as a defining attribute of a good pharmacist, and his experiences had been positive in that he thought pharmacists did do this:

*...pharmacists I think always spend time with patients, going through their pills. I've never heard a patient say, 'the pharmacist didn't explain that fully, about 'what was this pill? what was that pill?' So I suppose enough time with patients going over their pills...(Hospital doctor B)*

The pharmacist and doctor above quoted above both worked in the same cardiology department, where they perceived a generally positive situation with regard to pharmacists providing information to patients. However, the pharmacist quote below, based at a different hospital, described her frustration with what she saw as the inadequacy of medicines information provided to pharmacists on a surgical ward which she spent some of her time working on:

*...we've started to do a bariatric surgical service, gastric banding for people that are obese, erm so we have a consultant surgeon who comes to do that...for some reason they didn't think of pharmacy when they funded this, so we have no input with these patients until, well we attempt to see them when they've had the operation...and I say to them 'has anybody spoken to you about your medicine or have you seen a pharmacist?' and they say 'no, I've no idea what to do with my medicines', which I think is terrible...(Hospital pharmacist R)*

A pharmacy technician with experience of both hospital and community pharmacy, said that during her time in hospital, she regularly advised patients on how to use their medicines, however, her current role involved visiting pharmacies across her PCT area, and she perceived a lack of medicines information for some pharmacy users in the community sector:

*Interviewer: ...what do patients want from pharmacists...?*

*Respondent: ...more information about the medicines they are taking, they need to have the pharmacist there to speak to them about their medicines...at the point of delivery...about how their medicines work, or how to take their medicines safely...that is the kind of thing that I'm hearing that they're not getting enough of that...information about their medicines...I don't think pharmacists do enough of that...in community. (Primary care support staff A)*

The importance of pharmacists making active attempts to speak to patients was raised as a particular issue for community pharmacists. This pharmacist described a 'role model' from his past who was a positive example of a pharmacist who had done this:

*...a real passionate pharmacist...what impressed me was his, erm, interface with the customers and how good he was with them...how helpful he was...he was quite an extrovert as well I suppose which helps....he did make quite an impression on me...(Community pharmacist P)*

These lay pharmacy users seemed to value a pharmacist who actively offers them advice:

*...It's the people and the way they are...they advise, they're more friendlier...they are helpful when they step forward and advise you.. (Community pharmacy 2 user I)*

*Interviewer: In terms of what makes a good pharmacist, what would you look for?*

*Respondent: Generally someone that asks questions, if you need any more help, offers advice if you had asked for any. (Community pharmacy 3 user B)*

This pharmacy user speaks positively about the community pharmacists he has experienced, but recalled a negative experience at a hospital pharmacy:

*... [community pharmacists are] all pretty good actually, they do tend to be helpful...I was in hospital about five years ago and that was a case of you were discharged, go down to this room on your way out, sit there and someone'll throw a bag of pills at you, and that was it...and someone kinda went 'there you are, take them'. That was less helpful (laugh). (Community pharmacy 3 user A)*

Pharmacists themselves also perceived variation between pharmacists in how much pharmacists do approach pharmacy users :

*I always encourage people to ask me questions anyway, but looking around others, a lot of pharmacists would stay in the back, if you like, and not venture forth very often unless they really have to. (Community pharmacist P)*

The pharmacist above suggests that more pharmacists need to 'venture forth', indeed, this pharmacist, who encounters various pharmacists in her work across a PCT area, suggests a need for them to come out 'from the back'. She suggests that this might be more challenging for older pharmacists.

*...we're a shy profession...I think we've hidden away in our dispensaries for too long and I think this is why it's harder for pharmacists today...to try and move out from the back and be talking to patients, especially for the older ones. (Primary care pharmacist C)*

This pharmacist perceived a similar difficulty with trainee pharmacists:

*...I've actually pulled up my pre-reg's and said 'look you want to talk to these people don't you? You don't cross your hands, you don't go and look grumpy at them.' Because some of them do...I think it's accessibility and communication, and actually being seen, not hiding in the back. (Community pharmacist Q)*

A similar notion was expressed by this GP who recalled incidences where she has mistaken support staff for the pharmacist because the pharmacist themselves has not come forward to speak with her. Although she mitigates her 'criticism', saying that she thinks the majority of pharmacists are outgoing, and speculates that perhaps these pharmacists will act more confidently as they get older and more experienced, she nevertheless remembers more than one occasion where she been surprised by how introverted the pharmacist has seemed:

*[a good pharmacist is]...an outgoing person, friendly, approachable...if somebody's sort of quite mouse-like and hiding in the corner...a couple of times I've seen people and thought, 'are they the pharmacist or not?'...maybe because they were quite new perhaps and they weren't as confident yet...a couple I remember were quite young...they were quiet and took a sort of back seat and the technician was talking to me instead...most pharmacists are outgoing, and they are very friendly and they do talk and stuff...perhaps I caught people quite early on in their careers, I don't know, but they are usually quite outgoing and open. (GP E)*

A member of community pharmacy support staff also thought it was important for pharmacists to be quick to advise pharmacy users, and raised the importance of them having a confident manner, in order for people to feel convinced by their advice:

*Interviewer: So in terms patients or customers...what do you think they're looking for in a good pharmacist?*

*Respondent: Probably someone who knows what they're talking about...cos you know when someone's quite shy, and they don't really wanna say much?...if you go in a shop and you want some advice, it's easier if someone's stood there, like, talking to you... just advising you straight away rather than 'umming and ahhing'...knows the products and research...what's going on and what's coming out...Rather than not very sure about stuff. I've found that people...come back again then, if they've got a problem...and ask for that person again, cos the confidence is there in them isn't it? (Community support staff A)*

A similar idea, of the manner in which pharmacists put across their knowledge being important to patients, was expressed by this pharmacist in the hospital setting:

*...have a little chat about it and reassure them. I think they want some degree of confidence in you and I think that can come across in your personality as well probably, you don't necessarily have to have buckets of underlying knowledge but a lot of it's kind of reassurance and psychological support...(Hospital pharmacist Q)*

This hospital pharmacy user recalled occasions when she had felt reassured by a knowledgeable pharmacist:

*... being able to talk to them, to explain your problems you know if you're worried about anything, your medicines, side effects and them be able to understand and try and reassure you, put your mind at rest. Like especially as I'm on like TNF, quite advanced medications, that the side effects are safe, sometimes you're like 'oh god I'm gonna get this, I'm gonna get leukaemia', and they're there to reassure you, even though they're not a doctor, they can talk to you and reassure. (Hospital pharmacy user B)*

These respondents also perceived a similar identity for community pharmacists, perhaps as 'trusted advisors', to whom lay clients do turn for medicines advice:

*Interviewer: Describe a pharmacist in five words.*

*Respondent: Erm, somebody working in a chemist, who dispenses medicines...and also gives out medicines for which patients come with problems to them as their first port of call. (GP A)*

*... thinking about me own Mum and Dad and in-laws and how they relate to their local pharmacist, and they kind of treasure them, and use the pharmacist as their advocate for medicines...their advocate, for looking after them, they go to him to sort things out for them. (Community pharmacist O)*

#### **6.3.4 The information professional**

As well having knowledge about medicines and keeping up to date, an ability to work with information sources was seen as important for pharmacists. This included disseminating new pieces of information that they came across, as described by this hospital doctor:

*...they're also...exceptional at you know reading the evidence base and then saying, 'we should be using this drug or that drug' depending on, or 'there's a new licence for this'*

*and she's very good at information gathering and information distribution. (Hospital doctor B)*

Primary care pharmacists in a stage one interview recalled work they had done in the past which involved compiling information, in this example, to produce a set of guidelines and present these to the PCT management board. To do this it was necessary to have the ability to work with large volumes of information and also to communicate it clearly to others.

*PCP A: ...let's say you come out with guidelines on...Herceptin, for example, they need to know breast cancer inside and out...*

*PCP B: ...if we had to go to board with Herceptin...then it's knowing where to look for that information, doing your literature reviews, making sure you've got the evidence behind it...do like online searches...(Primary care pharmacist group interview 1)*

Pharmacists in this study also reported that they prepared bulletins to keep other staff up to date and guidelines which might be used in policies for the funding of medicines. They also contribute to formularies, which specify which products should be prescribed, and also to patient group directions, which set out protocols for a specified conditions and medicines that are used in their treatment. Pharmacists in two stage one group interviews associated MI and primary care-based pharmacists in particular as being good at condensing large amounts of information into written summaries:

*HP L: I think they have a lot of summarising skills cos they've got to take a lot of information and put a concise answer together, so their English skills are better than a lot of the other pharmacists. (persona 03)*

*PCP A: ...that ability to take the information up and to condense it down...we all have that ability to go through the literature...(Primary care pharmacist group interview 1)*

Lastly, in terms of dealing with queries, finding additional information when the limits of their own knowledge was reached was seen as an important aspect of pharmacists' work:

*...I don't profess or claim to know everything in the BNF or have this amazing kinetic background and knowledge base cos I don't and I think the key is if you don't know the answer, to hold your hands up and say 'I don't know...I'm sorry', but then have the skills to be able to go away and look that up and come back...(Hospital pharmacist R)*

'Medicines information' (MI) is a speciality of hospital pharmacy. Pharmacists working in MI are usually located in an 'office' environment (not on a ward or a dispensary) with access to a range of reference sources, and are a point of contact for any medicines-related issue. This pharmacist recalled a MI pharmacist he had worked with who he regarded as a role model:



*...if [pharmacists] don't know a particular aspect of a particular drug they know exactly where to find out about it as well...the first role model I had...was the medicines information bloke...quite a unique character, but he made it his business to know everything, or at least have every source of information that you could possibly need in order to answer queries. (Hospital pharmacist T)*

Several pharmacist participants in stage two recognised picture 06 as a MI pharmacist, and some commented on the usefulness of this role:

*Definitely we always need this kind of pharmacist who have got all the information...or access to information, studies, evidence based medicine, you know there is a lot of this. (PCT pharmacist C)*

This hospital doctor associated pharmacists with medicines reference sources:

*...if they're holding a BNF in their hand, that usually tells me they're a pharmacist. (Hospital doctor C)*

As well as being competent at using reference resources, a willingness to do so was appreciated:

*...any MI pharmacist I've come across particularly here have just been amazing, in that they're very friendly, very open and you know, more than happy to help you with anything, and will get you a very good evidence-based answer to the question that you've asked...(Hospital pharmacist R)*

*Well, obviously a very sound scientific background and knowledge of the subject, erm, and willingness to, or an ability to recognise where their knowledge may not be 100% and preparedness to go and look it up or ask somebody...(Hospital doctor D)*

*...one of the pharmacists...I'd ask them questions...she was brilliant and I used to say to her...'...how does a nebulizer bring down potassium?'...she'd go back and she'd look it up and she'd email me...it was great... (Hospital nurse B)*

*...acting as a, an adviser and conduit if you like, for specialist information as and when we need it...(Hospital doctor A)*

A member of support staff expressed a similar notion, that a good pharmacist would quickly turn to a reference source if they were unsure about a prescription:

*[a good pharmacist]...can look at a prescription and...they don't sit there going, 'er, er,' they just go, 'that's not right', and they go straight away and get the BNF and you know look it up and it's, 'I'll do something about it now.' (Community support staff A)*

Several pharmacists who took part in this study seemed to identify strongly with 'information finding' work, and highlighted it as something they particularly enjoyed. This hospital pharmacist was undertaking her MI rotation at the time of her interview, and she described dealing with a

range of enquiries related to medicines, from both staff within the hospital, and outside, typically GPs and community pharmacists.

*...you need to...know where to look, what resources to look in for information and provide it in a professional manner, so yeah, very enjoyable...(Hospital pharmacist O)*

A community pharmacist recalled the time that she had spent in medicines information in the past, and the second was undertaking her medicines information rotation in hospital at the time the interview was conducted.

*...Really enjoyed it...when the consultants or the patients or whoever is ringing you up, you have to know where to find the information and there's like a sort of core set of books that you need to know and I just knew where to find the information and I liked looking it up and sending it back to them. (Community pharmacist R)*

### 6.3.5 The checker

The clinical check is an important part of pharmacists' work, and involves checking:

- That the medicine is appropriate to the patient's condition
- Compatibility with other medications the patient is taking (e.g. potential to interact)
- Whether there is any risk of possible side effects or adverse drug reactions (e.g. the patient could be allergic to a particular medicine)
- That the dosing is appropriate in terms of – the dose (amount), the form (e.g. tablet, liquid) the regimen (when to be taken/given), the duration of treatment and the administration route (e.g. orally, intravenously).
- Consistency with formularies, protocols or other guidelines

(Derived from guidelines and standards developed for pharmacy education and practice by the RPSGB.<sup>26,125,126</sup>)

The interview schedules used during data collection for this study did not include any direct questions about checking tasks for pharmacists, but the issue of pharmacists checking the details of medicines was a recurrent theme throughout the interviews. Data analysis suggested a general image of the pharmacist as a 'checker'. This was expressed by pharmacists in relation to their own practice:

*Checker. (laugh) The first five words? Erm, so check, checking or checker...(Community pharmacist P)*

*Respondent: Mainly it's checking prescriptions, just checking they're correct before you give them out...(Community pharmacist T)*

And was also perceived by both professional and lay non-pharmacists:

*Mainly checking over the prescriptions they've got to do...(Community pharmacy 3, user B)*

*... [pharmacists] do a lot of checking on what the doctors are up to...(Hospital nurse D)*

The checking that pharmacists do to make sure that a patient gets the best possible medical treatment occurs in different ways and at different stages of patient care. The examples that emerged from analysis of the data were: checking prescriptions before they were dispensed, checking details with patients to ensure the appropriateness of non-prescribed medicines before they were supplied, and, in the hospital setting, 'picking up on' issues with patients' medicines after they have been prescribed, often through checking or reviewing the patient's drug chart. The contra-indications of medicines were a particular area of knowledge seen as relevant to this role. Contra-indications include interactions, that is, the potential for two or more medicines (or their constituent ingredients) to interact with one another and harm the patient, or the potential for medicines to have 'unintended effects' on the patient – as side effects of the medicine, or by triggering an allergic reaction in the patient.

*...how the drugs work, I think we know more about...interactions...(Community pharmacist P)*

*... they know much more about, the drugs and how they work, and potential side effects. (Hospital nurse A)*

In terms of checking prescriptions before the items are dispensed, doctors in both the hospital and community reported that pharmacists would alert them to potential drug interactions on prescriptions they had written:

*... sometimes if we've done something stupid (laugh)...if we've prescribed something where there's a potential interaction, they'll phone us. (GP B)*

*... I think generally speaking that medics are quite poor at recognising drug interactions and I think pharmacists have got an invaluable role to play in terms of keeping us on the straight and narrow. (Hospital doctor F)*

This seemed to be appreciated as a useful function – this doctor employed the metaphor of the pharmacist as a 'safety net', presumably who would 'catch' written 'mistakes' before any harm was done:

*...they're very good at checking things, in terms of if you've prescribed the wrong dose or there's an interaction, they'll always let you know, so it's like a sort of safety net if you like, for a lot of prescribing. (Hospital doctor B)*

This nurse who was also a prescriber expressed similar thoughts:

*... knowledge about the medications and the contra-indications and things like that, I just see them as the total knowledge for that...I do think...somewhere along the chain, you do need that [although computer software will warn of interactions]...I do see them ultimately as the experts in the medicines, and what's safe, and what's not safe. (Community nurse A)*

The following quote from a member of pharmacy support staff is useful as it describes her direct observations of pharmacists checking prescriptions with doctors in practice:

*...drug interactions...[pharmacists] probably know a little bit more about than the doctor, cos they're dealing with it every day and I think they tend to...look at a prescription and think, 'mm well the doctor shouldn't.'...they do generally ring up the doctor and say, 'do you know such and such doesn't go with...that particular drug...?'...I think doctors do know, but some...haven't thought [or] looked at what they're on...they don't know everything...a pharmacist...can...look that up, so it's like a double-checking almost, so I think that's a good thing. (Community support staff B)*

Lay clients using both community and hospital pharmacies also perceived the pharmacist as someone who checked on medical prescribing:

*...interactions and...side effects...there's no doubt will be cases where a GP might prescribe something which isn't necessarily the optimum, so I'd be looking for pharmacists to check on that. (Community pharmacy 1 user G)*

*... I've actually been in here when they've phoned my doctor up and clarified that they've give me the right drugs...(Community pharmacy 2 user A)*

This hospital pharmacy user raised the point that especially in the hospital, patients may see and receive prescriptions from more than one doctor, and that the pharmacist's checking function can be particularly valuable when a person is being prescribed several different medicines at once:

*...they can explain...what medications don't go well with other medications if your doctor hasn't noticed when they're prescribing, if you get prescribed by two different doctors, they don't always check what you're already on. (Hospital pharmacy user E)*

As well checking for potential interactions of prescribed medicines, community pharmacy users raised the issue that they could also be taking non-prescription medicines which could interact with those they had been prescribed, and that this was something the pharmacist could pick up on:

*...they will, counter-ask, it's like a double security check...to make sure that you're not gonna take anything that's gonna upset you...with the stuff that the doctor's given you. Cos sometimes you don't tell the doctor that you're already taking something else that you've bought over the counter, whereas a pharmacist says, 'are you taking anything else?' you'd say, 'oh yes I bought a bottle of this'... And they'll say, 'oh well you've gotta stop taking that before you can take this....' (Community pharmacy 2, user G)*

*...they'll advise you to take something different. So I find it is helpful... they make sure you're not taking anything else...so I think it's a lot more safer...(Community pharmacy 2 user I)*

Hospital pharmacists check or review patients' medicine regimes, including after the medicines have already been dispensed - the hospital pharmacist quoted below regularly attends the medical ward round, where the consultant will ask her to check the drugs charts:

*[on the ward round] The consultant tends to give me the [drugs] chart. And asks me if there's any problems, he'll sort of just give it to me and say 'any problems today?' (Hospital pharmacist O)*

Hospital pharmacists also perform their own 'pharmacy' ward rounds, and this pharmacist describes the details that she checks when she does this:

*...I'd check what the doctor's prescribed. Are the doses correct? Are they at the right time? Is it appropriate for this patient, given their disease state? ...Are they dangerous? Like for instance giving a beta blocker if they're asthmatic... if they have an infection and they're newly prescribed an antibiotic, are they allergic to that antibiotic?... I tend to go to the notes first, ...find out their presenting complaint...make sure that everything's clinically appropriate and safe on that chart...[might]...write extensions of information... '...blood pressure we know it's border-line low'...So that'll flag up...'be cautious when you're using this medication'...(Hospital pharmacist O)*

A further area of pharmacists' knowledge is legislation and other rules or guidelines pertaining to how medicines are allowed to be supplied. This was raised by pharmacists in both sectors:

*CP D: ...her law would be good, and law would be important to her...*

*...that's part of the job really, keeping up to date with changes in the law...(Community pharmacist Q)*

This knowledge of laws or regulations relating to medicines was seen to be applied through them checking that these were being complied with:

*[describing a pharmacist in five words]... professionalism, accountability for medication, what else have we got? I suppose checking, to an extent, dispensing, a lot of legal requirements to pharmacy. (Hospital nurse E)*

*...pharmacists have often got an in-depth knowledge of the medication and the guidelines and licensing and stuff. Whereas I know about the evidence base but I might not be entirely 100% about the licence of a drug, so the pharmacist might say 'actually you're using that off-licence, you know that don't you?' (Hospital doctor B)*

#### 6.3.6 A good eye for detail and a medicines focus

The data presented above showed that the pharmacists' knowledge of medicines and ability to check prescriptions for potential problems was widely appreciated. To be a good 'checker',

pharmacists need to pay close attention to detail. The following quotes from a hospital pharmacist and a doctor (who worked at different hospitals and in different specialties), both emphasise the importance of this, with the pharmacist stating that members of her profession must be 'precise', which means 'very attentive to detail'.<sup>124</sup>

*... an underlying trait is you've got to be precise if you like...whether you're a community pharmacist or a hospital pharmacist....extremely important that they're attentive to detail, cos you are the final check before the patient gets the drugs, so from a safety point of view it's important that you are a little bit bothered about making sure that you do your job right. (Hospital pharmacist Q)*

*... they're all very thorough, and you have to be, erm, and they're all very accurate in what they do and what they write, again which is pretty essential, and I don't think you can be a good pharmacist without having those characteristics. (Hospital doctor C)*

Interviewees who worked in the community setting expressed similar ideas:

*They have to be very alert...very methodical...a bit like how I think of airline pilots, they have to be able to deliver something at the same level all the time, you know, you can't have a good day or a bad day with those sort of things can you? There's got to be a certain minimum...they have to be quite disciplined...(GP D)*

*...you have to be, you know, accurate and just concentrate all day basically, that's how I think about it, just be alert. (Community pharmacist N)*

Participants in a stage one group interview also described a pharmacist with very good attention to detail:

*CP D: Yes, her checking will be absolutely bob-on...attention to detail...(Focus group 7, persona 02)*

However, some variation in this respect was perceived - although the hospital pharmacist quoted above referred to being precise as an 'underlying trait' of most pharmacists, she did think that there were some pharmacists who were not as attentive to detail as they needed to be:

*There are some slap-dash ones I think, then errors still creep on through and...you lose the point of having a pharmacist then. (Hospital pharmacist Q)*

Also, the same participants from the group interview described another pharmacist who does not pay enough attention to detail – this seems to relate to his attitude and being less committed to the task in hand than his ability:

*CP C: [with some locum pharmacists] you'd just get the minimum checking, sitting on the chair and just signing it off (laugh)*

*CP D: Or mobile phone, cos obviously the mobile phones are going off all the time*

*Interviewer: Yeah?*

*CP D: Oh yeah...they check with their mobile phones...Which is worrying seeing as you know you're not supposed to drive with mobile phones.*

The data presented above suggest that pharmacists in both hospital and community are widely seen as having good attention to detail, and that this is valued because it enables them to fulfil a very important function in checking that medicines are supplied safely. However, people who take medicines, or have had medicines administered to them, can suffer allergies or side effects which may not have been possible to prevent, for example if was the first time that a patient was exposed to a particular drug – in cases such as these the adverse effect would certainly be an unintended consequence, but it is not due to a 'mistake'. Pharmacists can be good at spotting these – the following two quotes are from interviewees who worked in an intensive care setting:

*...they're very good if you've got... side effects...maybe a patient develops like a new, problem...then they might say, 'well that could actually be a side effect of this.' And it's not something you would generally think about, it's not high on your list...(Hospital nurse A)*

*I had a chat with one of the doctors the other day, she said 'it's really helpful to have somebody like you who has a different angle from what we do'. Because I'm coming from the drug point of view and they're much more...from the kind of clinical disease state point of view, my priority is the drugs - Are the drugs contributing to this problem? Is it working for them?...certainly in intensive care, because the patients are you know walking a very fine line, the drugs can have quite a dramatic impact...so that's the angle...I mean there are consultants...I've come across to them and said, 'look this patient's suffering these symptoms and it's probably because of this drug', and they're 'oh right I didn't realise that'. (Hospital pharmacist T)*

As well as having good attention to detail, pharmacists were seen as having an overall 'focus' on medicines:

*...the doctor kind of is a jack of all trades...whereas all we've got to focus on is the medicines...there's more and more drugs and...complex interactions and side effects and things like that to consider these days...so we can make sure that with all these dangerous drugs...that everyone is on the right thing and it's safe and appropriate...So I think because drugs area such a high-risk component to peoples' care...it's useful having a group that specialises just in that...(Hospital pharmacist P)*

*...the unique thing that the pharmacists have is being able to sort of look at the drug chart...they're thinking, 'well is this the right treatment for this condition?' (Hospital nurse A)*

### **6.3.7 Challenges in employing this for maximum benefit**

The section above presented data which showed that pharmacists were appreciated for their function as people who 'keep an eye' on medicines, and that to do this reliably it was necessary to pay close attention to detail. However, other data suggested that there could be such a thing as too much attention to detail. This doctor suggests ways in which the tendency of pharmacists

to be meticulous could be irritating. Although he did not give specific examples, it seems to be referring to situations where doctors might prescribe, for example, two drugs which have the potential to interact on purpose, because they have decided this is the best course of action for an individual patient, and he perhaps does not appreciate always having these prescribing decisions questioned:

*...it would be very irritating if they erm, were over-zealous, you know you can imagine with a clinical team that they might be a bit nit-picky and pick up on all sorts of things of which we were perfectly aware, or had done deliberately. (Hospital doctor D)*

Other participants raised the issue that prescribing medicines was an area of work where there were guidelines which could be referred to, but that sometimes prescribers purposely 'override' these guidelines. This GP refers to doing this as using 'judgement':

*...it often seems like prescribing's like a cookbook, you know, you've got thyrotoxicosis, you look it up, here's the answer. Whereas in fact with actual human beings things are often a lot more fuzzy and difficult and you have to use your judgement as to what's going to be sensible for that individual...so I think a pharmacist needs to be able to have [their 'pharmacy'] knowledge but be able to exert judgement in liaising with someone else... (GP D)*

And this nurse refers to using her 'clinical knowledge', but seems to be referring to the same issue:

R *...we will get warning on our software if we try to prescribe something that clashes with another medication, and then we'll have to use our clinical knowledge to, erm, either go ahead and issue it, or something else...for example, one of the interactions they bring up...saying, 'warning, this may cause hypoglycaemia, it interacts with something else,' and I think 'well yeah, that's what I 'm giving it him for'. Or, 'this may reduce blood pressure,' and you think 'well yes, that's why I'm introducing another agent...'. So I know...that's safe to be given with the other one...clinical decisions, erm, involve the patient as well, it's not just from the text-book when we're making decisions about medications and other bits and pieces.*

Interviewer: *Ok, so do you see pharmacists...[use] clinical knowledge?*

Respondent: *I see them as using pharmacological knowledge....(Community nurse A)*

The quote from the nurse above is interesting as it suggests that pharmacists may have a tendency to look at 'text books' more than other professions. Indeed these quotes do convey an image of pharmacists turning to reference resources when they do not know the answer to a question:

*[they are knowledgeable about drug interactions]...although that does seem to depend on their computer systems (laugh). (GP A)*

*...they probably have an awful lot of knowledge...but they get the BNF out as much as anybody else does sometimes. (Hospital nurse B)*



*we tend to ask, 'are there any interactions with this drug?' and if they don't know they can go and look it up...on the computer'. (Hospital doctor D)*

In the quotes above, prescribers explain that they cannot always rely on 'text-book' knowledge when prescribing, and that pharmacists need to use not just knowledge available in text-books, but more judgement. The pharmacist quoted below refers to pharmacists' training and associates this with a 'black and white' mindset, which he differentiates from doctors' or nurses' greater tendency to 'see shades of grey', which concurs with the GP above who refers to perceiving 'fuzzy' areas:

*...[pharmacists] come from a scientist background really...they tend to be quite black and white, from the point of view of it's right or it's wrong and so I think that's a general sort of trait with pharmacists, unlike maybe medics or nurses who can be 'well there's shades of grey'. (Primary care pharmacist D)*

Several times during the stage one group interviews, 'newly qualified' pharmacists were described, and these tended to be seen as having 'text-book' knowledge. The group quoted below described such a pharmacist, who they referred to as having a 'black and white' view:

*CP D: Don't like grey areas, they don't like things that aren't right or wrong...*  
*CP E: I just think if they're newly-qualified generally, very much a rule-follower...little bit.*  
*CP C: Scared*  
*CP E: Yeah, don't always want to break the rules.*

However, a tendency to follow rules closely was not thought to be confined to newly qualified pharmacists. The same group described a middle-aged pharmacist, who placed a lot of importance on fulfilling administrative aspects of the dispensing process in a precise manner:

*CP D: If something needs to be filled in, it will be filled in correctly...I think...there's an element of the way they were taught at university. So they were taught that it had to be (chops hand across table three times). Like it is in't it? You do not cross out in the CD register cos you do not cross out in the CD register...(Community pharmacist group interview 2)*

A community pharmacist with many years' experience, and a current role that involved developing services across different pharmacies, perceived a 'type' of pharmacist that he believed to exist, who are focussed on 'doing everything right':

*...probably less than a third actually, who either don't have the confidence or can't be bothered whichever way to get involved, and think they've got enough to do with dispensing...I think that just reflects their personality, and I would guess in a cross-section of a group of people you're going to get that sort of split, and they're just going to be the more reserved, the quieter ones, 'I wanna concentrate on getting my prescriptions right and I don't really want to be bothered about doing, talking to patients and that, I will do if I have to, but really my main job is getting the prescriptions right and everything done correctly.' (Community pharmacist P)*

The same pharmacist also described his profession as a generally conservative one:

*Interviewer: Describe a pharmacist in five words...*

*Respondent: In general, conservative, careful...(Community pharmacist P)*

Another pharmacist remembered working with a community pharmacist during her pre-registration training, whom she cited as an 'anti-role model':

*...the pharmacist... had no people skills at all, he was quite rude to patients, he was quite unfriendly, and a lot of what he did was all about protecting him, so if someone asked for advice... 'can I take paracetamol with this?', or 'can I take this tablet even though I've got this problem or that?' And I remember the questions and looking back now I would have given completely different answers to him, but he was like, 'no the box says you can't do this, so you mustn't.' Because he didn't want to take any, what he saw as risks, not that they would have been risks, but he didn't wanna give any judgement...And could be completely unhelpful for the patient, not kind of offer suggestions or things like that... he kind of made me think, 'Oh god I don't want to be like you.' (Hospital pharmacist P)*

Doctors and pharmacists used adjectives such as meticulous, methodical, thorough and rigorous with to describe pharmacists. The general impression from these groups of interviewees was that pharmacists did possess these characteristics and that it was important that they did, therefore these are accepted and valued attributes. Meticulous' means 'careful and precise'.<sup>124</sup> While being meticulous and precise were valued as important attributes, some participants suggested that these could be taken too far. This was suggested by pharmacists from both sectors of practice, about their own profession:

*...fairly anally retentive (laugh) erm, bunch of people, cos that's your job really, is safety and picking up on things....Some of them are imaginative and everything, don't get me wrong...Hospital pharmacist Q)*

*Meticulous is a word that always comes up quite a lot, anally retentive comes up quite a lot as well (laugh). (Hospital pharmacist P)*

*Erm, being stereotyped about it, I suppose a lot of pharmacists are quite pernickety, erm, I think it kind of attracts a perfectionist... Yeah I think they can be a bit nit-picky and I can feel that sometimes in meself. (Community pharmacist O)*

And was also alluded to by this hospital doctor:

*A stereotypical pharmacist would be, erm, dare I say it, anally retentive, so they're very kind of obsessional and very good at checking things, but I think that's kind of in their job remit. And I know a couple of pharmacists socially, and actually they're quite obsessive people (laugh) in real life, I don't know if that's cos that's in their work and they bring it home... (Hospital doctor B)*

The traits set out in this section – being very meticulous, following rules ‘to the letter’ and focussing on doing things correctly, are sometimes associated with unattractive personality traits - the anti-role model described above was deemed to be ‘rude’ to patients.

Participants in a hospital group interview also perceived a similar type of pharmacist within their sector, although this person was seen as someone from the past:

*HP L: We did traditionally used to have, like, you know those horrible staff pharmacists...it tended to be the 50s spinster, who were really, really strict and everyone didn't like them and she didn't care they didn't like them but they ran the ship really...was always there...so she was in the dispensary all the time and like if you were late she would absolutely kill you. And she didn't care that nobody liked her but she just ruled it with a rod of iron.*

*HP M: They were an absolutely horrible breed*

*HP K: But they did a really good job. (Hospital pharmacist group interview 4)*

And a hospital pharmacist recalled a university tutor:

*I remember our dispensing tutor was a right dragon. (Hospital pharmacist Q)*

In order to carry out their role in checking on prescribing, it is often necessary for the pharmacist to make contact with the prescriber concerned and participants in both stages of this study described pharmacists who did not speak to people in the best manner. Participants in the group interview below suggested that pharmacists could intimidate doctors:

*CP D: If something needs to be filled in, it will be filled in correctly. And woe betide!*

*CP E: Woe betide!*

*CP D: Anyone who doesn't!*

*CP E: And she'll love phoning doctors and telling them when they've made a mistake...She'll think she has a really good working relationship with them, but*

*CP D: Intimidates the life out of them...(laughs)*

*CP E: 'Whatever you say, Carol, I'll just change the prescription!'(Community pharmacist group interview 2)*

This quote from a hospital doctor seemed to corroborate this:

*... if you've got someone who's...potentially correcting or highlighting mistakes or flaws that you've made, you know, it's entirely possible for you to feel threatened by that, so you need to have good interpersonal skills to bring up things in a tactful manner, and to clarify things without necessarily challenging their intelligence, or their decisions...[be]able to raise those kind of things without making you feel threatened, or you know, putting you on the sort of back foot and getting all defensive. (Hospital doctor C)*

A community pharmacist introduced the concept of the ‘ethical triangle’ whereby the pharmacist, prescriber and patient should behave respectfully and politely towards one another:

*We have an ethical triangle...between the doctor, the patient and the pharmacist, and the pharmacist can't ring up the doctor and say they're an idiot or tell the patient that*

*their doctor is an idiot. You've got to keep this triangle going and keep everybody happy. (Community pharmacist O)*

This quote from a GP suggests that a diplomatic approach from pharmacist is indeed appreciated by prescribers:

*I think the better ones are also good communicators, cheerful, know how to tell you you've made a mistake without saying 'you're a complete idiot'...I think you need a certain amount of tact and diplomacy. (GP D)*

A community nurse described how a pharmacist had roused her anger, by 'breaking' the ethical triangle:

*...it's on prescriptions I'd issued, that we had a clash of opinion, and it's the way she handled it with the patient that was very annoying...she told the patient that I was wrong...and she stopped the prescription, and the patient went away without the medication. Which I was absolutely furious about...I would like to think that if I had given something, if I'd chosen to override the information it gave me, I'd like to think that...the pharmacist...if they thought it was wrong and it was dangerous...would contact me, and say, 'do you know it does such and such?' In a nice way, rather than one-up-man ship way, which I think what's happened recently, so it puts you on guard. (Community nurse A)*

Similar views were expressed by non-pharmacist professionals in the hospital sector:

*...if they can say, you know, 'did you mean to do that, or have you made a mistake?' and if they've got the right sort of personality then that's fine...(Hospital doctor D)*

*... a lot of the time you're potentially going up to doctors and saying, you know 'I disagree with what you've prescribed here', you have to be able to put that across in a friendly way, without sounding like you're constantly nagging them, otherwise you don't have a very good relationship with them. (Hospital pharmacist P)*

As well as the triangle described above, one hospital pharmacist described the approach that she thought was helpful to take when raising potential problems with prescribers:

*...it's not going at them wagging your green pen going 'Oh my god, what is this? What have you prescribed here? You're blatantly going to do some real damage.' I think it's a matter of how you deal with them... if I've got a problem...or if I think I can make any suggestions I'll go straight to the junior doctor...tell them what I think and we talk a bit about it...so it helps them... (Hospital pharmacist Q)*

Interestingly, the pharmacist's 'green pen' was also mentioned by a doctor (based in a different hospital), this seemed to signify being scolded for making mistakes:

*...they write in green pen all over the drug card and make your life misery when you're a junior doctor...(Hospital doctor B)*

However, while pharmacists being 'aggressive' when checking on prescribing or suggesting changes was seen as problematic, some participants raised the issue that some pharmacists were actually not assertive enough. Participants in a stage one interview described a pharmacist who might attempt to suggest changes to prescription charts, but only did this in writing, instead of approaching the prescriber in person:

*HP C: Just leave little sticky notes, writing notes, just scurry around and get out of there, back down to the dispensary*

*HP E: Yeah she would leave notes rather than speak to them. (Hospital pharmacist group interview 2)*

The same issue was further mentioned by the nurse and doctor quoted below, who worked in different hospitals:

*...the pharmacist should be involved with doctors' prescribing more, actually talking to them, and what the system seems to be...all it is by note...communication between the pharmacist...and the team is just by a note left on a post-it, or a comment made on the drug chart, and there's not face to face interaction often...and doctors may not respond to that note, or not notice it, and I think that's a shame. (Hospital nurse B)*

*...I think sometimes on the wards, erm, the pharmacists erm, just kind of document stuff in the notes and they'll only very rarely actually track down a medic and discuss a patient with them...like a suggestion [written] on the drug cardex but that'll be it...and quite often I think they're making sensible suggestions that we don't always take on board. Cos as with many things in hospital...if you want to get something done, it's best to speak to someone face to face. But I appreciate that...it can be hard to find a nurse or doctor at times...(Hospital doctor F)*

Not communicating in person was deemed to be problematic because participants thought that pharmacists' suggestions were less likely to be actioned.

Pharmacists expressed mixed views on doctors' acceptance of their 'advice' on prescribing when it is offered pro-actively:

*Interviewer: And in terms of how doctors generally see pharmacists, what sort of view do you think they have?*

*Respondent: I think it's very positive...these days...the odd occasion tends to stick in your memory where someone's a bit rude to you, or doesn't take your advice too kindly, but they're so few and far between...I think they see us as a really useful resource, and to be there as a kind of safety check, to make sure that's what's on the prescription is ok and safe, I think most of them will have been involved at some point in a mistake, either a nurse or a doctor, with...prescribing a drug...so I think they're quite comforted to know that someone is coming along and just double-checking them, cos it helps to protect them from problems and coroners courts and things... (Hospital pharmacist P)*

*I know some GPs who think pharmacists are a bit of a nuisance, because they keep ringing up telling them what they've done wrong. (Community pharmacist O)*

*...some GPs really, really value the pharmacist, because they know that at the end of the day they could be saving their bacon, in terms of spotting something, erm, potentially fatal...once, there was a patient brought in this prescription...and I can remember thinking, 'this doesn't seem right', and I said... 'What did you go to the GP with?', and she explained it, and I thought, no, he's got himself muddled between...two drugs, and I 'phoned him up and he said, 'Oh my god...How embarrassing...I'm so glad you were there'...So there's that, 'Oh my god' factor, you know, they could be saving my bacon. And then there's the other ones where they're sort of, 'Oh god, they're on the phone again, asking about something.' So I think sometimes there can be a bit of, 'They're bothering me again.' But I think in the main, the GPs really value pharmacists. (Primary care pharmacist C)*

These pharmacists suggested that age may be a factor with GPs, and suggest that the more newly qualified doctors are more receptive to their queries:

*A lot of them...appreciate you ringing, and...bringing up a concern...but some of them still look down to us I think...some of them really do. They sound dead grumpy on the phone and you know, 'why are you ringing?' type of thing, they don't say it, but that's the impression you get...maybe the older ones...not everybody...a lot of the older ones are really nice as well, it's just the odd one, you're thinking, cos you're bringing something up, they're gonna be happy that you noticed it, but they don't really give that impression. (Community pharmacist N)*

*...newly qualified doctors and nurses I think have been trained about team work...but the old-fashioned ones, that qualified long ago, they automatically assume, if I ring them, that it's to tell them off because they've done something that they shouldn't have...sometimes they're a bit old-fashioned and sort of think of themselves as high up on a pedestal compared to us...but the medics coming out of school now...junior doctors...when I speak to them on the phone...they're absolutely completely different...without a doubt. (Community pharmacist R)*

However, the following doctor spontaneously acknowledged that his own profession may tend to have a demeanour or attitude that can make it difficult to question or 'correct' their actions:

*...doctors are not always the best people at taking advice, erm, so you need to find a way of being able to communicate with them...diplomatically...if they're headed in the wrong direction. (Hospital doctor A)*

And this was also suggested by these participants who thought pharmacists might need a certain 'mettle' to challenge some doctors:

*...need them to be a bit bolshy I think, if sometimes you've got to argue with doctors who think they've got it right and quite often they haven't, not nastily you know. (Hospital nurse D)*

*...check that what a GP is prescribing appears to be correct. And to have the, erm, you know the strength of character to say, to question it if there are questions there...(Community pharmacy 1 user G)*

This pharmacist mentioned pharmacists' 'safety checking role' in relation to media coverage of the profession, and seemed frustrated by lack of coverage or acknowledgement in the media:

*... they're quite often on ER, but it's quite a negative connotation, like 'oh my god we've got to wait for the drugs to come from pharmacy'... sort of thing. There isn't one portrayed as a positive... 'thank goodness the pharmacist said that, otherwise I'd have given eight times the dose that I should have given'...(Hospital pharmacist Q)*

A hospital pharmacist described the desirable combination of attributes which perhaps the 'ideal' pharmacist would have:

*I think the typical pharmacist is methodical, good at science, knows the rules and law, and has good people skills. (Hospital pharmacist N)*

### 6.3.8 Summary and comments

This section has presented data relating to the identity of pharmacists as medicines advisors. Pharmacists have a strong and clear identity as people who know about medicines and this was expressed in terms of all three dimensions of their identity by participants in this study. Some participants described pharmacists as medicines 'experts' or 'specialists'.

Pharmacists were generally seen as well equipped to answer queries or offer advice about medicines, and in the hospital setting, their professional non-pharmacist colleagues seemed to value them as an available resource for advice. As well as a sound knowledge about medicines it was deemed important for pharmacists to be outgoing and active in approaching clients and offering them advice, and also to be convincing and reassuring when doing so. However, the extent to which they did this for lay clients was seen to be variable.

When the limits of their own knowledge on medicines are reached, pharmacists often consult reference sources. Pharmacists were associated with medicines reference sources, were seen as skilled at using these and valued as a 'reference resource' by others. Pharmacists themselves valued reference finding skills and also reported enjoying this type of work. This suggests that this is a strong element of pharmacists' professional identity.

Pharmacists were seen as a safety check for the prescribing and supply of medicines by all groups participating in the study. This is therefore a very important role – key to pharmacists' identity and perceived in all dimensions of their identity. Attributes such as having close attention to detail and being meticulous were acknowledged as being valuable, perhaps vital/crucial to the identity of pharmacists. However there can be such a thing as 'too much' focus on checking and some data suggest that there is a fine line between useful checking and 'excessive' checking. Also, it appears that pharmacists' close involvement with reference

sources, guidelines and rules can give them an image of having 'text-book' knowledge, which can sometimes be seen as in tension with doctors and nurses clinical decision making, or perhaps professional judgement.

Good social skills were deemed to be important when making contact with prescribers to question their decisions or suggest changes – some data suggested that pharmacists were sometimes aggressive in their approach, but other pharmacists were also described who were too submissive. A combination of knowledge, attention to detail and good social skills was seen as necessary if pharmacists are to fulfil their role as advisors on medicines effectively.

## **6.4 Discussion**

This chapter has suggested the existence of two identities for pharmacists which are as people who know about medicines: the scientist and the medicines advisor.

The contemporary pharmacy policy literature positions the 'science of pharmacy' as one part of clinical pharmacy – which also includes the skills of the practitioner'.<sup>28</sup> There is no elaboration in the policy literature on what this science might be. However, this chapter has presented the identity of the pharmacist as scientist, both in training and in attitude. Because it is associated with training, it may be the case that the scientist identity is strongest, and most consistent, in recent graduates, who will all have had scientific teaching during their university degrees, and then as pharmacists go through their career this identity will become weaker or less important for many, as they go into practice. For pharmacists in a medicines information role, the connection with scientific research findings may remain stronger.

Pharmacists seem to have a strong identity as scientists – this seems to be the foundation of their training in terms of a knowledge base. A defining element of being a professional is, by definition, the application of knowledge in practice.<sup>39-41,134</sup> Therefore, understanding what pharmacists know about is a key part of understanding what kind of profession pharmacy is. The way in which clients see pharmacists (in terms of what they think they know about) may affect how they use them, or consult them, and what about. In practice, pharmacists' scientific knowledge is applied by them providing information about medicines to others, or using their knowledge to give advice. Overall, this suggested an identity as a medicines advisor, which manifests itself in different ways, depending on the setting or organisation worked in.

The idea of the pharmacist as an 'expert in medicines' is not a new one – it was mentioned by a report of the Council of the Pharmaceutical Society in the 1940s.<sup>9</sup> The concept is also well-established in the pharmacy practice literature. Quinney's study, dating back to 1964, refers to



'encouraging use of drugs'.<sup>73</sup> Hornosty included the functions 'accumulating relevant literature, providing information and advice about drugs to other health care professionals and counselling patients on drugs' in his questionnaire.<sup>78</sup> In the UK, Harding and Taylor suggested that pharmacists should capitalise on their knowledge of medicines.<sup>50</sup>

Acting as a 'check' or 'safety net' on medicines prescription and supply was identified as an important aspect of pharmacists' identity as medicines advisors – pharmacists described checking prescriptions before they were dispensed and also when reviewing patients medicines regimes after the initial prescribing and supply of medicines has taken place. These data resonate with descriptions of pharmacists found in the research literature. Cavaco reported that community pharmacy users associate pharmacists with having responsibility for medicines and that they can act as a 'vigilant',<sup>112</sup> Dingwall has described the work of the pharmacist as that of a 'seer' or 'prophet' who looks into the future and prevents harm before it has a chance to happen.<sup>61</sup> Leufkens's study, which forecast potential future roles for pharmacists, defined various scenarios, each of which involved a different relationship to doctors. In the clerk role, the pharmacist was dependent on doctors and fulfilled a 'limited, whistle-blower role' for the doctor. In the 'controller' the pharmacist was seen as more driven by accountability, and while still 'reactive' to the doctor's actions, was seen as more of a 'watch-dog'.<sup>89</sup> Both of these 'roles' can be seen as relevant to the medicines advisor identity for pharmacists set out in this chapter, depending on the setting and circumstances the pharmacist is in. Norgaard identified the roles of 'technical advisor' and 'drug expert' for pharmacists, and the second of these in particular, which includes having specialised knowledge of drugs and using IT databases to advise on medicines, seems to fit well with data presented in this chapter.<sup>87</sup>

Studies undertaken from a social psychological viewpoint, such as Hean's, which measured the stereotypical perceptions of different healthcare professions, also resonate with the findings in this chapter.<sup>37</sup> Hean found that pharmacists were seen as having high academic ability, but received relatively low ratings for social skills, which matches with data presented in this chapter which show pharmacists to be generally perceived as highly educated, but also include examples which are critical of pharmacists' social skills.

The safety checking function emerged as a key aspect of pharmacists' professional identity, relevant to all three dimensions. Some elements of this identity are seen as core traits of pharmacists, such as having close attention to detail, however, this can be a role that is difficult to 'get right' in practice, and pharmacists' own social skills or manner, as well as the attitudes (and possibly identities) of prescribers can affect how this manifests in practice. Previous studies have found that doctors are more accepting of advice on non-prescription medicines<sup>106</sup> and suggested that pharmacists might seem threatening if they suggest 'too many' changes. In

this study in terms of approaching prescribers to challenge or question their decisions, pharmacists' social skills were sometimes seen as problematic in that pharmacists were either too aggressive or too submissive in their approach. Either of these could reduce the potential for the benefits of pharmacists' knowledge be used to full potential.

Data presented in this chapter suggest that pharmacists can sometimes be associated with a 'black and white' attitude, or rigid mindset, where a focus on whether things are 'right' can narrow the focus of their role, and also be irritating to others. Previously, Harding and Taylor perceived a narrow professional identity for pharmacy students and argued that this is negative as it is concerned with not making mistakes, and being risk-averse.<sup>68</sup>

It is notable that non-pharmacist health care professionals do not mention the pharmacist's input into checking whether patients they have prescribed medicines for are taking other, non-prescribable medicines. This suggests that non-pharmacist health professionals may be unaware of this useful checking function that pharmacists perform.

This chapter has examined pharmacists' identities as scientists and medicines advisors. Chapter seven introduces the ideas of pharmacists as clinical practitioners, social carers and also as unremarkable characters.

## **7 Pharmacists as clinical practitioners, social carers and unremarkable characters**

### **7.1 Introduction**

This chapter is about pharmacists as clinical practitioners, social carers and unremarkable characters; the following sections present each of these in turn.

### **7.2 The clinical practitioner**

#### **7.2.1 Introduction**

The concept of clinical pharmacy is a prominent feature throughout the contemporary policy literature. Section 2.3.6 noted that the policy direction has been for pharmacists' input in technical supply tasks to reduce, to free them to devote more time to direct patient care. Back in 2001, the government stated that:

*clinical pharmacy services have become an established part of hospital healthcare*<sup>23</sup>

And in 2003 government policy stated that:

*Hospital pharmacists have moved towards increasing integration into clinical teams and are continually developing specialised clinical roles.*<sup>24</sup>

And the phrase was found throughout the policy review undertaken for this study. In 2008 the pharmacy professional body stated that a key role for pharmacists was to 'deliver patient centred care'.<sup>26</sup> In 2003, the government defined a 'key role for pharmacy' as being 'a point of first contact with healthcare services for people in the community'.<sup>24</sup>

Although I did not set out at the start of my data collection period to ask participants directly about their views on clinical pharmacy, as noted in section 3.4.2, a practice nurse referred to her own 'clinical knowledge' which she seemed to see as different from a pharmacist's knowledge, and this led to the incorporation of a specific question about what clinical means in relation to pharmacy being added to the interview schedule. This question generated a considerable amount of data, and the responses were interesting as they suggested different understandings of clinical work between different professions and between sectors. Additionally, analysis of the dataset as a whole revealed other material which, although they did not always include the word 'clinical' provided further insights on this topic, and clinical work is the overall theme of this section.

#### **7.2.2 Matching patient and medicine**

Pharmacists defined clinical work as to do with applying medicines at the individual patient level. These pharmacists provided their descriptions of this:

*...it's...in the case of the pharmacist...applying medication to patient care...so it's making sure that those two things, the medicine and the patient meet in the most effective way. So maximising the effect of the medicine, minimising adverse effects, good cost effectiveness... in hospital it's delivering the best service for that individual person...it's the way the medicines work in the people, so you can do your pharmaceutical chemistry and...say, 'this is a molecule and this is how it should work and...we would expect the following effect' but it's actually seeing whether it does that in individuals...(Primary care pharmacist D)*

*[clinical] means a service directly related to patients. So to me, if somebody gave me a prescription that said 'digoxin 125mgs once a day' and I dispensed that, that's not a clinical service. As soon as I start to think about '... is that the right dose for the patient, have they got any renal function?' if I attach any sort of patient factors to it, that makes it a clinical service as far as I'm concerned. (Hospital pharmacist Q)*

In the following quote, a hospital pharmacist refers to her work on the hospital ward as providing a 'clinical service', and her description suggests a varied set of tasks relating to the patient and their medicines:

*I tend to get on the ward...first job is sorting out any TTOs which involves talking to the patients, as well as sorting out their medicines, it might involve some counselling...[then] I go and check the charts...just chasing things up, checking blood results, the duration of things, antibiotics and just the usual clinical service. (Hospital pharmacist R)*

Having information about the patient was identified as a key factor of clinical pharmacy work, as if the pharmacist does not know anything about the patient, then they may know a great deal about a medicine and its actions, but this will be only theoretical until it is actually applied to that patient. A sector difference between hospital and community pharmacy, with hospital pharmacy being considered more clinical, was a recurring theme in the data collected for this study. A key defining factor here was the greater amount of information about patients available to hospital pharmacists. In the following quote, a hospital pharmacist describes her own work, which she considers to be clinical in nature; she then goes on to differentiate between this and how she sees the work of community pharmacists:

*[I consider]...the whole patient, all their medical problems...side-effect problems, allergies...making a thorough assessment of all of that when you're deciding what drugs to use...Whereas I think in community they're not really able to do that...partly because they don't know what's wrong with the patient, or...rarely...because they don't have access to the medical notes and all the doctors...I don't think they really get the chance to fully assess a prescription clinically and say 'are these drugs a good idea together? It looks like maybe they're treating afibrillation, well I wouldn't have used these two together...'...it's not classically what community pharmacists do. Whereas...on the ward, we've got a lot more information at our fingertips. (Hospital pharmacist P)*

This quote from a community pharmacist seems to correspond with the views expressed above:

*...in hospital, [pharmacists] focus more on the clinical...then community...it's not as clinical as hospital - they'll look at your lab reports, which'll say, certain levels of certain chemicals in your body for example, your sodium...if it's not [at the right level] then this is what you need to give. Whereas with us, we wouldn't look at any of those values...well we wouldn't have the report...then they would recommend...maybe put the patient on this drug, or...that drug, and we wouldn't do anything like that. So it's more in depth at hospital. (Community pharmacist T)*

The quotes above refer to hospital pharmacists interpreting the results of laboratory tests when reviewing the patients' medicines regime. As well as information about the patient not being available to community pharmacists, some participants felt that even if they did have more of this type of information available, they varied in their abilities to use such information.

*Clinical I would define, as knowing...for example, a hospital pharmacist would look at a set of blood results and think, 'yeah I know exactly what's going on with this patient and what we need to look at.' A community pharmacist would struggle, cos that's one of the things we did in [a pilot scheme], and we all had to have extra training around it... and they...would not necessarily have that. Some of them do, you know, you can't sort of pigeonhole everybody, but a lot of them would not have that skill, to be able to do that. (Primary care pharmacist C)*

Integration into the health care team also emerged as relevant to clinical work. Hospital pharmacist P quoted above mentioned that community pharmacists do not have access to 'medical notes or doctors', and the issue of integration was raised by other hospital pharmacists:

*Clinical means a lot more involvement with the patient and the team looking after the patient. (Hospital pharmacist T)*

*To me I think it's part of the clinical team really, so the pharmacist is part of the ward round, is part of the decisions regarding prescriptions and what tablets to give people, rather than just somebody who dispenses them, pharmacists aren't just dispensers, they are part of the clinical team making decisions. (Hospital pharmacist O)*

The pharmacist above suggests that being part of a team enables a pharmacist to have greater input into decision making about medical treatments. She goes on to describe how she is able to do this in practice, by attending ward rounds with a consultant with whom she has a good working relationship:

*... my consultant's very very good...he'll tend to value your opinion quite a lot, there's a lot of emphasis on if you've given the ok...I tend to try and get into discussions...so the whole point of going round as a team is that everyone has their input for the best for that patient. (Hospital pharmacist O)*

A consultant based at a different hospital, who also seemed to have a strong working relationship with the pharmacist on his ward, conveyed a similar image, of the pharmacist being closely involved with medics' decision-making:

*...she maintains a very high presence on the unit...reviewing all patients and their medication on a daily basis...debating the pros and cons of different therapeutic options with us...(Hospital doctor A)*

*... I suppose to me clinical means being hands-on...having a role at the bedside basically and being physically on the ward...Our ward pharmacist yeah he's certainly clinical in my book. I mean there must be people that are doing research, and like your medicine technicians, those people that work exclusively within the pharmacy department and perhaps I wouldn't call that, well I suppose it is kind of clinical, maybe less clinical than somebody who is physically on the ward, I suppose they've still got an indirect role. (Hospital doctor F)*

This community pharmacist perceived his sector of practice as less integrated with other healthcare professionals than hospital pharmacists:

*I think in a hospital you are part of a chain, so you know what is behind you, what is next to you, the doctor, you know, in a chemist they just pass through in a community pharmacy...It's less, I mean the doctors are next door, but not next to you. (Community pharmacist P)*

However, the extent of integration is also variable for hospital pharmacists – the participant below works in a surgical setting, and while she would like to be well integrated into the team, she describes a number of challenges she has faced in trying to do this, and expresses frustration with her attempts to be more integrated into the team being disregarded.

*It's very difficult because our consultant surgeons usually do the ward rounds at eight, half eight in the morning, the hospital department...doesn't allow us to work [that early in the day]...I feel pretty rubbish to be honest that, erm, I've worked on my ward now for three years and I feel the consultants have no idea who I am, even though I'm on there every single day...I send emails, I try and go and say 'hello', I'm not on there when they are on the ward...that's the problem, I might just happen by chance to be around, a couple of them have started to say 'hello' to me in the corridor now which is quite nice, but they've never directly come and asked me a question, it tends to be more their junior members of staff that I deal with...the surgeons are more often than not in the theatre...(Hospital pharmacist R)*

For pharmacists, a benefit of being well-integrated into a clinical team seems to be that it allows greater input into the 'clinical management' of the patient. Analysis of data pertaining to this theme suggested that doctors see themselves as being the 'team leaders' within healthcare, who take overall responsibility for the patient, managing the patient and making decisions about their treatment. The GP and hospital doctor quoted below placed their professions firmly at the head of the team.

*...well, the GP's the head of the team of course. I don't think of it in terms of status, but I guess I see it in terms of who has the co-ordinating role...if I'm talking about all the other members of the team as well... everybody's feeding their own bit of specialist knowledge into the team, and it's the GP really who takes ultimate responsibility for the*

*patient and the patient's management, so leader of the team I suppose, and with everybody else feeding in on a level. (GP B)*

*... within critical care, we're...one of the leading areas of multidisciplinary team management, and so we would see ourselves as very equal professionals, from the point of view of being a medical professional, a nursing professional, a pharmacy professional or a physiotherapy professional. However, someone does have to take a leading role within that team, and...it normally comes to the medical team to lead...but I hope both personally and as a team, we tend to treat our pharmacists as a fellow professional and very valued member of the team. (Hospital doctor A)*

Two further doctors, quoted below (a GP and a hospital consultant), both said that they would not consider pharmacists as 'not clinical' or 'non-clinical', yet do not seem to see pharmacists as being clinical in the same way as themselves. When questioned on this topic, these doctors found it difficult to decide on appropriate terminology for the work that pharmacists do – in the first quote, the GP says that pharmacists do deal with illnesses and medicines, but conveys a sense of pharmacists as more peripheral than the 'centralised' GP. Similarly, the hospital consultant says that pharmacists form 'part' of the clinical management of patients.

*It is [clinical] in a way because they are dealing with patients first of all, they're dealing with...all types of illness and the medications, so yeah, I can't say it's not clinical, yeah, they're dealing with slightly different, I think we're sort of centralised and they're on the outskirts, trying to bring everything closer to us in the middle, that's how I see it I think, but yeah their work is clinical. (GP E)*

*Respondent: .....part of the job [pharmacists] do is clinical, but...they don't go and examine the patient, so from that point of view, it doesn't fall into the clinical part but I think non-clinical would be an inappropriate word for them because they still form a part of the clinical management of the patient...*

*Interviewer: So in terms of the role they fulfil is there a different word you'd use to describe them overall?*

*Respondent: I'd rather use the word clinical support service but again I think that is not, yeah I mean, no I don't know, sorry, I'm caught out there. (Hospital doctor E)*

The pharmacist quoted below thought that the public may see pharmacists as having little decision making power compared to doctors:

*I think the public think that the doctor, erm, is in charge of the pharmacist, and that if the doctor says something then the pharmacist has to do it. Because I've had that conflict sometimes, where I've not been happy with what the doctor's dispensed, or whatever, and I say, 'no' and I've had patients say, 'But the doctor's told you.' (Primary care pharmacist C)*

A hospital pharmacist seemed to convey a similar notion in relation to pharmacist characters in television dramas, which he thinks can portray the pharmacist as passively carrying out the doctor's orders:

*...whenever you see Casualty or Holby City it'll just be some guy in a white coat in a darkened room, just giving the doctor controlled drugs, or whatever he wants. And you*

*get quite angry at the TV, going 'this is so unrealistic! Why can't we have a decent pharmacist who is more like what we do?'...(Hospital pharmacist S)*

In the two following quotes, a community pharmacist and a GP, present the reasons that these interviewees gave for claiming that community pharmacists are not clinical. This is due to the skills of the pharmacists themselves, and also the premises.

*...I personally don't think that community pharmacy as we've got it now is the right environment for that kind of intense clinical stuff, we need different sorts of clinical community pharmacists, they need to be in a different setting. (Community pharmacist O)*

*I know that community pharmacy, there's a move within community pharmacy to move much more towards a kind of managing minor illness role, and I don't think they've got the expertise for that, and I would resist that... I'd be very wary of it, because I don't think that they've got the, A, diagnostic skills, and B, got the kind of set-up, I mean the whole set-up of a commercial shop, often very small, you know, it's not a, erm, a kind of, I don't know, it's not conducive to it. (GP B)*

*they're not gonna do a proper job.' They don't have the confidence that the pharmacist can do it, and they're also worried that we're taking on a lot of their services, that really they should be doing, as far as they're concerned. (Community pharmacist S)*

The two pharmacists who work for PCTs, and therefore have experience of working with many different community pharmacists, both seemed to perceive variation in how clinical community pharmacists are. The first pharmacist here seems to suggest that some elements of community pharmacists' work is clinical, albeit in a different way from what is understood as clinical pharmacy in the hospital setting.

*In a community pharmacy it may be slightly different, but you know you'd be looking at advising patients directly, erm, and you may be doing, point of care tests and that type of thing, but I still think it's the interaction with the individual is what's involved...it's not really a clinical thing sticking labels on boxes, that type of thing, i.e. dispensing, because there's other people or even robots that can do that. So they do have to be interacting with the patients more and explaining how they use their inhalers, checking if they're having problems with their medications and answering questions...Or doing MURs...those sorts of things where it's interacting with the patient, talking about their medication, seeing how we can do better than we're doing at the moment, that type of thing. (Primary care pharmacist D)*

### 7.2.3 The minor medical practitioner

A further issue, cited as a defining factor of clinical work, was the diagnosis of illness. Doctors differentiated pharmacists from themselves on the basis that pharmacists do not examine patients to reach diagnoses:



*Clinical actually means the taking of detailed history and examining the patient and understanding what the normal and the abnormal variables are...that's how a clinician is trained, whereas pharmacists are not supposed to be trained like that because that's not their job, their job is to understand the basic principles of prescribing and pharmaceutical prescribing...they don't go and examine the patient...(Hospital doctor E)*

*I would never expect a pharmacist to know how to diagnose a medical condition, because...to gain a diagnosis is beyond their remit as far as I can see, and that's where my training comes in...also when it comes to investigating illnesses, I wouldn't expect them to come to me and say, 'you've done the wrong investigation here, you need to do this that and the other'. I would say that's where my expertise and my training enables me to diagnose medical problems...in terms of...pharmacological therapy, that's where their skills lie...(Hospital doctor C)*

*Interviewer: What is the difference between a pharmacist and a doctor?*

*Respondent: Oh I think it's to do with diagnostic skills...wide...management of illness beyond the narrow scope of drug usages...my impression is [pharmacists] learn about illness, and...treatment of illnesses...how drugs react together, but what they're dealing with is...an already diagnosed illness, rather than making the step of making that diagnosis, I don't know but I assume that they don't get the diagnostic training. (GP B)*

Lay pharmacy users made a similar differentiation:

*Interviewer: What's the difference between a doctor and a pharmacist?*

*Respondent: The doctor has to diagnose. (Hospital pharmacy user D)*

*... a doctor has the ability to diagnose, whereas the pharmacist is mainly just dispensing or offering advice as well. (Hospital pharmacy user F)*

*...a doctor I suppose examines you, and sort of, yeah, well a pharmacist wouldn't examine you in the middle of a chemist...Whereas a doctor would examine you and refer you...(Community pharmacy 1 user F)*

While the quotes above clearly demarcate a pharmacist as someone who does not diagnose, some interviewees' responses did seem to allow pharmacists some sort of diagnostic role for minor illnesses. This quote from a GP seems to imply a 'limited spectrum' of 'minor illnesses' that pharmacists could perhaps diagnose.

*...[pharmacists] don't have specialised knowledge of examining patients...they just have this one aspect that they're very skilled at, but they don't have necessarily the other skills of examining and making, erm, diagnoses. Some minor illness and those sort of things that are now within their remit, but not as broad a diagnostic spectrum. (GP C)*

However, several interviewees, both community pharmacists and lay pharmacy users, provided examples of pharmacists examining patients and making diagnoses. Two types of observable physical symptoms in particular - eye problems and skin rashes (mentioned five times and thrice respectively) were reported as being presented to community pharmacists to examine:

*... if it's a rash it's, 'can you show me where it is without embarrassing yourself?' If not, we go into the consultation room and have a look at it there...(Community pharmacist O)*

*I just wanted some advice on me eye, which [the pharmacist] gave me, she prescribed some cream. And then last week, me grandson was quite poorly and we came again for some advice and she had a look, so she's quite good, yeah. (Community pharmacy 2 user G)*

This hospital pharmacist expressed some discomfort about the 'onus' that was on her to diagnose, although she was recently trained (and undertaking a hospital pharmacy diploma), she seemed to have a 'traditional' view of the boundaries of her profession and its work, and did not identify with being a diagnostician:

*...you've got doctors, who are prescribers, we're not prescribers, unless we've done the course and qualified as a non-medical prescribers [doctors] put the pen to paper and sign it, yet we're expected to know the disease state and to diagnose it sometimes...[there is] a lot of onus, especially my diploma...on diagnosing, we don't diagnose, that's not what we do. (Hospital pharmacist O)*

Before consulting a health professional, people generally make their own assessment of their - or another's (typically their child or other person they are a 'carer' for) - condition. Both pharmacy users quoted below seem to describe a decision-making process where they are aware that there are different sources of healthcare that they could potentially access. The lay users quoted below reported using community pharmacists for symptoms that they were unsure about, but thought that the pharmacist may be able to identify and recommend a treatment for.

*...if I had a rash that I was unsure of I'd probably come to the pharmacist first and say 'would you have anything to treat this?'...cos I did come once and they gave me antihistamines and it went without having to go to the doctor's. (Community pharmacy 3 user C)*

*...if you've got something that you don't necessarily need to see your doctor about, because I think they're very well informed, er, dispensing medicines themselves that can be bought over the counter...a bad rash, or a bad cough...something reasonably simple, then I'm sure they could advise you on anything that you need. (Community pharmacy 1 user H)*

Both quotes above convey the idea of the pharmacist as someone who can be consulted as an alternative to the doctor. This provides evidence of an overlap between the work of GPs and that of community pharmacists, as either professional could have undertaken the consultation about those conditions and recommended a treatment. The hospital doctor quoted below seems to describe a similar role for pharmacists, although he uses different language, interestingly he

refers to community pharmacists as 'quasi-medical' and differentiates them from hospital pharmacists:

*...in the community I think they fulfil a slightly different role, they will offer more on the simple advice over the counter...if a patient comes to a pharmacist you know they may well offer quasi-medical advice, and the best therapy for whatever problem they have...so I can see them in the community in particular, fulfilling a more holistic niche, where they have to do a little bit of disease assessment, a little bit of disease diagnosis from the history taking, and then choose the best therapy...(Hospital doctor C)*

This quote from a lay pharmacy user expresses a similar view of the pharmacist as possessing medical knowledge:

*...and I think these days they give people advice on illnesses...somebody who has some knowledge of minor illnesses, I would say they need some medical knowledge now, because otherwise they can't give advice on it can they? (Community pharmacy 1 user J)*

When people experience symptoms with which they are familiar, they often 'self-diagnose'. Therefore, they do not consult a health professional to find out what is wrong with them, but to obtain a treatment for the condition that they have 'diagnosed'. The lay pharmacy users below give examples of using community pharmacists in this way.

*Interviewer: What's the difference between a pharmacist and a doctor?*

*Respondent: Well it's just the level at which they can help you I suppose, if you come in and you say, 'my son's got a cold-sore have you got cold-sore cream for like young people?' they can help you with that. If you come in and say 'he's got a hideous fever and he's come out in a big red rash' they'll just say 'go to the doctor'. So it's that level of severity and like from that level down they can say 'that'll sort it out, that will', once it goes above that it's 'go to the doctor'. I suppose the doctor's no different is he? Once he gets above that he says 'go to hospital'. So it's all about kind of knowing what they can diagnose and can't. (Community pharmacy 3, user A)*

*Respondent: ...once when we were on holiday...I had chronic diarrhoea...and I went to the chemist and said, 'I've got this problem is there anything you can give me?' and he said 'oh yeah this is what you want' and it did the job...it's that, the minor sort of ailment thing that I would go and ask advice on 'what would you recommend...?' I mean...if that diarrhoea persisted, even with medication, then I wouldn't go back to the pharmacist, I would go to my GP and say, 'this is, I think this is something more serious...'*

*Interviewer: So initially it would be the pharmacy?*

*Respondent: Yes, it's a self-assessment basically, you have to, so anything that I would call minor, relatively minor anyway, then I would speak to a pharmacist, go into a chemist and say 'can you help me?' (Community pharmacy 1, user I)*

In the examples given above, the lay users are effectively asking the pharmacist to 'prescribe' a treatment. Community pharmacies stock a range of medicines which are available without prescription, both 'pharmacy medicines' (P-meds) which are available only from pharmacies, and general sales list (GSL) medicines, which can be sold from other retail outlets – these can

be referred to collectively as 'over the counter' medicines. Community pharmacists were described as a source of information about products available over the counter by several participants in this study. Both GPs and also hospital doctors, reported referring their patients to community pharmacists for advice about which medicine would be the best one for their condition:

*...I encourage people to talk to their pharmacists about over the counter type treatments. (GP D)*

*...I feel that the pharmacist knows more about over the counter medications that are non-prescribable than I do, so if there are simple health problems, like, the last time I remember telling a patient to go and talk to their local pharmacist was about a thrush infection and they wanted to know what they could take...I gave them a possibility, but I said 'have a chat to your pharmacist and see what else they've got to offer'. (Hospital doctor C)*

Further evidence of this 'prescribing' role for community pharmacists is provided by the quotes from a pharmacist and lay pharmacy user below:

*... a lot of people...ask questions over the counter as well, about minor ailments and things, what I would recommend to them, sometimes I'll have doctors and nurses ringing up and asking me what product's best to give...(Community pharmacist T)*

*Respondent: Just from seeing adverts and stuff like that I thought that you could come in and [say] like 'I'm an insomniac I can't sleep, what do you recommend?' that kind of thing, they would have an idea...[and be able] to say 'well this is better than that one'.*

*Interviewer: For a product?*

*Respondent: Just for a product yeah. (Community pharmacy 3 user B)*

In order to fulfil this role, the importance of pharmacists having a confident and convincing manner was raised by support staff based in different pharmacies. From their point of view, it was important that pharmacy users were convinced by the pharmacist so that they would purchase products, and so that they would want to come back:

*...the pharmacist has got to be confident...a couple of times I've seen customers come in, and [pharmacists have been] like, 'ooh, I don't know', or, 'you could try this...but I'm not sure what it is,' and I wouldn't feel confident buying anything, if they didn't really know what it was. I know the pharmacist can't know what everything is, but I just think that they've got to be confident enough to recommend something. Or else I don't think I'd buy anything. (Community support staff C)*

*...we've had pharmacists who work in here who don't particularly like coming over the counter to give advice...some pharmacists just don't like recommending things and although they would say to customers, 'take this for this', or whatever, they would still think you should see your GP, where there's other pharmacists who like being on this side, and like giving advice to customers, and like recommending products and being helpful generally. (Community pharmacy Support D)*

Community pharmacists are also consulted when people have a particular product in mind and they want the pharmacist to 'approve' it before they use it:

*...if they see things in magazines or hear about things on the television then they'll often come to the pharmacist, perhaps after they've been on Google (laugh)...read...about something that would lower your cholesterol or be good for your arthritis...they'll say 'I've read such and such is really good and can I get it or do you sell it?' I think they'd like it as reassurance of something they've read so they might go and ask the pharmacist for clarification, or to say 'Yes I've heard of a study with that and it looked quite good,' or, 'I've not heard of it.' Something like that. (Community pharmacist R)*

The data presented in this section have shown several ways in which community pharmacists examine and diagnose illnesses and recommend or prescribe medical treatments, and that their ability to do so is appreciated by lay pharmacy users. However, the quote from a lay pharmacy user below presents a different viewpoint, and suggests that this person chooses to use the pharmacist in a more limited way, in that he will decide that he wants to obtain a particular product, and might ask the pharmacist for further information about that, but would not consult them about symptoms, or even usually expect them to recommend treatments:

*...if we were looking for a certain product, and you wanted more information on it, or an alternative, then you'd ask the pharmacist, but I wouldn't have thought of coming in with specific, 'I've got this, can you help me with that? sort of thing.' (Community pharmacy 2 user H)*

#### 7.2.4 A valued alternative to the GP

The section above showed that there is an overlap between the work of doctors and pharmacists in the areas of diagnosing and advising on minor illnesses, and prescribing treatments for these illnesses, and that people sometimes choose between the two. Analysis of the data suggested specific factors which sometimes encourage the use of the community pharmacist instead of the GP, and these are the subject of this section. The community pharmacist as a 'preferred' source of healthcare, was mentioned by several lay pharmacy users as well as community pharmacists. Reasons for choosing the community pharmacist were accessibility, approachability, perception of the pharmacist as having more time than the GP, not wanting to use the GP for something too minor and wanting to avoid doctors.

Firstly, community pharmacists are recognised as being accessible because they can be consulted without appointment, unlike the GP:

*Well I think if people've got minor ailments you would go to the pharmacy, especially as you can't get an appointment at the doctor's for I think it's about three weeks...I would think for anything minor...this would be the first port of call, because there's always somebody here. (Community pharmacy 1 user J)*

*... they want somebody there who's accessible to talk to, and that's the one thing we've got going for us really, you don't have to make an appointment usually. (Community pharmacist Q)*

*Interviewer: ...what would you say is unique about pharmacists...?*

*Respondent: Er, I think we're more readily approachable, because with other health professionals you've got to make an appointment to see them, with us you just walk in, and you can talk to a pharmacist, and I think we're just more approachable...I'd say that was the main difference between us. (Community pharmacist T)*

Lay clients may choose to consult the pharmacist because they think they will give them their time:

*That they're approachable, that they were happy to speak with you, that they've got the time to do that, which I always find that they have...(Community pharmacy 2, user C)*

Indeed, the community pharmacist is sometimes viewed as better in this respect than the GP, both in that they are more engaged listeners, and also more sympathetic to the problem that the client is presenting with:

*Well I can talk to these [pharmacy staff] better than the doctor. He's just on the computer to be quite honest...(Community pharmacy 2 user G)*

*... usually you can talk to them better, to a pharmacist better than a doctor...Doctors, you try and talk them about something and they just don't wanna know, I've got a spine problem... went to the doctor's, they just fob you off...say, 'well you're on pain killers'. At least when you come to the chemist they might not be able to give you anything but they'll listen to you, give you a bit of advice if they can, doctors don't...(Community pharmacy 2 user K)*

This community pharmacist's understanding of the same issue corresponds closely with that expressed by the lay users above:

*Sometimes they just don't wanna go to the GP cos he's, "can't be bothered". They just fob me off in five minutes.' Whereas a pharmacist has got the time...(Community pharmacist S)*

Similarly, in the community setting, this GP acknowledged that people may not always want to consult the GP, and the pharmacist may sometimes be a preferable alternative. She also points out the potential for user anonymity at the community pharmacy, where users can obtain treatments without having to book an appointment, and she mentions that they can 'pick up' what they need, which implies that their visit to the pharmacy, and any encounter with the staff there, will be brief:

*...sometimes as a starting point before people even reach the GP, because you know lots more people go to the chemist than would come to the GP, you [have to] make an*

*appointment to come and if you don't like doctors or nurses...or you've got a phobia you wouldn't bother to make an appointment, whereas you can walk into a pharmacy, pick up whatever you wanted...(GP E)*

This community pharmacist provided an interesting anecdote, which encompasses the issues of the lay user seeing him as logistically accessible, and also 'less busy' than the doctor:

*...[a client] came in to me many years ago and said...'Hope you don't me asking you see, but I'm asking you because the doctor's so busy.' So the inference was that we're not as busy as the GP, therefore she could take my time and it wouldn't matter quite so much. That could say in a way she felt the doctor more important, but in another way it was quite a compliment in that she felt she could approach me...It didn't bother me, it just sort of amused me a little bit. But it led me to think that you know some people, they don't feel they can ask the doctor often because of time constraints, whereas they could ask the pharmacist so they do perceive us as being more accessible and approachable, because of being under less time pressure. (Community pharmacist P)*

This quote from a lay pharmacy user suggests that he will perhaps wait to 'bother' a doctor until he knows that the complaint is too serious for the pharmacist to deal with:

*... I've got two little kids so if there's something wrong with them I'll come in and say 'the eldest one's woken up and he's got this that and the other, is there anything you've got for that?'...so I tend to come here for that and then bother the doctor, sort of use it for a first port of call...(Community pharmacy 3 user A)*

This lay user denotes the pharmacist with an 'in-between' role in her system:

*I just see a pharmacist as...like a buffer zone in-between...doctors and checking out yourself online. (Hospital pharmacy user G)*

Interestingly, this lay user reflects that while the pharmacist can certainly be a convenient source of medical advice for people such as herself, she is not sure whether this is what they are 'supposed' to do.

*...sometimes it's easier to speak with them, and then they'll suggest if you do need to go to the doctor's. But whether it's fair on them I don't know...I don't know that's if that, the role they play, their official role. (Community pharmacy 2, user C)*

### 7.2.5 Summary and comments

This section has presented the concept of the pharmacist as a clinical practitioner. Clinical work was considered to be defined by several factors: having information about the patient's condition, which allows the treatment to be matched to the individual patient, and being integrated into the clinical team. Both of these were mentioned several times by pharmacists, and there was an inter-sector difference, with hospital pharmacists describing working at the

individual patient level, with access to detailed information about their condition, and being integrated into the health care team in the hospital, while generally community pharmacists were seen to have less information about patients and also to be less integrated. These issues were raised by pharmacists and by doctors. Some doctors took the view that pharmacists did not examine patients, and both they and some lay users cited this as a factor which differentiated pharmacists from doctors. However, reports from other lay pharmacy users and from pharmacists, provided evidence that community pharmacists did actually examine physical symptoms, and 'diagnosed' conditions and 'prescribed' over the counter treatments.

The community pharmacist as a 'preferred' source of healthcare (over the GP) was mentioned by several lay pharmacy users as well as community pharmacists. Reasons for choosing the community pharmacist were accessibility, approachability, perception of the pharmacist as having more time than the GP, not wanting to use the GP for something too minor and wanting to avoid doctors. This seems to be a complex area and on every point mentioned there was variation in the views expressed.

### **7.3 The social carer**

#### *7.3.1 Introduction*

The 2005 pharmacy public health strategy<sup>25</sup> mentions 'assessing the health and social needs of the local community' as a role for pharmacy, although this refers to strategic planning. There is little explicit mention of pharmacists' input into the social needs of patients in the policy literature, apart from the following role for pharmacy described in the same document:

*providing information and advice on health improvement and signposting to other services.*<sup>25</sup>

This section is about pharmacists and their work with individual pharmacy users that is not directly related to medicines.

#### *7.3.2 The community figure*

The image of the pharmacist as a key figure within the local community arose repeatedly through the interviews conducted for this study. A community pharmacist gave the following response to the first interview question asking him to describe a pharmacist:

*...pillar of the community... somebody that they can obviously come to with anything.....a confidante, who's trustworthy...who can give them information about problems... be it social, emotional or physical. (Community pharmacist S)*



Participants in two stage one interviews described figures who represented community pharmacists they had come across previously:

*CP F: People will know him won't they?... he's the kind of person that would probably have quite a good contact with customers, he'll have a bit of a customer base won't he? Bit of a loyalty figure. (Community pharmacist group interview 2)*

As well as being perhaps beneficial to pharmacy users psychologically or emotionally, interviewees suggested that pharmacists could find getting to know patients on a personal level rewarding

*CP A: Yeah she'd have a good relationship with her patients.*

*CP B: Yeah, they'd be people that she knew and they would trust her*

*CP A: And they'd come back for her help and tell her how things had changed and been made better since she's done that and so she'd probably get quite a lot out of it. (Community pharmacist group interview 1)*

This pharmacist reported that this sometimes happens in the hospital sector as well:

*...one patient actually bought me a wedding present, she'd been in and out of hospital for such a long time...I'm on an acute surgical ward...patients come in and go home [quite quickly]... but we do have some long term patients...you do get to know them quite well...sometimes...you get to know all about their families and it's really nice actually...(Hospital pharmacist R)*

However, often pharmacists do not have a chance to get know their clients, and some who took part in this study expressed regret about this – pharmacists in the second stage one group quoted above contrasted the relationships that exist within a typical village pharmacy set-up, against the large shopping centre pharmacy that community pharmacist 02 works at:

*CP B: That kind of place [the village pharmacy] is a whole different one to the Trafford Centre or the city centre, you don't see the same patient do you?*

*CP A: Hardly ever, we see a few and when I've done stuff for them to help them and they've come back and said 'you really made a difference', and you just think 'ah that's so nice' but it's hardly any of them, hardly any. (Community pharmacist group interview 1)*

The following quote from a community pharmacist conveys a similar feeling:

*Interviewer: ...do you have a chance to get to know regular customers round here?*

*Respondent: No not really I don't and that's the bit I miss to be honest, 'cause everyone knew me where I was previously, and I knew most of them by their first names...so you do miss that contact...(Community pharmacist P)*

The community pharmacist quoted below thought that lay pharmacy users preferred to deal with the same people when they visit a pharmacy:

*I think they tend to like to see the same faces everyday so they want someone they know personally so continuity, they want someone who knows what their medication is, what their problems are so you know who you're dealing with to start with, instead of having to explain everything again to a new person...(Community pharmacist S)*

This point was further substantiated by a pharmacist who divides her working week between two different pharmacies, one of which is in a village setting:

*In my village pharmacy they do...I think your community pharmacy that's where they really know and sometimes they come in and if I'm not there, they'll come back the following day and vice versa if they wanna see my colleague and I'm in, they'll come back and see him. (Community pharmacist R)*

Several lay pharmacy users spontaneously mentioned that they preferred to use the same pharmacy for their prescriptions, and the woman quote below cites the fact that staff at the pharmacy know her as a reason for doing this:

*That's why I come here, because I get me prescriptions here, and they know me. They know what I take. (Community pharmacy 2 user B)*

The issue of trust was a recurring one within this area and has already been alluded to in some of the quotes presented in this section. This hospital pharmacist recalled a community pharmacist she had worked for in the past and cited trust as an important element in the relationship he had built up with the local community over time:

*Because he'd been there so long and the community liked him so much, the customers didn't come there for the nice clean shop or anything like that, because it was a bit of an old wreck, but they came there because they trusted him. (Hospital pharmacist P).*

The quote from a pharmacy user below refers to his experiences over decades of using his local pharmacy, which is in an affluent city suburb, with an affluent population and provides evidence that trust is indeed an important element from the lay pharmacy user perspective:

*... there used to be a Mr [Smith], going back many years...Now Mr [Smith] was always there, he always made up the prescriptions...and you got to know Mr [Smith], by name. I wouldn't know any names here at all you know...so there's not that personal relationship now, and I would've trusted Mr [Smith] to ask him probably more than any of these here. That's not because I disparage them, it's just that not knowing them, and there's not that relationship. 'Cause it was his own business you see, er, that's the difference I think...they tend to work on shifts so it's never quite the same person that's making up the drugs. (Community pharmacy 1 user I)*

Finally, two GPs described a preference for a regular local pharmacist who they got to know over time:

*...where I used to work...there was two independent pharmacies and Boots...our experience was that the independent...we built a better relationship with*

*them...because...in Boots the pharmacist was always changing...it wasn't even the same person all week...So the big chain was a much less sort of functional relationship I guess than the independent who was the same guy for the 12 years I was there...in the evening if I wasn't sure if they'd got something in stock or I wanted them to hang on...I'd always ring the independent pharmacist...say to the patient..., I know [pharmacist's] got it, go and take it down to that pharmacy.'...cos I'd worked with him for years, and I got to know him, whereas Boots, a different person all the time, you never knew who was gonna be in there. (GP B)*

*...probably less good advice...if somebody's there longer then they get to know the local GPs then they become more experienced...(GP A)*

This pharmacist described his experience of buying a pharmacy in an area where a high proportion of the population were asian, and he thought that two factors – being asian himself, and also learning the local languages, had helped to gain the trust of the local community:

*...it was a very asian-oriented area. And all my staff were English. I was the only asian guy there...over the years I've picked up the lingo...Urdu...Punjabi and Hindi, those are the three common languages that they speak here...I speak Urdu pretty fluently, and Hindi. Punjabi I can get myself by...my father speaks a language called Gujurati which is again similar. But it helps with the rapport, really does...that's where we made the business flourish, cos people trusted you, because you could understand what they're trying to say...we used language line, a translation service, over the phone... If I wasn't there...if they were struggling to make themselves understood... my locums were mostly asian...I had regular locums in, or a manager in, that was asian...I know it's discriminatory, but it was just to make life easier for the staff more than anyone else... most of them could speak the language, and one particular regular pharmacist that I had, and she was fantastic. Really was fantastic with the patients...I think, that the language was a big barrier...because when I first bought it, the owner was asian, but he had an English pharmacist in, and they struggled...and once they had an asian face, it sort of, exponentially, the business rocketed, it really did. (Community pharmacist S)*

Two community pharmacists raised the issue of empathy, and seemed to enjoy interacting with pharmacy users with whom they have something in common:

*[at university] the particular thing that I enjoyed was the counselling aspect over the counter..And cos I'm a Mum as well I tend to be able to give that much more when other mums come in, advice on feeding, advice on children's medicines, I really enjoy that side of things as well... (Community pharmacist R)*

*Respondent: I went into community to start with and I quickly found I didn't like it...I was very unhappy for the first few years... I didn't like the interaction with the patients either...I think that's probably something that changes as you get older, but...didn't get on with the staff particularly, and was just generally miserable...*

*Interviewer: So have your feelings about interacting with pharmacy patients changed?*

*Respondent: Yeah. Now it's one of the best bits of the job, and the staff are...as well. I've always got this saying that when I was younger I didn't really like locumming cos it was full of middle aged women talking about their kids all day, and suddenly I woke up one morning and found myself a middle aged women talking about the kids all day, (laugh) and you fit in, and you're part of the group...I think your social skills improve,*

*and you've just got more in common with the people that come in quite frankly. And your life experience adds to it...I think when you're 22 and 23...you don't have that experience of what it's like to be ill, to be looking after people that are ill, to be pregnant, to be with somebody who's dying...(Community pharmacist O)*

### 7.3.3 An approachable manner

In terms of building relationships with their clients, having an approachable manner was cited as a very important element of pharmacists' identity. A community pharmacist, (who had many years of working in different community pharmacy settings and also of employing and supervising pharmacists in a 'superintendent' post) felt that a warm, approachable manner was something that pharmacy users really valued, although he did not see this as a universal trait, but perceived variation between individual pharmacists.

*I think it's approachability and the way they're greeted...if it's a friendly, warm, 'How are you Mr Jones? How are you getting on?' That sort of thing, then they just love that, cos the GP often doesn't have the time for that. A lot of pharmacists don't, but really it doesn't cost a lot to say that to people, and it can make a difference to them, that you are presenting an environment for them, where they're welcome for a start, and they feel free to ask for help and advice if they need to...(Community pharmacist P)*

This point is supported further by this quote from a member of community support staff.

*...it's the way you come over to a person as well, so if you have got a good pharmacist...patient-friendly person...nice staff...greeting people in a nice manner, and seem quite interested...giving them advice, I think they appreciate that. I think if you go into a pharmacy where the staff aren't as friendly, and the pharmacist is a bit abrupt...then people will probably not go in there. (Community support staff B)*

This hospital pharmacist thought that having some kind of personal connection and interaction with pharmacy users was valued by pharmacy users, whether in the hospital or the community:

*...people can develop quite a rapport with their community pharmacist that they see. People develop a rapport with us when they're in hospital, and often when they're compus mentus, come round and have a chat and ask what you're doing at the weekend, and stuff like that, so...a little bit of normality helps a lot of people probably.(Hospital pharmacist Q)*

This hospital pharmacist found that patients sometimes would share give her more information than they had to the doctor, and thought that the manner or 'personality' of the health professional made a difference:

*...having the personality that people will come and ask you things...I like to talk to people...and they start to talk to you...they will divulge all sorts of personal things to you, sometimes without you even asking...so that sort of personality, inviting them to come and speak to you does help cos all sorts comes up from that...you do find that*

*patients will tell you things and you know, you ask 'have you mentioned that to the doctor?' (shakes head)...(Hospital pharmacist R)*

The following quotes from lay pharmacy users confirm that the pharmacist's manner is indeed important to the lay public, and these interviewees gave positive examples of their interactions with community pharmacists:

*Respondent: ...they tend to employ the right sort of people, well they all seem pretty friendly at work.*

*Interviewer: Do you think that makes a difference?*

*Respondent: Oh massively yeah, there's nothing worse than going into sort of a medical environment and then if everyone's really stand-offish then you're out of your comfort zone to start with...you're going to struggle to open up and discuss sort of medical issues. (Community pharmacy 3 user D)*

*She's welcoming when you come in and a friendly face...even if they're new, they're still open and forward to go to you and it's the general, way they approach you, you know, they don't like turn their nose down at you... (Community pharmacy 2 user I)*

The section above showed that community pharmacists were often seen as having more time for patients than doctors, but participants suggested that hospital pharmacists were less likely to seem to be approachable or to have time to talk to lay clients. This hospital pharmacist speculated that lay users of pharmacy services would perceive the manner of some pharmacists to suggest to patients that they wanted to retain a certain distance from them:

*I think they look on doctors, they put doctors on a very high pedestal...because essentially they're there to get better and the doctors are there to make them better...I think they'll see nurses and coming to their every beck and call... they're there all the time, they have a buzzer, 'a nurse comes if I press my buzzer', I feel very sorry for them sometimes. And then pharmacists, I think they think, a lot of impressions I get is they think that pharmacists are either too busy, or, not stuck up, but a bit too proper, to sort of get into the nitty gritty and things, so when you have pharmacists that do, they're a bit shocked, erm, and it shouldn't be like that, but I can imagine some pharmacists do come across like that. (Hospital pharmacist O)*

This hospital nurse makes a similar point, confirming that his own work is more patient immediate-demand led, as opposed to the pharmacist's more 'ordered' work. He again makes the point that pharmacists 'do their work' on a ward and move on:

*I suppose there is a certain element of task-orientation to the pharmacist's role in terms of they've gotta go and see everybody's cardex, they've gotta do the TTOs or if there's anything in the tray...to dispense...Whereas I suppose with ours if a patient buzzes us or something else comes up, it's a bit harder to forget sometimes what we've got to do in the next five minutes, I mean pharmacists'll still get queries, something'll come up and they'll have to check it with the GP but still on the ward they've got to go round and see every drug chart and then they can move on and go to the next ward, and do the job there, that's probably a difference. (Hospital nurse E)*

This community pharmacist also thought that the personal demeanour of some pharmacists may well make them appear unapproachable and suggested that the structural organisation of

the hospital may make it more difficult for patients to approach pharmacists in than in the community setting:

*I think it's more the setting, as well. Erm, cos some people do find different pharmacists unapproachable because of the way they are, but some are more open...more friendly, ...smiling, and I think it's more the set-up...In hospital they probably won't be able to come and just approach you...(Community pharmacist T)*

The following quotes from lay hospital pharmacy users convey that they have found pharmacists to have a reserved, sometimes cold, manner:

*...it's nice when they are actually friendly, because it doesn't happen often...when I think of pharmacists, I think of a certain atmosphere of sterility, both in their working environment and in themselves, so you take your piece of paper, they give you what you've asked for and you leave, but you know, the very few occasions when they have actually been quite personable, it's like, 'oh that's nice!' I mean it doesn't make a big difference but it's nicer. (Hospital pharmacy 1 user G)*

*... I'd prefer someone a bit more friendly, some of them seem, very professional but they don't seem to have the other side, the friendly sort of talkative side to them. (Hospital pharmacy user F)*

This community pharmacy client expressed a similar idea. It is, however, notable that although he begins by describing a general impression of pharmacists as 'non-personal', he then goes on to qualify that in his experience he has not actually usually found pharmacists to be like this.

*Well the first thing that occurs to me is that they preserve a very non-personal front. Although that's my thought about a pharmacist as an abstract. If I think about the pharmacists here, they've got a very personal front, they're nice people to deal with. [But] my first thought is that, they're an impersonal, they're doing a professional job, and so you wouldn't discuss the weather with them. (Community pharmacist 1, user D)*

#### 7.3.4 Social issues

Working in the community setting, pharmacists sometimes have knowledge of patients' home lives. The two quotes below are from interviewees who recalled previous work in community pharmacy where the pharmacists and pharmacy staff had been aware of the social needs of their clients:

*...[the pharmacist] was quite soft, so a lot of the elderly patients would phone up and say 'I can't come and pick up my prescription I'm not feeling well enough, can one of the girls drop it round?'...and we'd go...and she'd be like 'could they pick up some bananas on the way?' So we'd end up doing a bit of their shopping en route for them cos we were on a little row of shops...there was one woman who used to phone up all the time, and then when she stopped phoning, he got worried about her and went round to check and she'd fallen over....he was quite inspirational, cos you know he wasn't just dishing out tablets, he really helped people...he really cared about patients...(Hospital pharmacist P)*

*...when I worked in community, we used to have a house-bound patient who could not get out and if they needed things that we do keep in the pharmacy like toiletries etcetera, loo rolls, and they had a delivery on that day and we'd price it up and they would have it. And it wasn't just 'oh we can get some extra money', that patient's needs were being met, not necessarily their medical need, but then it will impact on their medical need if that patient can't wash and take care of themselves...it wasn't about the five pounds or whatever, it was that that patient has got what they need, for social needs...and if you go to most of the pharmacies that are doing home deliveries, you'll find that, you know the delivery driver knows the patient and knows what their needs are. (PCT support staff A)*

The pharmacists quoted below reported enjoying this type of work:

*I was doing flu vaccinations, in people's homes as well, people who were housebound...So we did a lot of add-on services... It wasn't just a job for me, it was more like social work sometimes. (Community pharmacist S)*

*I've got one guy who's just been diagnosed with hepatitis C, which he was devastated about, and on the same day he'd signed a lease for a flat and the landlord then said, 'I don't want you.' ...he came to me to ask my advice, 'what can I do about this?'...I took him in the consultation room, he showed me this letter, he trusted me with confidential information, which I thought was rather lovely...(Community pharmacist O)*

After medicines have been prescribed, often it is nurses and pharmacists who work with patients to make sure that the medicines are actually administered effectively. For medicines which are self-administered by the patient, this is also about compliance. In the community setting, there are patients who are 'isolated', or have complex medical and social needs. Where there is a good relationship, doctors, nurses and pharmacists can work together on this:

*...district nurses may see a chronic patient of yours, who may be housebound, and you'd not known something, if you've got the rapport with them you'll find out, 'oh well they're not taking their meds properly.' (Community pharmacist S)*

Two GPs reported how the pharmacist can have an important role in working with them to gain access to 'hard to reach' patients, or alert them to the needs of patients.

*...this week where we weren't sure if this lady was getting her drugs for various reasons, bit of a complicated story...we weren't quite sure if the person who was supposed to be looking after her was in fact looking after her, it was all a bit tricky, and so the pharmacist and I agreed that next time a prescription was requested the pharmacist would say that he couldn't dispense it until I'd reviewed the lady, and that did enable me to get in the house to review her, which actually was clinically quite an important thing to do, and I hadn't been able to get in for all kinds of reasons, and then we had a conversation about the best compliance aid for her, so it was kind of part of a management plan...(GP D)*

*...sometimes you get a phone call from a pharmacist saying 'we're worried about such and such a patient, have you seen them recently?' and we'll say 'well actually no not really at all for such a long time' so it's quite useful, I've often written to patients saying 'your pharmacist is a bit concerned about you, can you make an appointment to see me, just to discuss about such and such a thing'. (GP E)*

### 7.3.5 Summary and comments

This section has presented the idea of the pharmacist as social carer.

Firstly, the image of the pharmacist as a key figure within the local community was presented. Community pharmacists thought that they could sometimes build up links with a local community over time and come to be seen as a trusted figure. This was seen as a desirable situation, and several pharmacists enjoyed getting to know patients on a personal level. This was perceived as something that tended to happen in community pharmacy. The theme of a regular pharmacist being more trusted was raised by pharmacists, lay users and also GPs. Also, the issue of pharmacists being similar to their users was raised – both in terms of this being preferable for users of the pharmacy, and also in terms of pharmacists enjoying having things in common with their users.

The issue of pharmacists being approachable was raised mainly by pharmacists and lay pharmacy users, who were in agreement, unsurprisingly that it was preferable for pharmacists to have an approachable manner. A sector difference was perceived here, with hospital pharmacists being seen as less approachable.

Several community pharmacists described the insights that they often gain into the social circumstances of their clients. This was also mentioned by two GPs, but seems to exist mostly at the first dimension of identity, and is not often mentioned by non-pharmacists.

## 7.4 The unremarkable character

### 7.4.1 Introduction

Throughout the course of carrying out the interviews, a repeated sense that pharmacists are a familiar presence, but that pinning down who they actually are was often difficult, was perceived. There are some areas of overlap with themes that have already been presented throughout this thesis. Closer analysis of the data suggested that sometimes a clear or positive identity for pharmacists is lacking. This is not a positive aspect of pharmacists' identity, and is also difficult to map onto specific roles that pharmacists fulfil, or tasks that they actually do, and therefore are not present in the pharmacy policy literature, however, the latest government pharmacy white paper did suggest that:

*public knowledge and confidence in what pharmacy has to offer in terms of improved clinical services and facilities needs gradual build-up.*<sup>28</sup>



Further examination and consideration of the data which seemed to related to this overall theme have been grouped together into three subthemes which are: the anonymous pharmacist, the invisible pharmacist and the uninteresting pharmacist, and these are explored in the following sections.

#### 7.4.2 *The anonymous pharmacist*

Data generated for this study showed that in the hospital setting, the pharmacist is often an anonymous character. The first pharmacist quoted below felt that he was seen as part of a general 'pharmacy' workforce, as shown by the way he had heard nurses referring to him:

*...sometimes [nurses will] just say 'oh pharmacy are here', not like, 'here's a pharmacist and a technician'. (Hospital pharmacist S)*

The following quote from a hospital pharmacy technician shows that he has experienced the same issue with patients:

*...[patients] get confused cos when you say you're from pharmacy, they think you're a pharmacist, not a technician...I used to introduce myself to the patient and say, 'I'm [name] I'm a pharmacy technician'...we are supposed to be getting uniforms so that should help...(Hospital pharmacy technician A)*

In hospital, pharmacists and doctors tend to be the only 'non-uniformed' professions. Hospital doctors and nurses concurred that it was difficult to distinguish pharmacists from doctors because of this:

*...the doctors and the pharmacists don't wear a uniform, so if they're all on a ward round they could be all the same. (Hospital nurse A)*

*No, well...the ones on the wards of course are not wearing uniforms, so you've got name badges but...they're not immediately recognisable no, not like nurses. (Hospital doctor D)*

In the following quote, a hospital pharmacist provides proof of this through her experiences of being mistaken for a doctor by patients as well:

*Interviewer: When you go on the ward rounds do you think patients know who you are?*

*Respondent: Mm very difficult, I'm always, always mistaken for a doctor, they'll come in and ask me questions and I'll say 'I'm not a doctor' and they'll go 'sorry'...if you're looking at their drug chart, they'll go 'are you the pharmacist?' (Hospital pharmacist O)*

*Interviewer: Do you think patients know who [pharmacists] are?*

*Respondent: No I think sometimes they get confused between doctors and pharmacists cos I've had that when I've done some ward-based work...when I go on the ward, as soon as you pick their medication up or something they think you're a*

*doctor, the first thing they say is 'can I speak to you about this doctor?' and you say no you work in pharmacy...[technicians are going to be getting uniforms here] I don't think the pharmacists, but technicians are...I don't know if you'll still be to tell the difference between a doctor and a pharmacist on the ward then, you'll still have that confusion. (Hospital pharmacy technician A)*

When asked if they could recognise a pharmacist in the hospital setting, lay clients gave responses similar to the following:

*I mean I wouldn't know the different uniforms they wore and it would only be from looking at a badge that I would know who anyone was. (Hospital pharmacy user A)*

In the community sector, pharmacists work in a much smaller organisation, and they are often the only pharmacist on the premises, however, several participants said that community pharmacists are often indistinguishable from pharmacy support staff:

*Interviewer: Ok and do you know who the pharmacist is when you come into a pharmacy?*

*Respondent: No, I'd just ask anyone at the desk really. (Community pharmacy 1 user C)*

*There are two or three moving about and I have no idea if there is a pharmacist, there could be three...(Community pharmacy 1 user D)*

*Erm I think you probably would have to ask, I wouldn't say you could definitely recognise the pharmacist. (GP C)*

In a similar way to hospital pharmacists just being indistinguishable from either a general pharmacy, or even general hospital 'workforce', the following quotes from community and hospital lay users suggest that pharmacists are not very noticeable:

*You never really notice them, you just go in, put your prescription in, you know they're up there working...(Community pharmacy 2 user G)*

*...maybe in terms of the experiences I've had they're quite a grey character, that you never really see, now that I think about it. (Hospital pharmacy user A)*

*I imagine the actual pharmacist's probably in a white coat somewhere, but I don't think about it. (Hospital pharmacy user G)*

*We're all very mousey in pharmacy, very colourless. We've been beaten into submission... (Community pharmacist Q)*

As well as being physically 'anonymous', data analysis suggested that sometimes, non-pharmacists are not aware of who pharmacists are, in terms of what they do. This practice nurse described variability in the working relationships that she has had with the pharmacists at

the pharmacy located nearest to her surgery, and seems to criticise some pharmacists for not doing enough to become more integrated:

*...this anonymity, I don't know the pharmacist, I've still not met her...It depends on the pharmacist... another pharmacist, who was quite good and decided to be integrated into the primary health care team...would occasionally come to meetings, to discuss any problems...with prescriptions...stock control...it wouldn't be necessary for the pharmacist to come to that all the time, but it would be nice to meet them every now and again... 'How are things going? Are we making mistakes that irritate you?'...Feedback from patients, and just communicating to try and get the whole thing working smoothly really...(Community nurse A)*

This community pharmacist had made a conscious effort to become closely involved with his local GPs, and explained his views about the importance of pharmacists doing this if they wanted others to be aware of what they do in terms of 'extended services':

*...with GPs, if you haven't got the rapport with your local practices... they'll say, 'well what's the pharmacist? He's just a glorified dispenser, really. He doesn't know too much.'...go out and see your patients...speak to your GPs, go to practice meetings...with the GPs, cos we had the rapport there, they wanted me involved in their processes...you're helping them to achieve their targets, the nurses...you all work together...if you go and talk to them, if you go and show what you can and can't do...put your name and next time he or she has a problem, they may come to you...even now as a locum, I go to practice meetings and discuss what I can do...(Community pharmacist S)*

Other participants suggested that some community pharmacists do not attempt to forge closer working relationships with the rest of the health care team. Participants in a stage one group interview described an older pharmacist who was reluctant to engage with local doctors:

*CP A: Do they usually get involved with the local surgeries?  
CP B: No, they don't like to go over to them...very submissive, pharmacists.  
(Community pharmacist group interview 1)*

And this PCT pharmacist expressed a similar notion, and seemed to think that there was still some way to go for pharmacists to become confident at promoting themselves:

*...we had our non-medical prescribing meeting the other week...I had pharmacists, nurses, physios, podiatrists in there, you've just got to be prepared to work with all these sorts of people. Whereas I think some pharmacists might find that initially a bit threatening...you've gotta be prepared to work with all sorts of other people, business analyst type people...professional clinicians are in the minority in a building like this but you've still got to put your point over...We've gotta fight our own corner...(Primary care pharmacist D)*

The theme of pharmacists needing to promote themselves more was also raised by this hospital pharmacist:

*I mean I think of the main things about pharmacy is that to be a good pharmacist, you need to be a bit of a self-promotionist...you know patients don't really understand what you do, doctors don't really understand why you're there, nurses don't really understand what you're there for, until they actually start interacting with you and then they kinda fill up your job because of the self-promotion that you've done...I think sometimes...pharmacists, they're not actually promoting themselves as much as they could do...I sound like an old fogey but you know a lot more approaching patients and trying to figure out whether they understand their drug therapy, I think it's easy to just walk around the ward picking prescription sheets looking at them and walking out again. I think they could be a lot more pro-active... in counselling patients and what have you also at my last job... my boss there was a very hands-on kind of guy, and he always you know was there promoting pharmacy [and another pharmacist] was really very clinically-orientated and again was always promoting pharmacy as well. (Hospital pharmacist T)*

#### 7.4.3 Lack of visibility

When participants were asked about the portrayal of pharmacists in the media, most responses reflected the absence of this. When asked for examples of famous pharmacists, nine of the 22 pharmacists interviewed could not think of anyone:

*I'm trying to think of somebody who a non-pharmacist would know and I can't really think of anybody to be honest...(Hospital pharmacist T)*

*...there's really bad, erm, media showing of good pharmacists, I don't think there's, you know many famous pharmacists you can name. I think, you know you need to get somebody who's a positive role model or an interesting character maybe onto a TV show or I don't know exactly how we'd do it but pharmacy is crying out for some who kind of represents, you know, everybody here [on the pictures]... maybe we should write a pharmacy drama (laugh) (Hospital pharmacist S)*

*You don't get pharmacists doing an awful lot on TV I mean if they're in a drama they don't do an awful lot or seem to get involved, it's always doctors and nurses...(Primary care pharmacist D)*

*... in things like Holby City and that, there's never a pharmacist, you never see them on the ward, erm and it's all about the nursing staff and the doctors.. in real life the pharmacist is there all the time, and is you know making just as much a difference as the doctors and nurses, but it's not portrayed like that [on television], I think they see us as being boring...(Hospital support B)*

The lack of pharmacy presence in the media was further highlighted when compared to other health professions, and acknowledged by the doctors quoted below, from both the hospital and community sectors:

*Interviewer: Can you name me a famous pharmacist?*

*Respondent: (laugh) no...sorry*

*Interviewer: And if I put the same question to you about doctors?*

*Respondent: Oh yes I could talk to you for half an hour about famous doctors' names and the odd nurse as well starting with Florence Nightingale I suppose, but no, that's terribly unfair isn't it? No great historical figures...(Hospital doctor D)*

*...doctors do tend to be more high profile, the Dr Finlays and all sorts of TV programmes where doctors feature...there may be ones where pharmacists feature but I haven't particularly seen those, perhaps for obvious reasons...I mean like in terms of...I'm not sure if they do have a very strong public image. (GP A)*

No lay pharmacy users could name a famous pharmacist. Most (23/35) said they could not think of any examples (some mentioned pharmacy companies but not actual pharmacists).

Pharmacists were also noted for their absence from news and factual media:

*The public need to understand a lot more around what pharmacists, I mean, the government have talked about this, and it is partly down I think, to our professional body to actually, put, you know, pharmacy on the map really, erm, and they haven't done that...(Primary care pharmacist C)*

*They're invisible in the majority of cases (laugh). They play a critical role, but it's in like in isolation to everyone else...the Department of Health doesn't put pharmacists and pharmacy at the top of their agenda for anything...you see it in the media, you hear it from the minister's mouth, the NHS is nurses and doctors...unless pharmacists...have the same lobbying or support within government their voice will still be unheard...(PCT C)*

*...maybe the people that we need to raise the profession's profile with, should it be the department of health, local non-execs of PCTs, that kind of decision-maker influence, MPs? Might be more important than the public...maybe the PR effort should go to the decision-makers. (Community pharmacist O)*

*... not modern days pharmacists, unless it's something to do with some new drug and they talk to a pharmacist...and nowadays it's all politicians they talk to about new drugs, the Health Minister or something... 'why ain't this drug out?...' (Community pharmacy 2 user G)*

#### **7.4.4 Uninteresting, unfortunate or unpleasant characters**

Overall, the data presented in this study has shown very few explicitly negative views of pharmacists from non-pharmacist interviewees. The doctors quoted below describe pharmacists as 'nice' and 'good':

*I think pharmacists are just quite nice people...it's always pleasant to liaise with them, I can't remember the last time I had a barney with a pharmacist, whereas I can remember the last time I had a barney with one of the junior doctors, or another of my colleagues...I've never really had a heated discussion with a pharmacist. (Hospital doctor B)*

*I can think of plenty of good pharmacists quite easily, I could easily think of half a dozen that I work with regularly that are excellent, thankfully...I don't think I've ever met someone where I've thought well they're a bad pharmacist. I've met plenty of people who I thought were not very good doctors, I've met plenty of people who I thought weren't very good nurses, but I honestly can't think of anyone that has stood out to me that I've thought they're not a very good pharmacist. (Hospital doctor C)*

The following quote from a GP is interesting as her 'real life' experience of pharmacists seems to match closely to that of the hospital doctors quoted above, although she contrasts this with her perception of media coverage of pharmacy, which she spontaneously remarks on as being unrepresentative of the reality:

*You don't see them on the news or in the paper very much, the ones you do tend to be defrauding the NHS (laugh) which I don't think that's typical or anything, that tends to be newsworthy...I think that's cos most pharmacists are tremendously diligent and kind of respectable people who just get on with their task don't they? In a kind of normal way. (GP D)*

The doctors above describe pharmacists as 'good', 'respectable' and 'normal' – all qualities which it could be argued are desirable for any professional person to possess. However, other data can be seen to suggest that when it comes to having a public presence, these traits do not attract attention:

*...there's more things based on doctors and nurses like Casualty...whereas pharmacy's not a particularly glamorous job, you couldn't base a TV series on it, it wouldn't get massive viewings. (Community pharmacy 3 user D)*

*...yeah it's not as glamorous is it? I suppose you don't get films about or programmes about chemists. (Community pharmacy 3 user A)*

*They must think we're uninteresting...We do need somebody, a role model in one of these soaps, because people believe them, because doctors do get a better showing, nurses as well...I do think it matters and we're not happy about how it's portrayed, or has been. We could do with a doctor Finlay of pharmacy and a few interesting characters of who there's been loads. (Community pharmacist P)*

The fictional pharmacist mentioned most frequently in the interviews was a character in the American television drama *Desperate Housewives* (which is shown in the UK). One of the main characters, Bree, a sophisticated and glamorous woman, who is married to a doctor, has an affair with the local pharmacist. The hospital pharmacist below recalled watching the episode where Bree's husband found out about this:

*George the pharmacist, he was erm going out with Bree and then her husband didn't like it or estranged husband, and he came in and went 'women like Brie don't go out with pharmacists, they go out with doctors.'... and I was like, 'that's about right'. (Hospital pharmacist P)*

The following quote comes from a hospital nurse, talking about the professional status of pharmacists:

*[pharmacists]...they probably don't have as much cache as the doctors...(Hospital nurse A)*

The data above suggest that pharmacists lack a strong or interesting presence in the way they are represented to the public, and this was generally expressed alongside a comparison with the medical profession, which was seen to have more, and better coverage in fictional media. Several interviewees also perceived a lack of coverage of pharmacy in the news and factual media:

*It's very negative in the media, if you listen to the 'you and yours' programme, when you get doctors on it's always done with reverence and full attention, when you have a pharmacist on...we've got nobody who's eloquent, who's believable, they always sound shifty, they always put somebody on there that hasn't got a good command of the English language, or hasn't got a good command of putting the argument across, and we always just get attacked...Tim Astell who unfortunately died, he was very good...ebullient...could get his point across...sometimes he had to get it across in a forceful way, but no we haven't got anybody up to the job... (Community pharmacist Q)*

However, analysis of the data revealed that when pharmacists were shown in the media, there actually seem to be plenty of examples of 'bad' pharmacists:

*We're shy (laugh)...We're not really...in fictional or drama very much. And whenever we are, it's always bad (laugh)...(Primary care pharmacist C)*

The pharmacists quoted below remembered seeing fictional pharmacists who were misusing alcohol and/or drugs:

*The only one we've had...was Emmerdale, but he had an alcohol problem and was abusing drugs. (Community pharmacist P)*

*...we tend to be alcoholics as well on television programmes (laugh). (Hospital pharmacist R)*

The 'Desperate Housewives' pharmacist was mentioned again – George the pharmacist, who used drugs from his pharmacy to poison someone:

*...whenever you see someone it's always portrayed as an evil pharmacist...there was an evil pharmacist in 'Desperate Housewives' a while ago...(Hospital pharmacist S)*

Just two lay pharmacy users recalled seeing fictional pharmacists on television one in Sherlock Holmes and one in the drama series 'Doc Martin':

*...only in 'Doc Martin'. She wears the collar in the programme, in the pharmacist's shop. She's like a hypochondriac or something I think...She's a bit dizzy I guess...it's quite comical really, but I think she fancies the doc, you know, it's that kind of situation. But that's one I see...that's what comes to mind. Going into her shop, and facing this woman wearing a neck brace. (Community pharmacy 2 user C)*

The quote above is interesting as the pharmacist is associated with wearing a neck brace and having hypochondria, being dizzy and comical – these physical and psychological health problems, along with being a 'silly' person – who 'fancies' the doctor, (but whose feelings are

presumably not reciprocated) – combine to convey an image of a somewhat unfortunate character.

#### *7.4.5 Summary and comments*

This section has presented data which suggest a general perception of the pharmacist as an unremarkable character as they are often anonymous, go unseen or unnoticed, or are not seen as particularly interesting.

The anonymity of pharmacists was reported by all participant groups, and manifested both in terms of pharmacists not being visually distinguishable either from pharmacy support staff, or, in hospital, from doctors and also in the issue that often non-pharmacists do not seem to have a clear understanding of what pharmacists do.

Much of the data generated in response to the portrayal of pharmacists in the public eye – in the media, whether factual or fictitious, referred either to pharmacists' low levels of portrayal, or to their portrayal as unfortunate or even evil characters.

### **7.5 Discussion**

This chapter presented identities for pharmacists as clinical practitioners and as social carers. In addition, it has also presented the idea that pharmacists often lack a clear identity, and are unremarkable.

The term 'clinical' is used in different ways and has different meanings. In terms of pharmacy policy it means services provided at the individual patient level. The most recent white paper described the 'skills of the practitioner' as being combined with the science of pharmacy in contemporary clinical pharmacy practice.<sup>28</sup> In terms of being clinical practitioners, data presented in this chapter suggested an inter-sector difference, with hospital pharmacists' identity as clinical practitioners being perceived within all three dimension. This resonates with the highest status and most pro-active role for pharmacists identified in Leufkens's study – the pharmacist as 'care-manager', working in 'partnership with doctors'.<sup>89</sup> A more recent study reporting pharmacists' involvement in a new scheme being piloted in the USA suggested a new 'family practice' identity for some pharmacists, where they were seen to use their clinical judgement more and to have a less black and white mindset.<sup>90</sup>

The clinical identity is less secure within community pharmacy - generally community pharmacists were seen to have less information about patients than hospital pharmacists and also to be less integrated into the wider healthcare team. However, data presented in this



chapter showed that the community pharmacist is often the first choice of lay pharmacy users for consultations about minor health problems. This echoes the findings of previous studies. However, one user, did give the community pharmacist a more limited role, and did not see them as an alternative to the doctor, more just a source of medicines and advice specifically about the medicine, not about symptoms or illnesses. Participants in this study spontaneously expressed what roles and functions they saw pharmacists as fulfilling, so it may be the case that there are many more lay pharmacy users for whom the doctor is always the first choice for health consultations. This was described by a community pharmacist in this study, who reflected on what he perceived as a somewhat 'double-edged sword' where his own perceived accessibility made him 'popular' but lower in status than the doctor.

Pharmacists reported that there is much intrinsic satisfaction to be gained from building relationships with clients over time. However, often pharmacists do not get to know their clients well, indeed, often the relationship between pharmacist and client is characterised by one-off, fleeting encounters. This is likely to be partly due to structural factors in community pharmacy such as the potential for pharmacies to be used by 'passing trade', and high staff turnover, in particular the high numbers of locums within the pharmacy workforce. While most of the data reported on this related to the community pharmacy sector, a few hospital pharmacists did report enjoying the social interaction they have with patients.

The data presented in the social carer section shows some of the social issues that community pharmacists come across in terms of their lay pharmacy users that are not directly related to medicines. Harding and Taylor previously perceived the difficult issue that there are many people who mainly want 'reassurance' – rather than specific treatment for a health problem – and that it can be difficult to know how to manage these people.<sup>135</sup> Because of their accessibility, community pharmacists can often be the health professionals that these people come into contact with. Other research has shown that many lay clients have chosen to use community pharmacies as a 'first point of contact' and Dingwall evoked the folk symbol of the neighbourhood consultant.<sup>61</sup> Rogers et al also previously described a certain type of community pharmacy as a 'haven' where staff-customer interactions extended beyond conversations about medicinal products to discussions about everyday life.<sup>136</sup> Other than these studies there is little available evidence in the research literature on this topic. There is little in the research literature on this – the literature tends to show the role of community pharmacists as consultants on medicines. This may be because research has focussed on users of community pharmacy services, and some of the people who pharmacists in this study were talking about were people who had medicines delivered to them at home and did not use the pharmacy.

Data from this study suggest that there are multiple factors at play that affect pharmacy users' decisions on which professional to consult, for example the process of booking, waiting for, and attending, the doctor's appointment, could obviously be more disruptive than an immediate visit to the pharmacy at a time more of their choosing. It also implies a hierarchy of illness, where the ailment is seen as less serious, and therefore probably able to be 'treated' with a visit to a pharmacist.

Non-pharmacists interviewed for this study often did not find it easy to express clearly what it is that pharmacists do. This resonates with Cavaco's finding that because community pharmacy lay clients do not know the details of the requirements of the service that pharmacists provide, and because there is sometimes 'ambiguity' about who is in charge of or responsible for what within a pharmacy, and that patients cannot tell difference between pharmacists and support staff.<sup>112</sup> Another previous study found that a quarter of respondents reported having difficulty in identifying the pharmacist, and/or agreeing that pharmacists 'keep out of sight'.<sup>137</sup>

While participants in this study did not report direct experiences of bad pharmacists themselves, questions about the portrayal of pharmacists in the media generated responses that were strikingly different in that there were no positive portrayals of pharmacists. Media coverage of pharmacists was compared to that of doctors, and suggested that pharmacy is seen as lacking glamour. A hospital pharmacist recalled an episode of the television drama 'Desperate Housewives' the husband of a leading character finds out that she is having an affair with the pharmacist, and there is a suggestion that a pharmacist would not attract a glamorous woman.

This chapter has presented the identities of the pharmacist as clinical practitioner, the pharmacist as social carer and as unremarkable character. The final findings chapter presents two further identities for pharmacists – the business person and the manager.

## **8 Pharmacists as business people and managers**

### **8.1 Introduction**

This chapter is about pharmacists as business people and managers. As noted in section 2.3.5, 70% of pharmacists in England work in the community sector, which means that they are employed within the private sector (as either business owners, salaried employees or self-employed locums), although they provide NHS services (dispensing and other services). Pharmacy policy literature rarely explicitly addresses the issues of pharmacists as business owners, private sector employees, or as managers within the health service. However, these were noted as frequently recurring topics throughout the course of conducting interviews for this study. Analysis of the data suggested various categories which could be grouped together under the overarching themes of business and management, and the following sections present each of these in turn.

### **8.2 The business person**

#### *8.2.1 Introduction*

In 2003 the government stated that:

*too often community pharmacy is seen as separate from the NHS, as part of the retail sector rather than as a vital element of healthcare delivery*  
and to combat this, proposed the introduction of an 'NHS identity' for community pharmacies.<sup>24</sup>

This implies a vague sense that it is a problem for community pharmacy to be perceived in such a way, however, no detail is provided on who sees 'pharmacy' in this way, how pharmacists themselves are seen, what the differences are between retail and healthcare, or any specific reasons why this should be a problem for pharmacists, their clients or anyone else. There was no further mention of pharmacists as private sector workers in the policy literature. It is, however, notable that this was the only occurrence of the term 'identity' found within the policy documents reviewed for this study.

While this issue has not been tackled within the policy literature, issues pertaining to the identity of the pharmacist as business person were mentioned spontaneously throughout the interviews conducted for this study. Close inspection of the material suggested four subthemes within this area, the pharmacist as a seller of goods, the pharmacist as a seller of services, community pharmacists as seekers of high salaries and community pharmacists as employees of large impersonal corporations.

### 8.2.2 The retailer

The image of the community pharmacist as a person in a shop selling medicines and other goods to the public was a one that recurred throughout the interviews conducted for this study. Community pharmacists typically work in premises which include a dispensary 'shop floor' area and counter. The dispensary area is not accessible to the public, and this is where prescription only medicines and medical devices are stored. Pharmacy medicines are usually on shelves behind the counter, and must be requested from a member of pharmacy staff. In the shop area are a range of 'general sales list' medicines as well as other, 'non-medical' products available for clients to buy, many of which can be considered directly health-related, in that they are used to treat 'health problems' – illnesses and their symptoms, or minor injuries - for example cough sweets or bandages. Pharmacies also typically stock baby products, toiletries and household goods, as well as cosmetics and hair accessories. Community pharmacy premises range from the small, independently owned shop in a village setting, to large city centre branches of Boots.

The policy literature uses the term 'community pharmacy', but in everyday talk, such premises are often referred to as a 'chemist's shop' or simply a 'chemist's'. The interview opening 'task' asking participants to 'describe a pharmacist in five words' generated several responses that reflected an association of pharmacists with the local 'chemist shop': GPs used the words 'commercial' or 'retail'; 'toiletries' or 'cosmetics' were mentioned by two GPs, a community nurse and four lay community pharmacy users, while baby products and health drinks were mentioned by pharmacy users – three and one respectively:

*Interviewer: Describe a pharmacist in five words*  
*Respondent: Chemist...local...(Primary care pharmacist C)*

Lay users of community pharmacies interviewed for this study reported making use of the chemist to obtain various products:

*Interviewer: Describe a pharmacist in five words*  
*Respondent: Chemist would be the first word I'd sort of think, would come to mind. Erm, a chemist where you can get all sorts of drugs and toiletries. (Community pharmacy 1 user I)*

The community nurse quoted below seemed to view the pharmacy as a useful local amenity:

*...they are very convenient cos they've got all the local medications and plasters, and hair ties, and (laugh) lots of other bits and pieces, yeah...*

This hospital pharmacist outlined her reasons for not wanting to work in the community sector, and cites the involvement in retail work as a particular factor. She also seems to suggest that the prescription medicine related work involved is uninteresting. Elsewhere in her interview, this

pharmacist expresses a strong preference for what she calls 'clinical' work, where she is able to see the effects that medicines have on patients, and she seems to see a contrast between this and 'shop' work:

*I did my first summer at Boots and I hated it. Erm, just cos I'm no good at selling perfume and makeup...I couldn't see myself tied to the dispensary bench checking amoxicillin all day long and selling, as I joke with my community pharmacy friends...[I didn't go into pharmacy to be] sat in the dispensary just having prescriptions come down every day and dispensing and checking. That's why I wouldn't do community pharmacy. (Hospital pharmacist Q)*

The following quotes from community pharmacists provide further evidence for a divide between retail business work and clinical work – although they both seem to be suggesting that this is not a view they hold themselves, but they believe that this is how some non-pharmacists see their sector:

*[talking about the media portrayal of pharmacists] We're just perhaps seen as businessmen, rather than as clinicians. (Community pharmacist P)*

*...some [patients] just think you're a glorified shop-keeper. You've got stuff on the shelf... (Community pharmacist Q)*

This Community pharmacist S expressed a sense of pharmacists being part-business people and part health service workers:

*...sort of half our feet are in the NHS family and half are in our own business world. (Community pharmacist S)*

The same community nurse quoted above who said that community pharmacies were a convenient source of products, also perceived a 'conflict of interest' in terms of pharmacists stocking and selling branded medicines. In the example below, she refers to paracetamol, a drug widely available (a GSL medicine) in tablet form, while 'Panadol' is the name of a particular brand of paracetamol tablets, which tends to retail at a much higher price than 'generic' paracetamol tablets:

*... why are they selling them stuff that really you could get a lot cheaper? I mean they'll sell Panadol, why don't they just sell paracetamol? Cos there's a huge mark-up on one of them. So there I see a little bit of a conflict of interest, but it's convenient, we wouldn't like it if they couldn't sell us these things, you know, if you always had to go to the doctor's. (Community nurse A)*

The GP quoted below (who had no connection to the nurse quoted above) seems to have a very similar view, in that she is happy for the pharmacist to sell non-medical products,. However, when it comes to medicines, she expresses some concern about the potential for pharmacists to attempt to steer patients towards more expensive, branded products. Although her example is slightly different from the example of Panadol – as Lemsip is a branded product

which contains paracetamol but also other ingredients – she seems to be expressing a similar discontent about the way pharmacy users may be sold medicines:

*...obviously they have to sell, and I mean I don't mind them selling, it sounds odd doesn't it? I have no objection to them selling cosmetics and hair products and all that sort of thing, because you know they've got to do that to survive haven't they?... I suppose it's the sense that they'll be independent enough to sort of say to the patient, 'well actually, you know, just take some paracetamol, it's just as good as taking, you know, all the fancy Lemsips and everything else'. GP B)*

Another GP said that he was perfectly happy for pharmacists to sell some over the counter medicines:

*I mean things like paracetamol, that kind of thing I wouldn't have a problem with or ibuprofen, all those sort of things. (GP A)*

However, he then raised the issue of pharmacists selling cough medicine to pharmacy users, even though he does not often prescribe cough medicines for patients, because he does not believe them to be effective:

*Most of our patients know that if they come to us and ask for a cough bottle they will not be given one... chemists make a lot of money from selling cough bottles...as far as I can see, if somebody goes to a chemist and says, 'I want a cough bottle' they will then be given a cough bottle of some sort...the better chemists may kind of question them and if they think it's maybe a sign of something more serious, may direct them towards the GP, but they still give them a cough bottle...Sell them...(GP A)*

The GP who used the Lemsip example also mentions 'cough bottles' and also expresses a similar view about pharmacists selling health supplements – which she seems to see as a large source of financial income for pharmacists, but of which to her have no reliable health or medical benefit. Interestingly, she does spontaneously reflect that 'patients want' these products, inferring perhaps that pharmacists may be compelled to supply products that their clientele desire, or that they may feel under 'patient pressure' to do so:

*...there's a little bit of a tension cos they make most of their money from selling over the counter rubbish that doesn't work.(laugh) How can you stand there all day every day and sell cough medicine?...sell people loads of stuff that they don't need....the stuff of dubious use ...vitamins, having shelves and shelves of health food products really irritates me.....But again that must be hard mustn't it...cos patients want them...I'm sure there's a huge mark-up on them, so they must make a lot of money out of them. So it must be quite hard to resist doing that...(GP B)*

This quote from a community pharmacist shows that he perceives the issue raised by the GP above to exist – he uses the metaphor of juggling, perhaps different interests – the benefit of the profit-making business he works for and the benefit of the client both working for a profit-making business working in the client's interest:

*I think pharmacists always have to keep in mind the best interest of the patient, not the balance sheet...there is a sort of juggling act...juggling the business aspect with the patient care aspect, trying to get a balance between making a decent turnover but still doing the right thing by the patient, giving them what they need, or if they simply don't need anything, then telling them that rather than selling them something, or telling them they're better off seeing their GP... (Community pharmacist S)*

Another community pharmacist expressed a similar issue:

*...[patients] probably see a good pharmacist as somebody who sells them...what they want to buy, whereas I think a good pharmacist sells something appropriate to their needs, or in some cases not selling anything at all...(Community pharmacist O)*

She also perceived employment tenure type to be a factor which may affect how pharmacists behave in this respect:

*If I lose money by not selling them something, but that's the best advice I can give them, I will do that. I won't say...'I need money to pay my staff this week, so I'll sell them something just for whatever'. Some pharmacists will do that, independent pharmacy owners are more likely to do that I think. Because they need the money for their expenses, whereas...it's not my money I'm taking or losing, I'm more concerned about the condition, the ethical aspects. (Community pharmacist O)*

Participants in this stage one interview also described some pharmacy owners as prioritising making the maximum possible profit when supplying prescription medicines and give the example of a pharmacist wanting to ensure that the prescription is filled with a cheaper brand of drug, in order to do this.

*CP A: How to make most money out of the prescriptions I'd say  
CP B: Yeah. Oh I hate working for them, they go mental about 'Oh you've given the more expensive brand'... (Community pharmacist group interview 1)*

The pharmacist who mentioned the juggling act thought that if he owned his own business he would be more keen to sell products than he is in his current roles as locum and employee:

*...when I'm working as a locum I'm less interested in the sort of profit for the business I'm just sort of there providing my services as a pharmacist but if they own the shop and are looking at profit and turnover they might be more keen to sell a product to a patient like a cough bottle or something even if they didn't really need it, just to make the sale, so I think that is a bit of a problem...(Community pharmacist S)*

This community pharmacist and a member of support staff (who worked in different pharmacies) both raised the issue that sometimes when prescriptions are written for medicines which can be bought over the counter (because they are P or GSL medicines) – and if the medicine is available this way at less cost to the patient than the prescription charge, then they will supply it to the patient this way:

*...if somebody comes in with a prescription for 30 paracetamol I won't do it – you could but I don't think that's ethical (Community pharmacist O)*

*Respondent: Well you sort of look at the prescription...plus the fact if something's on that prescription that they can buy cheaper, then you have to tell them that they can buy it cheaper.*

*Interviewer: Do you have to do that?*

*Respondent: Well, it's just, yeah it's ethical to do so I think. (Community support staff B)*

Finally, this community pharmacist suggested that GPs resent pharmacists having the right to supply medicines for money, when they do not:

*...[doctors] see us as inconsequential, a nuisance, er, possibly a threat...the difference between us and doctors...we have a till, they don't have a till. But they'd like a till, they'd like to have the cash. (Community pharmacist Q)*

### 8.2.3 Providing services for money

The issue of community pharmacists being paid for providing services for money was also a recurring theme, as raised by this hospital pharmacist:

*... [referring to picture 06] it's all about services for money... (Hospital pharmacist R)*

Several community pharmacists themselves mentioned this topic. One service in particular was mentioned – MURs, for which the company is remunerated on a fee-per service basis. The pharmacist quoted below worked for a large pharmacy chain and explained that the company managers put pressure on him to provide these services to make money for the business:

*The bad sides are non-pharmacist managers...who interfere with your job...MURs, they think about them just as a number, like money...(Community pharmacist P)*

This pharmacist who worked both for a chain and for an independently owned pharmacy reported differences between their approaches to this:

*I work for Alliance-Boots now one day a week and then I work for an independent another day. So I get both aspects. You can see the differences, whereas in the Boots work it's very much push, push, push, MURs, push, because it's all money. (Community pharmacist S)*

However, this pharmacist also worked for a big chain, but she saw her company as more ethical in their approach whereas she thought that other companies pushed pharmacists more to provide MURs:

*... I don't think [names company] are as ethical. I think they're 'just get as much money as you can off the patients' with MURs you can do up to 400 a year which the*



*managers interpret as 'each pharmacy has to do 400 a year' otherwise we're losing money. (Community pharmacist O)*

The pharmacists above expressed discomfort with what they described as large companies pushing pharmacists to provide services against their will, which they seemed to think was an example of prioritising profits over client health benefit. Community pharmacists also thought that GPs were unhappy about pharmacists providing some 'extended services', because they were being remunerated for these, which they saw as taking money that previously would have gone to GPs:

*[GPs] don't like it at the moment, because of the vascular checks, we've taken some money off them as far as they're concerned. (Community pharmacist Q)*

*...in certain areas...colleagues have said, the GPs think we're just trying to grab every buck from them, they think we're screwing the system totally...For money, money-grabbing...glorified retailers...that are tryin'a make money...Especially with this, vascular screening pilot that's been going on recently. Most GPs have embraced it, but there are GPs that were sceptical about it, saying that, 'ooh, they're gonna defraud this money... I can understand their point of view, vascular screening is part of what they do...I think it's part of [their quality incentive scheme which affects how much they are paid]...(Community pharmacist S)*

*... it's tricky, being involved in the flu vaccination I had to work with doctors and nurses...and some doctors said, effectively, not in the actual words but 'I'm not going to help you do this service because however many you inject is less money for me'. (Community pharmacist O)*

#### **8.2.4 Money-motivated community pharmacists**

In addition to the issues of pharmacists proving medicines, and also services, for money, a more general association of community pharmacists with money emerged as a theme. Participants in several stage one group interviews described locum pharmacists who they saw as strongly motivated by money. The quote below portrays this stereotype, as described by one of the groups:

*CP E: That's your professional locum*

*CP D: ... that is your professional [locum]...I don't see him a hospital setting, I see him very much in community*

*CP C: Just about money*

*CP D: Fast cars...three mobile phones. 'Pharmacy, don't give a monkey's! Dispensing errors, not my fault! Clinical knowledge, quite good, but don't care!'*

*Interviewer: He sounds nice!*

*CP C: He's out there, he is out there.*

Picture two was designed to represent this type of pharmacist, and this picture generated many responses. Amongst community pharmacy interviewees, the character was associated with

locum pharmacists. Hospital pharmacists placed this type of pharmacist firmly within the community pharmacy sector:

*Definitely (laugh) I've come across like this...this is very much community-focussed, to be the manager and be on mega-bucks...I would have thought and you get some people that are very financially-focussed and I have come across people like that before. (Hospital pharmacist R)*

The hospital pharmacists quoted below also cited the importance of money as a factor that differentiated them from pharmacists working in the community sector:

*...I think that's kind of what community pharmacists are all about really...Making money. (Hospital pharmacist T)*

*HP M: Money's more of a motivation for community pharmacists.*

*HP K: ...Money and income doesn't even enter the heads of the hospital pharmacist, it's all about the patient...The only time they'll time look at money is from the cost effectiveness point of view of the drug...*

*HP M: Or when they're starting a family maybe, they might sort of look for promotions and stuff. (Hospital pharmacist group interview 4)*

*...in community...you'd go in, you'd be on a very high pay packet...essentially what I've done...is pay ten thousand pounds for more clinical knowledge (laugh)...when pharmacists are coming out of university and...going into a hospital setting they're...choosing clinical knowledge over money. But I don't regret it... All my friends would be slating me right now because I have very many friends that work in community, it's just I couldn't do that, but then on the days when I'm working extremely long hours for very little pay, on call, I have my diploma on top...all my extra assignments...audits and things that I've been given by my manager...competencies...all these pressures...you think 'shall I just take ten thousand pounds and go into community and have an easy life?...'(Hospital pharmacist O)*

*[commenting on picture 02] works in community, with his swanky sports car and he's after his pennies, and he works every hour that god sends and he's probably all into his own business, or is looking to own his own business, cos I think if you work in community and you want to make lots of dosh, that's where it's at, to own your own pharmacy.*

Some of the pharmacists quoted above seem to portray members of their sector of work as more altruistic than community pharmacists in that they are more concerned about the welfare of patients than their own financial benefit. However, the hospital pharmacist quote below did acknowledge that he was motivated by a range of factors, including working to get promoted so that his income would increase:

*I guess the money side does come into it...I mean you wanna progress, you want fresh challenges, but you know you'd be lying if you said you didn't want to get higher to get more money, you'd be lying if you said otherwise. (Hospital pharmacist S)*

### 8.2.5 A generic, less personal service

Analysis of the data suggested that people associate pharmacists with the companies that they work with, as implied by the way that pharmacy company names were often spontaneously used by participants in this study. This pharmacy user commented on the decrease in independently owned pharmacies, and the increase in chain pharmacies:

*...you don't get many local pharmacies any more do you? It all seems to be like high street brands that are doing it, like Lloyds pharmacy or Boots. (Community pharmacy 3, user D)*

This nurse also perceived the nature of community pharmacy to have changed – she recalls a pharmacist from her childhood who she says was like a ‘family friend’, and compares them to the ‘old GP’ who she also puts within this category. She expresses nostalgia for this pharmacist of the past, and perceives an absence of this type of pharmacist today, and between the lines which describe these things, she refers to contemporary community pharmacists as ‘profit-making businesses’ and ‘commercialised’:

*I think the old-fashioned pharmacist, was almost kind of like a family friend in a way. Like your old GP would have been, but you just don't seem to see that any more ...as a little girl, I remember there was a particular pharmacist that I used to love going into, near where my parents lived... I see pharmacists generally as profit-making businesses. More and more so, more commercialised. Whereas I think the old-fashioned pharmacist, was almost kind of like a family friend in a way. Like your old GP would have been, but you just don't seem to see that any more. (Community nurse A)*

The quote below from a community pharmacist, responding to picture four, seems to express something of a similar notion to the nurse above – she describes another pharmacist that she encountered who she did not feel had a ‘genuine’ manner, and she associated this type of person with ‘big companies’ with a ‘business’ focus:

*Respondent: ...[picture 4] looks like a picture for an advert, it doesn't look very realistic to me...when I was a student I went to a pharmacy one day and the pharmacist smiled at me, but it wasn't a friendly smile, it was made up...do you know what I mean? It was like a manufactured smile, it wasn't real, so I didn't feel, I could ever approach that type of person if I had a problem...*  
*Interviewer: So do you think pharmacists are approachable generally?*  
*Respondent: Yeah, most of them are, definitely, but some, and I think it just tends to be the bigger companies...maybe cos they concentrate on the business side of things, they forget about their patients...(Community pharmacist N)*

This community pharmacist expressed a similar notion, and thought that the personal manner of the pharmacist was an important factor that could affect whether clients chose to use a pharmacy, sometimes more so than the physical surroundings of the premises:

*...they will go in some grotty shops, but if the person in there is really good and helpful, they will put up with the environment in favour of going to see an individual they trust, and think will give them good advice, and conversely, the all-singing all dancing pharmacies that have perhaps an impersonal, sort of atmosphere about them then they'll go to them but probably out of convenience rather than anything else.  
(Community pharmacist P)*

The following quote from a lay pharmacy user provides some substantiation for the suggestion above, as he says that he chooses to use his local pharmacy whenever possible, in preference to some 'big' pharmacies:

*Respondent: Well I go to Tesco's, I see the pharmacist in there, but they don't seem to, there's no personal touch in a place like that. Here, they get to know the customers, you know.*

*Interviewer: So do you use the one in Tesco's much?*

*Respondent: I have done in an emergency...[when] this one was shut...I think that the gimmicky ones are the big ones aren't they? Boots, Lloyds and places like that. They're the big pharmacies that run the gimmicks, three for two, things like that. Er, you get pharmacies like this... you know, it's not in the town centre, it's localised, so you get a more of a personal service. (Community pharmacy 2 user A)*

Finally, a community pharmacist who worked for a large company, raised the interesting issue into some recent changes that her company was making, whereby they were going to make their pharmacies and the products stocked more standardised, something that she thought may not be successful for the company because there may be preferences for different products between different areas:

*CP F: I think they're going for a much more sort of universal face of pharmacy, like Boots would have, you know...what they're going to try and do is put in products that are stocked in every single one of the stores...across the board, so what they keep in each pharmacy is sort of generic...I just don't think that's gonna work for them, cos people who've worked in them have taken years and years getting in the lines that sell for that local community. (Community pharmacist group interview 3)*

#### 8.2.6 Summary and comments

The data presented in this section have shown that the community pharmacist has an identity as a person running the local chemist's shop, which is a source of medicines and other medical and non-medical goods. This is perceived (within the third dimension of professional identity) by lay pharmacy users and some GPs and nurses. Lay pharmacy users expressed awareness of this identity for pharmacists, and confirmed that they used pharmacies to obtain various items, in neutral terms, neither finding fault with it nor remarking on its benefits. GPs and a nurse also commented on this, and while they expressed appreciation of the convenience of such local retail outlets, their positive comments were outweighed by their suggestions that pharmacists sell products for their own financial gain which are sometimes of no benefit to clients. Retail work was viewed negatively by a hospital pharmacist who commented on it. Community

pharmacists perceive differences within their sector in the motivations of pharmacists of different employment tenures to sell medicines to customers, non-owner pharmacists suggesting that pharmacy owners are more likely to sell products than salaried or locum pharmacists.

Community pharmacists did not report enjoyment of, or affinity with retail work, also, some thought that they were perceived as retailers by others in a negative way. While it is indeed the case that some non-pharmacists, and also hospital pharmacists, do seem to hold negative views about community pharmacists being retailers, data from this study also suggest that this is in fact a function that is valued – and community pharmacists are perhaps not aware of this positive view that some people do have of them.

Some GPs expressed dissatisfaction with pharmacists selling branded products, because they think the client should be sold a cheaper generic product, products which they consider to be no more effective than simple medicines (Lemsip versus paracetamol) or cough medicine which they seem to consider to be of no medical benefit.

Data in this section suggest that community pharmacists are also perceived by others to provide services for money, and not in a positive way- within the sector, community pharmacists themselves feel unhappy about pressure from within large companies to provide higher numbers of services which for which money is given on a fee-per service basis. This seems to be a factor that is in tension with pharmacist's own 'core' identity. In terms of the second dimension of their professional identity, some community pharmacists think GPs have a negative view of them as people who are now receiving money for providing services that GPs would have had. Section 8.2.4 suggested a further association of community pharmacists with money – several hospital pharmacists raised the issue that salaries are higher for community than hospital pharmacists, and some community pharmacists raised the same point in relation to locum pharmacists.

Lastly, data are presented, from community pharmacists and some of their lay clients, which suggest a perception that community pharmacy has become more 'commercialised' which is associated with a reduction in the level of individual service. Comments from participants in this section seem to imply an association of larger companies, and by association the people working in them, to be less 'caring' and less likely to provide an individualised service to the client.

## 8.3 The manager

### 8.3.1 Introduction

There is some mention of pharmacists as managers in recent pharmacy policy literature – hospital pharmacists are positioned as managers of the supply of medicines,<sup>24,25</sup> but the issue of management is not addressed in relation to community pharmacy. The training competencies for pharmacists include requirements to have the skills to manage the dispensing process. However, in the interviews conducted for this study, the issue of pharmacists as managers was a recurring topic. Close examination of the data relating to this topic suggested three sub-themes – pharmacists as traditional pharmacy managers, the issue of changing forms of pharmacy management and the emergence of the new pharmacy manager and sections 8.3.2 to 8.3.4 present each of these in turn.

### 8.3.2 The traditional pharmacy manager

Traditionally, community pharmacies were owned and run by ‘owner-manager’ pharmacists. One interviewee, who had previously owned his own pharmacy, recalled the happiness he had felt on obtaining his own pharmacy:

*That was my baby. That was the very first one I bought, it was my little pride and joy...I didn't want anything to go wrong with it... (Community pharmacist S)*

As well owner-managers, the ‘employee-manager’ is a well established position within the community pharmacy sector. The following quote from a group interviews describes a pharmacist who identifies strongly with running a shop and takes pride in doing so, even though she is not the owner - she is an employed manager:

*CP C: They want it perfect the shop so...they want the shop perfect, they want it to be the best, so I would say they work about 40 hours to keep it perfect...*

*CP D: That's her shop...she's looking after it. (Community pharmacist group interview 2)*

The following quote, from a pharmacist aged in her fifties, who worked in a range of community pharmacies through her career, provides further evidence of the existence of this management identity. Although she has never owned her own business, she described how having the authority over what happens in a shop has been a significant feature of her working life.

*...I've always been in my pharmacy, and it's been my, well it's not been mine, but it has been my pharmacy, and I've always run it...the stock for everything, it's my dealings, it's my pharmacy...I've never had a manager, over me to tell me how to run the pharmacy. (Community pharmacist Q)*

The above quote implies that the pharmacist has 'autonomy', although she does not use the term. This pharmacist, however, did so, spontaneously, and seems to associate the ability to work independently with pharmacists in general.

*...[pharmacists are]...in general terms able to work, erm, autonomously, used to making decisions for themselves...(Primary care pharmacist D)*

This Community pharmacist contrasts working for a large pharmacy chain, where the way the pharmacist works seems to be more constrained by the company's rules and procedures, whereas he mostly works for a small local group of pharmacies, and thinks that he has more freedom to work in his own way there:

*...my sister is also a pharmacist, she works for Boots...[compared] to a smaller company like this...the rules are a lot stricter... a lot of company policies they have to adhere to, whereas here tends to be a bit more relaxed and you're kind of you own person, you manage things the way you like to manage them...(Community pharmacist S)*

### 8.3.3 Changing forms of management

This interviewee described recent changes in the pharmacy she worked for where the managers of each shop were still pharmacists, but there were some new area managers (who oversee a number of pharmacies) were not pharmacists. Although she does not report any specific problems, she seems to refer to a lack of clarity on how this will affect the pharmacists like herself, and a sense of general irritation with the fact that they are not pharmacists:

*CP F...they've just changed the system [with area managers]...a lot of them aren't pharmacists, much to the annoyance of (laugh) the pharmacists that do work there. So, it's not always entirely apparent to us what their job role is, you know, when they're coming round, so it's actually a little bit tricky...(Community pharmacist group interview 3)*

Other community pharmacists reported some areas of difficulty experienced where non-pharmacists had come to manage pharmacies and had not been familiar with certain requirements or procedures:

*...that's an issue where...quite a lot of the store managers are not actually pharmacists, or certainly area managers, with a number of multiples which is causing us obviously contracting for services with them something of a problem in some cases. Cos they don't necessarily understand the professional requirements...because they've come from Woolworths or something like that (laugh) beforehand. (Primary care pharmacist D)*

*...our area manager and the regional pharmacy manager do actually spend time on the shop floor, actually being pharmacists....Which is good because it does keep their feet on the ground and helps them understand what's going on there. 'Cause a lot of...store managers are not pharmacists, which can cause problems. They see the running of a dispensary as an economic exercise, whereas I see it from a pharmaceutical point of*

*view, and that has caused problems...where I am at the moment...the store manager there isn't a pharmacist....all the people who work in a pharmacy have to either be qualified or registered on a course. But the store manager wouldn't appreciate the legalities of this...So [she] says 'well we have somebody on number seven who can count tablets, put them in the dispensary for the day because we're short staffed'...We can't do that. But they don't appreciate that you can't do it, or why you can't do it. (Community pharmacist O)*

Section 8.3.2 presented the idea of the 'traditional pharmacy manager' who had made their own decisions about how their pharmacy was run. Participants in the group interview below suggested that sometimes when these traditional types of pharmacist have encountered managers who have chosen to continue doing things 'their way':

*CP E: And she'll see people come, she'll see people go. She'll see managers come and tell to do one thing, and then they'll have moved on, but she'll actually know best.*

Indeed, this pharmacist, who had worked in a variety of community pharmacies, confirmed that she liked to make decisions about how the pharmacy is run:

*...the other thing I don't like about some of them was...too strong a non-pharmacist influence over what happened...staff members who were too dominant...or area managers who were too influential over what happened in a professional capacity...if I'm there, I'm in charge, I decide what happens and what doesn't...I've been in pharmacies, erm, where area managers have told us to do illegal things, non-pharmacists, and I'm like, 'no I'm not going to do that'. (laugh) The example being, erm, delivery of controlled drugs...the prescription has to go out with the driver to the patient, for them to sign the back of the prescription...that's not right, there's a different process by which it should happen but [the other staff in the pharmacy say], 'no it says it here [on the 'operating procedure for that pharmacy]', I go, 'I don't care if it says it there', I don't care where it says it, it's still not gonna happen...(Community pharmacist O)*

MURs were mentioned particularly in terms of being an area where some community pharmacists felt their autonomy was threatened or reduced, and specifically refer to 'non-pharmacist' managers telling them to provide MURs when they would prefer to be able to decide when to do these themselves:

*... a lot of shops tend to have non pharmacist managers there which means that the pharmacist has less power over what goes on in the shop so they may have a sort of non pharmacist manager telling them how many MURs they're supposed to be doing...(Community pharmacist S)*

*...I mean I understand...the company sets you a target, but it's down to the pharmacist to understand when an MUR is due...there are some shops in which managers...push the pharmacist every time to do MURs, and that's not good...if you like doing things properly and...you are there to help people...part of the NHS...you want to do an MUR in the right way, at the right time, with the right person...in other chemists' where I've been working, they just push you...Even if there's no reason to do an MUR...(Community pharmacist P)*



The pharmacist quoted below seems to feel frustrated and perhaps patronised by her employer's approach to these targets:

*CP A: ...you get emails round all the time saying 'this store has done this many MURs and they're store of the month' . We even had a teddy bear...you got Tigger if you got the most MURs and if you got the least you got Eeyore...it's not fair...just stupid, absolutely ridiculous. (Community pharmacist group interview 1)*

As well as large private companies introducing more non-pharmacist managers within the community pharmacy sector, the issue of an increased public sector management influence was also perceived. Two community pharmacists spontaneously raised this point – the first was an independent pharmacy owner, who expressed strong dissatisfaction with his perception of government policy within his sector:

*... I'm glad I don't work for a multiple, I'm glad I'm my own boss...I dislike the management that's coming from the PCTs...And that's the government strategy isn't it? For the PCTs to manage pharmacy. (Community pharmacist Q)*

This pharmacist also perceives an increase in the application of rules about how pharmacists operate, and suggests a more 'managed' community pharmacy environment:

*... PCTs seem to be a lot more heavy with reinforcing the rules, making sure pharmacists conform to the rules cos there's a lot more checks, a lot more sort of visits and audits...(Community pharmacist S)*

There was much less talk about hospital pharmacists as managers than there was about community pharmacists in the data generated for this study. Participants in a stage one interview, however, raised some interesting issues in their description of this hospital manager. Although this person was in a senior position, it was deemed important for her to 'play by the rules' of the hospital trust – she was not simply able to do things 'her way'. The interviewees said that this was reflective of the way that hospital pharmacy has changed, and that previously a pharmacist who was senior within the pharmacy department would have had more control over operational matters within pharmacy but that this has reduced:

*HP K: To get where they've got they have to be good at toe-ing the party line don't they? They've got to be very politically aware*

*HP L: Yes, politically aware*

*HP K: And probably not that much of a trouble-maker...they're probably more 'yes-people' than*

*HP L: Nowadays. In the past I don't think they were, but I think they are now, because I think the managers of the trust have such expectations and they'll come to them and say to them, 'We want you to be open longer hours, we want you to do this' and they don't really expect the Director of Pharmacy to say 'That's not gonna happen.' They just expect it to happen I think. (Hospital pharmacist group interview 4)*

The following quote is from an interviewee who previously worked in hospital pharmacy, but now works in a management role for a PCT which gives her an overview across different community pharmacies. She compared the recent changes in the community sector to those that took place in pharmacy some time before and thought that community pharmacists may need time to adjust to working with non-pharmacist managers:

*I think it will take time because in hospital that's how it used to be that your pharmacist would be there and you'd have your department manager and there was you know conflict because people weren't too sure how to work together...at the end of the day they're all working for the same aim (laugh) and I think once they get that..But it will take some time, I think it's a change that is not easy for anyone. (PCT support staff A)*

Finally, three community pharmacists explained why they saw the increase in the non-pharmacist managers within community pharmacy as a positive trend – this was mainly because it released the pharmacist from operational or administrative issues and let them devote more time to do other work such as extended services:

*...I think the way things are going and services are developing, I think it's good that there is a manager of the store...who will oversee a lot of the admin, managerial type duties, and processes, because that takes that strain away from the pharmacist and so that the pharmacist can be released to do the clinical work, those things that their five years of training and studying (laugh) has given...so they can get on with that, I think is a good thing. (PCT support staff A)*

*It frees up the pharmacist then, to be providing the clinical, and I think that's a really good way of going, because, having worked in community pharmacy for many years, you do get rather fed up of actually being responsible for everything. You know, from the Hoover breaking down, and it's, I used to say, 'Have I got Hoover-repairing skills here? Or light-repairing skills? Why has it all got to come down to me?' Ok, I'm the manager, but I'm not necessarily responsible for everything, and I think that that is a really, really good move on the part of Lloyds, that they're actually doing this. (Primary care pharmacist C)*

*I can just concentrate on the pharmacy side of things and don't have to deal with payroll and succession planning for the store, you know, to a large extent, it just means that I can just do my training, do the role that I'm trained for. (Community pharmacist R)*

#### 8.3.4 The new pharmacy manager

Lastly, data from this study suggest that some pharmacists may identify with aspects of community pharmacy management in a positive way. This hospital pharmacist thought that pharmacists could gain job satisfaction from managing a shop:

*I feel the initial reasons some people may have gone into community is to get money up front, but then you know these other elements of the organisational bit is I think the bits that keep people interested in say running your own shop 'I can run this I can run my own shop I can hit all my targets, I can set up all these extra services and things'.. (Hospital pharmacist S)*

Participants in a stage one interview described a hospital pharmacist working in a management position, who was similarly motivated by meeting service targets and managing budgets:

*HP D: ... gets the erm accolade for hitting his targets and budgets but doesn't get himself the financial reward... (Hospital pharmacist group interview 02)*

This group described a community pharmacy area manager, who they thought would not have been satisfied doing a day to day 'pharmacy' job:

*Interviewer: Ok, so why did she want to be a pharmacist?*

*CP D: She probably wanted the management stuff*

*CP E: Either that, or she thought she wanted to be a pharmacist, but suddenly, but got bored very quickly...*

*CP D: Yeah, that's the ones in't it? So she wanted to do pharmacy, she saw pharmacy to be a caring and interesting career for her, but actually realising that it's quite boring and quite dull, so she wanted something to keep her brain ticking over.*

*CP E: Wants to go out and about... the networking, the getting to know people, she likes knowing what's going on.*

*CP E: ...if her group of stores come out top in some kind of league table, she'll be*

*CP D: Fab*

*CP E: She'll think that's amazing...*

*CP D: She would want to hit a bonus not from the fact that she's bothered about the money, she's bothered that the bonus shows that she's doing a good job... Are our store managers driven by the bonus? Only if they're about an inch away from it. If they're miles away from it they could not care less...What is of importance to her is the recognition from her colleagues...recognition from her manager that she's doing a good job. So she'd be far more upset about...that they've achieved less MURs than the next area along. That's why she's close to her other area pharmacists, cos she wants to know how they've got to where they've got to, so if they've...done 100 this week, and she's only done 10 it's like 'Why have you done 100? What did you do? How did you do it? And why am I looking so bad?' (Community pharmacist group interview 2)*

*I've always liked a lot of variety, I get bored very easily, and I realised that spending eight hours a day in the same pharmacy in the same pharmacy with the same staff and the same customers wasn't for me, I got too bored...[so I moved to a management job in a PCT]...it felt exciting... you could create whatever you wanted to create. So it was all very exciting and new at that stage. (Community pharmacist O)*

This hospital pharmacist, responding to picture 02, seemed to perceive a particular type of person who was not focussed on the individual patient:

*This is sort of your high-flying, career minded, money-focussed pharmacist, loving his PDA, loving his technology, erm, everything that I think a pharmacist shouldn't be, but there we go. But there are definitely pharmacists like that, so, they're probably more managerial, or I personally can't see him having patient contact and relating to a little old lady on a ward.... (Hospital pharmacist O)*

This pharmacist who works in developing community pharmacy services perceives variation in pharmacists' willingness and confidence to do this:

*...you've got [a proportion of community pharmacists] who are quite, go-ahead and will get stuck in and embrace new services and a 'bring it on' attitude, you know? We've got another third who will do it but need to be encouraged, to varying degrees, and helped, and supported. (Community pharmacist P)*

*...we do a lot of services...needle exchange...chlamydia testing... we do morning after pills, minor ailments services, I'm trying to set up a smoking cessation service at the moment, so it's not just standing there ticking boxes, that would just bore me. I like to get involved in all sorts of other things as well. (Community pharmacist O)*

The pharmacist quoted below seems to be describing traits such as creativity and being willing to experiment, qualities that she believes are part of her own personality, but that she suggests other pharmacists may lack:

*I always imagine pharmacists being really good chefs, cos they must follow the recipe to the last letter, and I'm not that kind of cook, I'm chuck it in and see what turns out really, which erm is not what you want in a pharmacist I don't think, some of the time. But there's some things you do want it, it is a useful skill. (Community pharmacist O)*

### 8.3.5 Summary and comments

The data presented in this section have explored pharmacists' identity as managers. A traditional pharmacy manager identity was perceived, who ran their pharmacy with a large degree of autonomy, and took pride in doing so. Some pharmacists seem uncomfortable with the increase in non-pharmacist managers in community pharmacy. Reasons given for this were that it seems to reduce the freedom of the pharmacist to run the pharmacy in the way that they want to. Pharmacists also perceived an increase in the influence of management from within the public sector. Pharmacists also suggested the emergence of new types of pharmacist managers. It is notable that all of the data presented in this section were drawn from interviews with pharmacists.

## 8.4 Discussion

This chapter has presented two identities for pharmacists, that of the business person and that of the manager.

Community pharmacies are private sector businesses. Their main sources of income have traditionally been dispensing NHS prescriptions, for which they receive a fee, and also selling non-prescribed medicines and other products. The community pharmacist as private retailer, or shop keeper, is a concept that is virtually ignored by the government policy literature, but emerged repeatedly during interviews for this study, and is a well-rehearsed theme in the pharmacy practice research literature. Quinney's scale included the tasks 'arranging shop displays' and 'handling sundry goods'.<sup>73</sup> GPs in this study suggested that pharmacists

sometimes supply items unnecessarily in the interests of profit, or supply more expensive items. This issue of pharmacists being likely to supply a more expensive brand of medicine in the interests of profit, was a finding in Cavaco's study of community pharmacy users in Portugal.<sup>112</sup> . Some pharmacists thought that GPs saw them as shopkeepers, not professionals. These findings resonate with those of Hughes and McCann who described a prevailing shopkeeper image for community pharmacists.<sup>99</sup> Traditionally, there has been an understanding that business and professional values<sup>73</sup> are in conflict and previous studies in pharmacy research often reported allegedly negative consequences of the dual business and professional roles.<sup>76</sup> This has been a generally accepted theory, despite empirical evidence to the contrary, such as Kronus's study which showed that business-oriented pharmacists were no less altruistic.<sup>138</sup> Therefore, the continuing image of pharmacists as shopkeepers may constrain their acceptance as health care professionals, in the view of doctors, and also in terms of pharmacists' own comfort with feeling like they are a fully integrated member of the NHS team.

In terms of community pharmacists and money, hospital pharmacists present the issue as if community pharmacists are different from them in that they are more motivated by money. This seems to be a divisive element, and because being altruistic is a defining aspect of being professional, in raising the issue of such extrinsic motivation for doing their job, they are portraying themselves as more altruistic and perhaps more professional. While the focus of this study was not professionalism, this is relevant as it contributes to an overall image of community pharmacy as money focussed and suggests that the character of that sector of the profession are more driven by money. However, the issue is actually more complicated than this, as community pharmacists in this study described their discomfort with being provided with financial 'incentives' to provide services, and other pharmacists state that managers are more motivated by self and others recognition for doing a good job than by money. The fact that some pharmacists see others within their profession as so differently motivated in this respect suggests an area of fragmented identity. Hospital pharmacists may claim an identity for themselves as altruistic professionals, but this only exists in dimension one, there was no evidence that it was perceived by others. No community pharmacists described hospital pharmacists as altruistic. Holloway stated that 'a suspicion of entrepreneurialism is to be found among British hospital pharmacists'<sup>7</sup> and this may still be the case today.

Data from this study showed a perception that community pharmacy has become more 'commercialised' which was previously reported by Hughes and McCann.<sup>99</sup> Data presented in this chapter suggest that a specific problem with this is the association with a reduction in the level of individual service. There was a sense of nostalgia for pharmacists of days gone by, who were seen to be more of a 'family friend' who knew local people, and this is seen to be lost to an extent when pharmacists work for large organisations. Shaw previously described the

pharmacist's image as 'tarnished' by the association with being commercial – now it seems community pharmacy is tarnished by the association with being 'too corporate'.<sup>60</sup>

Section 2.3.5 noted that increasingly, community pharmacies are owned by large companies – the data referenced in this study come from the government itself. There is also a trend within chain pharmacy companies for the premises to be run by non-pharmacist managers. However, despite these changes, the idea of pharmacists as managers is receives more mention within pharmacy policy with relation to hospital pharmacists rather than community pharmacists.

In terms of pharmacists as managers, this section presented the idea of the traditional pharmacy manager, who ran their pharmacy with a large degree of autonomy, and took pride in doing so. Managing the supply of medicines by controlling the way in which medicines come into and go out of the shop is still a key part of the identity for some pharmacists. Running a pharmacy, in the 'shop' sense, as in a premises with a stock of physical objects, seems to be a key part of professional identity for some pharmacists, and there were mixed views about the increase in non-pharmacist managers in community pharmacy, with some seeming to feel dislocated from an important aspect of their work that they identified with. Hospital has a longer history of general management – working in a 'managed healthcare' environment, where there are non-professional managers around. Pharmacists also suggested the emergence of new types of pharmacist managers. It is notable that all of the data presented in this section were drawn from interviews with pharmacists.

## 9 Conclusions

### 9.1.1 Introduction

This concluding chapter discusses the findings presented in the previous four chapters and draws together some of the key findings, reflects on the method used and finally suggests some possibilities for further research.

### 9.1.2 General discussion of the findings

The overall aim of this study was to investigate the topic of professional identity in pharmacy.

The objectives of the study were to provide answers to the questions:

- How do pharmacists see themselves? (identity dimension one)
- How do pharmacists believe that others see them? (identity dimension two)
- How do non-pharmacists see pharmacists? (identity dimension three)

Analysis of the data generated for this study revealed the existence of nine identities for pharmacists: the maker of medicines; the supplier of medicines; the scientist; the medicines advisor; the clinical practitioner; the social carer; the unremarkable character; the business person and the manager and each of these were presented in the preceding chapters.

Of these nine identities, the pharmacist as maker of medicines was the least expected. This is the identity associated with the physical task of making medicines from their constituent parts, which has not formed a regular part of community pharmacy work for decades. In stage one of this study, reference was made to an 'old-fashioned' type of pharmacist who was old enough for this role to have been part of their early years of practise. When I included picture one in the interview prompt tool I expected it to be quickly dismissed. However, during the stage two interviews, although participants emphasised that in practical terms community pharmacists no longer spend time making medicines, the data generated in response to this picture was striking both in that they conveyed a strong emotional attachment to a particular pharmacist identity and also because this identity seemed so clear.

Indeed, it seems that the medicines maker is the clearest identity revealed by the data in this study. This does not mean that there were necessarily pharmacists who were 'purely' makers of medicines, other identities may well have contributed to 'who' these pharmacists were, but it does stand out as clearly discernable. As noted, this thesis is a study of professional identity, not roles, however, roles and their constituent tasks are salient because they provide points of reference. Perhaps such a visible function, whereby material objects are produced, helped this identity to emerge clearly and be easily understood. The maker of medicines can be considered

the 'original' pharmacist identity, and since it stopped being a regular feature of practice, the identity of pharmacists has been harder to define.

The pharmacist's identity as a supplier of medicines is one which has been increasingly played down by pharmacy policy makers, but, similarly to the medicines maker, was discussed at length by participants in this study. The issue of the pharmacist as medicines supplier is more complex than that of the medicines maker. The supply of medicines seems to be accepted as a vital role within healthcare that must be fulfilled, indeed, it would seem senseless to argue otherwise. However, while pharmacy as a sector of healthcare, and pharmacists as people, are strongly associated with the supply of medicines, pharmacists' actual identity in relation to this is no simple matter. In terms of identity dimension one, a small minority of pharmacists in this study seemed to accept being a dispenser as part of who they are without expressing any negativity about this. However, for other pharmacists, medicines supply work is in conflict with who they want to be; they find dispensing boring, pressurised and wasteful of their skills and training. In terms of identity dimension two, some pharmacists believe that others see them as 'mere suppliers', whose main purpose is to provide them with medicines as quickly as possible. However, non-pharmacists do indeed want their medicines supplied quickly, but some do share pharmacists' sense that supply work is a waste of pharmacists' training. Two further aspects of the supplier identity for pharmacists are worthy of comment here, and both of these overlap with other identities. These are the necessity of accurate work and the 'hidden' nature of medicines supply work.

Firstly, as noted, the necessity of medicines supply work is easy to appreciate, and having them supplied accurately is vital. Pharmacists were generally seen as people who were accurate. Accuracy as part of the pharmacist's identity is also closely linked to material included within the medicines advisor identity (in chapter six), specifically with regard to pharmacists' role in checking the safety and appropriateness of medicines prescription, supply and ongoing use.

Secondly, the image of pharmacists as hidden from view seems to stem from the practical issue that much medicines making and supply work takes place out of sight of anyone who does not work in pharmacy. The same issue also occurs in chapter six, when participants discuss pharmacists as advisors and claim that pharmacists need to 'come forward' more to speak to clients. This was raised in relation to community pharmacists and it was implied that some still tend to stay towards the back of their shops. Chapter seven presented yet more evidence about pharmacists being hidden, in the broader sense that they are largely absent from elements of cultural and social life in that people do not seem to become famous for being pharmacists, and that they rarely feature in either the news or fictional media. This latter point is an aspect of the identity described as an 'unremarkable character'. As well as the issue of pharmacists having a



low visibility, the data which combine to convey the image of the pharmacist as an unremarkable character show that pharmacists are often anonymous, both visually anonymous in the sense that they are indistinguishable from doctors in hospitals or support staff in either sector, and also with regard to the fact that although pharmacists are very familiar, perhaps omnipresent in daily life, people generally struggle to name a famous one. Being unremarkable, lacking a distinctive or positive identity, cannot be good for the status of a profession. However, it is difficult to link this directly to particular elements of practice, or show evidence of its relation to any actual harm.

Thus far, this chapter has covered some of the areas of overlap between the pharmacist professional identities which this study has revealed. Possibly the clearest identity for the contemporary pharmacist is provided by the data in chapter six which show that pharmacists are scientists. Data relating to identity dimensions one and three (pharmacists' views of themselves and non-pharmacists' views of pharmacists) combine to show an accepted and clearly perceived identity, without conflict or negativity, indeed this seems to be valued, as people respect pharmacists' high level of education. While the 'fact' that pharmacists are trained in science is certainly not a new finding, it is worthy of attention due to its importance to pharmacists' professional identity. Because all pharmacists are trained in science, 'the scientist' can be considered a core identity, contributing to the makeup of who all pharmacists 'are'. The limitations of having an identity as a scientist in terms of being a pharmacist is that science can be 'practised' in a laboratory, but pharmacy is practised in health care settings. A pharmacist may well be a highly trained scientist, but their knowledge remains theoretical in nature until it is applied in practice. The application of knowledge in practice is a defining feature of professional work, and by acting as an advisor on medicines, pharmacists are able to apply their scientific knowledge in practice.

This study showed that the pharmacist's identity as medicines advisor identity manifests in a variety of settings and roles, and is associated with functions such as information giving and acting as a safety net which are highly valued by both professional and lay people. However, although identification with the medicines advisor is strong (within all three dimensions of pharmacists' professional identity), its application in practice is often complex. Unlike the more straightforward 'scientist', the medicines advisor is made up of multiple elements, some of which overlap with other identities set out in this thesis, and which are associated with some areas of tension or difficulty. While pharmacists' knowledge is complemented by their good attention to detail and rigorous or methodical approach, which helps to ensure the safety of medicines prescription and supply, there seems to be a fine line between a helpful amount of checking and an excessive amount, which can then make pharmacists appear rigid and rule-bound. Personal demeanour was also very important with this identity, and again pharmacists seem to need to

get the right balance between being assertive enough to raise concerns with prescribers, without coming across as aggressive.

A further theme running through several of the identities presented in this thesis was a sense of nostalgia for pharmacists of the past. This was notable in chapter five's compounding pharmacist, chapter eight's traditional pharmacy manager and also, as shown by participants quoted in chapter eight describing a preference for traditional local pharmacies which are contrasted to the modern, 'commercialised' chain pharmacies which are seen as impersonal. Data generated for this thesis convey a sense of pharmacy as a profession which has become more 'managed' or restricted in how much control they have over their practice – pharmacists are not allowed to make medicines on community pharmacy premises and chapter eight refers to several ways in which pharmacists feel uncomfortable about the way they are being managed, whether directly by non-managers in their shops, or more strategically by government policies implemented via PCTs. Either way, the sense is of pharmacists as people who perceive the traditional identity to be more constrained than previously.

### *9.1.3 Potential areas for future research*

In terms of further research, previous studies relating to professional identity in pharmacy have used factor analyses to identify particular types of pharmacist. One potential way of extending the current study would be to further validate the nine identities revealed through analysis of the qualitative data and use them to develop a tool which could be administered to obtain up to date quantitative data in this area.

A strength of this study is that the exploratory approach served to generate some unexpected findings, which would not have happened had a quantitative method measuring attitudes to predefined concepts been employed. The idea of the pharmacist as medicines maker was one of these, and it was interesting to discern this theme, which may contribute to an understanding of pharmacists' professional identity, but may not be worthy of much more investigation in its own right. In contrast, I did not anticipate as much discussion of the pharmacist as social carer. This is not an 'official' community pharmacy role, and receives much less attention in the research or policy literature. However, this has the potential to increase in importance if the current policy emphasis on a public health role for pharmacy is pursued. This is therefore an area that may warrant further research in the future.

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## **10 Appendices**

- Appendix A: Documents relating to Manchester University ethical approval
- Appendix B: Documents relating to Oldham NRES and also NHS R&D ethical approval
- Appendix C: Stage one interview schedule
- Appendix D: Stage two interview schedules
- Appendix E: Pharmacist pictures

**UNIVERSITY OF MANCHESTER**  
**COMMITTEE ON THE ETHICS OF RESEARCH**  
**ON HUMAN BEINGS**

**Application form for approval of a research project**

**1 Title of project**

Professional identity in pharmacy.

**2 Details of applicant(s)**

*(Name, title, school/academic section, email address)*

*Please indicate whether any of the investigators hold honorary or substantive appointments in the NHS.*

Ms Rebecca Elvey

PhD student

Centre for pharmacy workforce studies (CPWS), School of Pharmacy and Pharmaceutical Sciences

rebecca.elvey@manchester.ac.uk

**3 Details of project**

**3.1 Context**

*Outline the research problem and its scientific background*

Professional identity has been defined as the conception of oneself as a professional. This conception includes an understanding of the professional role and expectations of performance in that role.(1) In other words, professional identity relates to who a professional person is, what they do and how they do it.

Professional identity is not a fixed entity, but develops through the process of professional socialisation. Professional socialisation occurs within educational and practice settings and may be influenced by both formal and informal factors. The professional socialisation of university students within schools of pharmacy has been the focus of several research studies conducted in the USA. Chalmers defines professional socialisation within pharmacy as ‘the general process whereby students learn about the professional role of pharmacists and expectations of performance in that role.’(2) Hammer describes professional socialisation as involving the transformation of individuals from students to professionals, and the development of beliefs, attitudes and behaviours with regard to pharmacists’ roles. The

pharmacy student's development into a professional pharmacist is seen as being shaped by various factors such as the school curriculum, the school culture and role models within the school, as well as the individual's own values and beliefs.(3)

Authors such as Chalmers raised concerns about perceived 'inconsistent socialisation' in schools of pharmacy. Similarly, Shuval argued that formal socialisers (members of faculty staff) often played up the scientific and research aspects of pharmacy at the expense of addressing the dilemmas that exist around professional issues in pharmacy.(4)

Subsequently, attention turned to addressing these issues and improving the professional socialisation of pharmacists. The Student White Paper for pharmacy education makes recommendations for students and faculty to assist in the development of professional attitudes and behaviours.(5) Hammer developed an instrument to assess the behavioural aspects of professionalism. This was developed by extracting relevant items from student evaluation forms used at schools of pharmacy and from the literature. In another study, pharmacy students were asked to rate their level of agreement with the objectives contained within their college's curricular competency statement on professionalism. (6)

In recent years, professional issues in pharmacy education have become a focus of increased attention from the professional body and from academic researchers in the UK. The Royal Pharmaceutical Society of Great Britain recently published a set of principles for pharmacy education and training. This document states that the purpose of pharmacy education is to 'produce professional practitioners'. Professionalism is defined as 'the autonomous application of capability in a professional context and in a manner which meets the expectations of peers, patients, the public and society.'(7)

A study undertaken at Aston University compared the content of the curricula of all UK schools of pharmacy and interviewed staff and surveyed students about their views on these curricula. Students were asked about their views on pharmacy as a profession and their motivations for choosing pharmacy as a degree subject.(8) Willis et al are currently undertaking a longitudinal cohort study with 2006 pharmacy graduates. This study started when the cohort were third (penultimate) year students and is investigating career choices, intentions and expectations. (9)

Taylor and Harding note that within the UK, studies about the process of training pharmacy students have tended to focus on curriculum content, with little attention being paid to professional socialisation. Their research provides some insights into pharmacy students' views on their development of a professional identity, including the skills and abilities that they feel are important for pharmacists to possess, and the role models that they encounter during the course of their training. (10)

A small number of research studies have investigated the professional identities of pharmacy students, by using or adapting existing scales designed to measure professional identity or related concepts.(11;12) While these studies provide some useful insights, none of the scales used were developed specifically for use within pharmacy.

### 3.2 Purpose

- To determine what professional identities exist among undergraduate pharmacy students
- To identify factors which may contribute to the formation of this identity
- To determine what perceptions about professional identity exist among teaching staff in the School of Pharmacy

### 3.3 Similar research

*If any similar research has been done indicate how this study relates to it and why it is necessary*

The studies outlined in section 3.1 provide useful insights into a number of topics relevant to understanding what the professional identity of pharmacy students is and how it develops. However, there are a number of issues which warrant further investigation. For example, Wilson et al explored the career image of pharmacy by asking students whether they were strongly committed to the values and ideals of the pharmacy profession, however there is no detail available on what these values and ideals actually are. Similarly, in the same study, almost four out of five students agreed or strongly agreed that assessments on the pharmacy degree measured their knowledge base, but did not measure the skills needed to be a pharmacist. The authors suggest that this raises further issues about the development of assessment methods and strategies that can reflect the qualities needed for professional practice. Again, however, there is no research on what pharmacy students (or faculty) believe these skills or qualities to be.

The studies from the USA referred to above do offer some statements about and descriptions of, the values and behaviour of professional pharmacists. However, the authors took existing materials and used these by asking students to rate agreement with the statements on a numbered scale, or to form a tool to be used for quantitative assessments. Hammer did conduct discussion groups with experts to validate her tool, however, no in depth research has been conducted to ascertain what pharmacy students or staff think about the issues related to professional identity.

Previous research, such as findings from the cohort study, tell us that students choose to study pharmacy because they want a science-based course, or because they want to help people. However, there is no research that establishes what pharmacy students think a pharmacist's role involves. Given that current health policy in the UK sets an agenda for pharmacy which advocates pharmacists taking on new roles and making the most of their clinical knowledge, it would be useful to know how students view their future roles as practicing pharmacists, and how teaching staff responsible for training pharmacists see the professional identity of pharmacists.

Furthermore, professional identity includes an understanding of expectations of performance

of the professional role. As well as self-expectations, this may include the perceptions of others, such as patients and the general public. The investigator is not aware of any research about what students believe patients expect from pharmacists. Similarly, there is little qualitative evidence about how pharmacy students and staff view themselves in comparison to students or staff involved in other health care professional degrees, or their views on the status of pharmacy compared to other health care professions, or the contribution of pharmacy to health care and the place of pharmacists within the wider healthcare team. Deeper knowledge on these issues would contribute to building up an understanding of how students and staff perceive the professional identity of pharmacists.

### 3.4 Methods

*Additional sheets may be attached*

Individual and group interviews will be conducted with students registered on the MPharm degree, and with teaching staff employed within the School of Pharmacy at the University of Manchester. The interviews will be semi-structured in nature. The interviews will be audio-recorded with the participants' consent.

The researcher will use a topic guide covering the areas to be investigated. The interviews will be conducted in the manner of a 'structured conversation'(13) to allow the interviewee to introduce additional topics that the researcher may not have included.

The topic guide will contain open questions such as 'Describe what a pharmacist is and what they do', 'Where do pharmacists fit within the health care team?'. The investigator will also use terms from existing scales which have been used in the investigation of professional identity, for example Kumpusalo's scale, which includes descriptions such as 'healer', 'prescriber' 'listener',(14) and ask participants how well they think such expressions describe pharmacists.

The data will be transcribed and subjected to thematic analysis with the assistance of Nvivo v.7. The transcripts will be anonymised. Participants will be given the opportunity to request a copy of their transcript if they wish.

#### *Setting*

The interviews will be conducted in meeting rooms on the premises of the School of Pharmacy and Pharmaceutical Sciences at the University of Manchester.

#### *Sample*

Undergraduate students registered on the MPharm degree, and teaching staff at the University of Manchester.

### 3.5 Duration of the study

6 months.

### 3.6 Location of the study

The study will be conducted from the Centre for Pharmacy Workforce. Interviews will be conducted in meeting rooms on the premises of the Drug Usage and Pharmacy Practice (DUPPG) research group, in the Stopford Building at the University of Manchester.

### 3.7 Staff involved

*Give details of staff involved other than the investigators named above, their role in the study, the appointment they hold, including any honorary or substantive appointments in the NHS.*

Professor Karen Hassell, Chair of Social Pharmacy, Director of the Centre for Pharmacy Workforce Studies, School of Pharmacy and Pharmaceutical Sciences, University of Manchester.

Dr Jason Hall, Senior Teaching Fellow, School of Pharmacy and Pharmaceutical Sciences, University of Manchester.

Professor Hassell and Dr Hall will be supervising the project due to their expertise in professional issues in pharmacy and the training and education of pharmacists.

### 3.8 Initiator/sponsor

*Details of any outside body, eg a pharmaceutical company, if such has initiated or given financial sponsorship to the project; details of any payments to be made to the investigator or the investigator's department.*

This work is part of a PhD funded by the School of Pharmacy and Pharmaceutical Sciences over a three year period.

## 4 Details of subjects

### 4.1 Total number

Up to a maximum of 60 participants will be included in the study.

### 4.2 Sex and age range

The project will involve both male and female participants, all of whom will be aged 18 years or over.

### 4.3 Type

*Students, staff, general public - healthy or patient volunteers; if patients, indicate their disease or condition, whether in-patients or out-patients, under treatment or observation*

Undergraduate students registered on the MPharm degree, and pharmacy teaching staff at the University of Manchester.

### 4.4 Inclusions and exclusions

*Indicate rules to be applied; for healthy volunteers indicate screening process*

Inclusion criteria: undergraduate students registered on the MPharm degree, and teaching staff employed in the School of Pharmacy at the University of Manchester.

Exclusion criteria: anyone not currently registered as an undergraduate student on the MPharm degree, or a member of staff in the School of Pharmacy at the University of Manchester.

#### 4.5 Method of recruitment

*Attach a copy of any proposed advertisement*

##### *Recruitment strategy*

The investigator (RE) will send, by email, an invitation to participate in the study to all undergraduate pharmacy students. A copy of the wording for this email is attached. The investigator will attend pharmacy undergraduate lectures to make an announcement about the study and invite students to volunteer to take part in interviews. Students will be asked to contact the investigator themselves by email or telephone if they are interested in taking part in the study. The investigator will respond to all students who make contact, to arrange a convenient time for them to come to the DUPPG offices for the interview. The researcher will attempt to answer any additional questions that potential participants have about the study.

The aim is to include students in all four years of the pharmacy degree. The investigator appreciates that students in the earlier stages of the course, particularly first year students, will have less experience to draw on, both in terms of training, being newer to the degree, and possibly in terms of exposure to the practice of pharmacy. Therefore first year students may have less developed views and understandings of the profession. However, if there are indeed differences between students at different stages of the degree, collecting perspectives from students in all years will enable allow comparisons to be made which may enable the identification of specific, or critical, points in the formation of their professional identity and the factors that contribute to this identity.

To collect a wider range of views, teaching staff in the school of pharmacy will also be invited to participate in the study. To recruit these staff, the investigator will email potential participants asking them to respond if they would like to participate in the study. Those who express an interest in participating will then be contacted to arrange a convenient time to carry out the interview. Participants will be provided with copies of the information sheet and consent forms before the interview.

Participation in the study will be entirely voluntary and a student's decision to participate or not will have no bearing on their assessment for the degree. This is stated on the information sheet and the investigator will endeavour to reassure all students who agree to participate of this. All participants will also be assured that they are free to withdraw from the study at any time and without giving a reason. Participants will be provided with information sheets and consent forms prior to the interviews.

Copies of the information sheet and consent form are attached.



- 4.6 Payments to volunteers  
*Indicate any sums to be paid to volunteers*

Not applicable.

## 5 Details of risks

- 5.1 Drugs and other substances to be administered  
*Indicate status, eg full product licence, CTC, CTX. Attach: evidence of status of any unlicensed product; and Martindales Pharmacopoeia details for licensed products*

DRUG	STATUS	DOSAGE/FREQUENCY/ROUTE
------	--------	------------------------

Not applicable.

- 5.2 Procedures to be undertaken  
*Details of any invasive procedures, and any samples or measurements to be taken. Include any questionnaires, psychological tests etc.*

Individual or group interviews will be undertaken with students. The interviews will be audio-taped with the participants' permission. The data will be transcribed verbatim and subjected to thematic analysis.

- 5.3 Potential dangers, discomfort or inconvenience

The research is considered to be low risk and it is unlikely that any dangers, discomfort or inconvenience will be experienced by the participants. It is possible that participants could feel uncomfortable during the interviews but this is unlikely given the nature of the project. Participants will be assured by the researcher that they are free to withdraw from the study at any time and without giving a reason.

- 5.4 If a patient group is being studied:

- 5.4.1 Indicate whether (and if so, how) participation will affect their general treatment regime

Not applicable.

- 5.4.2 Direct benefits  
*Indicate any possible direct benefits to patients resulting from their participation, compared with conventional treatment*

Not applicable.

## 6 Safeguards

6.1 Precautions

*Indicate precautions to be taken against adverse reactions, collapse, etc; in the case of drug trials on healthy volunteers, consult the ABPI guidelines*

Not applicable.

6.2 GP's initial notification

*Indicate when, if at all, it is intended to notify the volunteer's GP of participation*

Not applicable.

6.3 GP's notification of events/findings

*Indicate that the GP will be informed of any pertinent findings, results or adverse effects*

Not applicable.

6.4 Ethics Committee's notification

*Confirm that the Committee will be informed of any adverse reactions or untoward events*

The Committee will be notified as soon as possible of any problems or untoward events.

6.5 Informed consent

*Attach a copy of the consent form and volunteer's information sheet, including any details of payment arrangements, and compensation arrangements. In cases where it is not proposed to obtain the volunteer's written consent please state why not.*

Informed consent will be obtained from all participants. Copies of the consent form and information sheet are attached.

6.6 Confidentiality

*Confirm that confidentiality of medical and research records will be maintained. Where appropriate, explain the methods to be used to maintain confidentiality.*

Audio recordings and paper copies of transcripts will be stored in a locked filing cabinet within the Centre for Pharmacy Workforce Studies.

Electronic data (interview sound files and transcripts) will be stored on password protected computers.

6.7 Insurance

*Detail arrangements made for insurance/compensation of participants, and attach evidence of this.*

Not applicable.

## 7 Approval by another recognised ethics committee

*See page 2 of the Guidelines for Applicants*

Indicate whether the research

- (a) Needs the prior approval of another recognised ethics committee

YES/**NO**

*If yes, please attach a copy of the letter of approval*

*or*

- (b) must be notified to another recognised ethics committee after approval by the University committee

YES/**NO**

*If yes, please append a brief explanation*

### Signatures of applicant(s)

26/09/2007

.....  
Signed Date

*Karen Harrell*

26/09/2007

.....  
Signed Date

## APPENDIX

### A: Checklist of attachments required:

- 1 Volunteers consent form
- 2 Volunteers information sheet
- 3 Advertisements soliciting volunteers
- 4 For drugs, extract from Pharmacopoeia or evidence of status as appropriate
- 5 Copies of any documents recording contracts and indemnity/compensation arrangements
- 6 The full protocol (one copy)

### B: MODEL CONSENT FORM

*Sections in square brackets may not be applicable to all projects.*

Title of project

X has explained to me the nature of the research and what I would be asked to do as a volunteer, and has given me my own copy of the volunteer information sheets, which I have read. [I acknowledge that the risks mentioned in the volunteer information sheets have been explained to me.]

[Having had *x period* to consider my decision since seeing the information about the trial,] I consent to take part as a volunteer and I understand that I am free to withdraw at any time without giving any reason, and without detriment to myself. [I understand that I will receive any payments promised to me for taking part, up to the time of my withdrawal.]

[I confirm that *(list any facts about the volunteer which are to be elicited by questioning and which exclusions are dependent on, eg "I do not smoke")*]

[I agree that my GP may be informed of my participation in the trial.]

[I agree that during my participation I will observe the safety precautions listed in the volunteer information in section X *(this would be the section, if relevant, which lists things the volunteer should not do - eg drive within so many hours of receiving a given drug)*]

Signed.....Date.....

NAME (BLOCK LETTERS).....

Witnessed.....Date.....

NAME (BLOCK LETTERS).....

I confirm that I have fully explained the purpose and nature of the investigation and the risks involved

Signed.....Date.....

## Reference List

- (1) Niemi PM. Medical students' professional identity: self-reflection during the preclinical years. Med Educ 1997;31(6):408-15.
- (2) Chalmers RK, Adler DS, Hadded AM, Hoffman S, Johnson KA, Woodward JMB. The Essential Linkage of Professional Socialization and Pharmaceutical Care. Am J Pharm Educ 1995;59:85-90.
- (3) Hammer DP, Berger BA, Beardsley RSEMR. Student Professionalism. Am J Pharm Educ 2003;67(3):1-29.
- (4) Shuval JT. The Pharmacist: Processes of becoming. In: Wertheimer AI, Smith MC, ., editors. Pharmacy Practice: Social and Behavior Aspects. 2nd ed. Baltimore MD: University Park Press; 1981. p. 27-36.
- (5) American Pharmaceutical Association Academy of Students of Pharmacy - Americal Association of Colleges of Pharmacy Council of Deans Task Force of Professionalism, Benner J, Beardsley R. White Paper on Pharmacy Student Professionalism. J Am Pharm Assoc (Wash) 2000;40(1):96-102.
- (6) Hammer D, Mason H, Chalmers R, Popovich N, Rupp M. Development and Testing of an Instrument to Assess Behavioral Professionalism of Pharmacy Students. Am J Pharm Educ 2000;64:141-51.
- (7) Royal Pharmaceutical Society of Great Britain. The Principles of pharmacy education and training. 2007.
- (8) Wilson K, Jesson J, Langley C, Clarke L, Hatfield K. Survey of Teaching, Learning and Assessment Methods in Pharmacy Undergraduate Programmes. sarah. Aston University Pharmacy Practice Research Group; 2005.
- (9) Willis S, Shann P, Hassell K. Who will be tomorrow's pharmacists and why did they study pharmacy? The Pharmaceutical Journal 2006;277(7410):107-8.
- (10) Taylor KMG, Harding G. The pharmacy degree: The student experience of professional training. Pharm Educ

2007;7(1):83-8.

- (11) Adams K, Hean S, Sturgis P, Clark JM. Investigating the factors influencing professional identity of first-year health and social care students. *Learning in Health and Social Care* 2006 Jun;5:55-68.
- (12) Hind M, Norman I, Cooper S, Gill E, Hilton R, Judd P, et al. Interprofessional perceptions of health care students. *J Interprof Care* 2003;17(1):21-34.
- (13) Kvale S. *InterViews: An introduction to qualitative research interviewing*. Thousand Oaks: Sage publications; 1996.
- (14) Kumpusalo E, Neittaanmaki L, Mattila K, Virjo I, Isokoski M, Kujala S, et al. Professional identities of young physicians: A Finnish national survey. *Med Anthropol Q* 1994;8(1):69-77.

## PROTOCOL

### Background

Professional identity has been defined as the conception of oneself as a professional. This conception includes an understanding of the professional role and expectations of performance in that role.<sup>(1)</sup> In other words, professional identity relates to who a professional person is, what they do and how they do it.

Professional identity is not a fixed entity, but develops through a process of professional socialisation. Professional socialisation occurs within educational and practice settings and may be influenced by both formal and informal factors. The professional socialisation of university students within schools of pharmacy has been the focus of several research studies conducted in the USA. Chalmers defines professional socialisation within pharmacy as 'the general process whereby students learn about the professional role of pharmacists and expectations of performance in that role.'<sup>(2)</sup> Hammer describes professional socialisation as involving the transformation of individuals from students to professionals, and the development of beliefs, attitudes and behaviours with regard to pharmacists' roles. The pharmacy student's development into a professional pharmacist is seen as being shaped by various factors such as the school curriculum, the school culture and role models within the school, as well as the individual's own values and beliefs.<sup>(3)</sup>

Authors such as Chalmers raised concerns about perceived 'inconsistent socialisation' in schools of pharmacy. Similarly, Shuval argued that formal socialisers (members of faculty staff) often played up the scientific and research aspects of pharmacy at the expense of addressing the dilemmas that exist around professional issues in pharmacy.<sup>(4)</sup>

Subsequently, attention turned to addressing these issues and improving the professional socialisation of pharmacists. The Student White Paper for pharmacy education makes recommendations for students and faculty to assist in the development of professional attitudes and behaviours.<sup>(5)</sup> Hammer developed an instrument to assess the behavioural aspects of professionalism. This was developed by extracting relevant items from student evaluation forms used at schools of pharmacy and from the literature. In another study, pharmacy students were asked to rate their level of agreement with the objectives contained within their college's curricular competency statement on professionalism.<sup>(6)</sup>

In recent years, professional issues in pharmacy education have become a focus of increased attention from the professional body and from academic researchers in the UK. The Royal Pharmaceutical Society of Great Britain recently published a set of principles for pharmacy education and training.<sup>(7)</sup> This document states that the purpose of pharmacy education is to 'produce professional practitioners'. Professionalism is defined as 'the autonomous application of capability in a professional context and in a manner which meets the expectations of peers, patients, the public and society.'

A study undertaken at Aston University compared the content of the curricula of all UK schools of pharmacy and interviewed staff and surveyed students about their views on these curricula. Students were asked about their views on pharmacy as a profession and their motivations for choosing pharmacy as a degree subject.<sup>(8;9)</sup> Willis et al are currently undertaking a longitudinal cohort study with 2006 pharmacy graduates. This study started when the cohort were third (penultimate) year students and is investigating career choices, intentions and expectations.<sup>(10)</sup>

Taylor and Harding note that within the UK, studies about the process of training pharmacy students have tended to focus on curriculum content, with little attention being paid to professional socialisation. Their research provides some insights into pharmacy students' views on their development of a professional identity, including the skills and abilities that they feel are important for pharmacists to possess, and the role models that they encounter during the course of their training.<sup>(11)</sup>

A small number of research studies have investigated the professional identities of pharmacy

students, by using or adapting existing scales designed to measure professional identity or related concepts.(12;13) While these studies provide some useful insights, none of the scales used were developed specifically for use within pharmacy.

The studies outlined above provide useful insights into a number of topics relevant to understanding what the professional identity of pharmacy students is and how it develops. However, there are a number of issues which warrant further investigation. For example, Wilson et al explored the career image of pharmacy by asking students whether they were strongly committed to the values and ideals of the pharmacy profession, however there is no detail available on what these values and ideals actually are. Similarly, in the same study, almost four out of five students agreed or strongly agreed that assessments on the pharmacy degree measured their knowledge base, but did not measure the skills needed to be a pharmacist. The authors suggest that this raises further issues about the development of assessment methods and strategies that can reflect the qualities needed for professional practice. Again, however, there is no research on what pharmacy students (or faculty) believe these skills or qualities to be.

Previous research from the USA referred to above does offer some statements about and descriptions of, the values and behaviour of professional pharmacists. However, the authors took existing materials and used these by asking students to rate agreement with the statements on a numbered scale, or to form a tool to be used for quantitative assessments. Hammer did conduct discussion groups with experts to validate her tool but no in depth research has been conducted to ascertain what pharmacy students think about the issues related to professional identity.

Previous research, such as findings from the cohort study, tell us that students choose to study pharmacy because they want a science-based course, or because they want to help people. However, there is no research that establishes what pharmacy students think a pharmacist's role involves. Given that current health policy in the UK sets an agenda for pharmacy which advocates pharmacists taking on new roles and making the most of their clinical knowledge, it would be useful to know what students think about the roles that they are being prepared for.

Furthermore, professional identity includes an understanding of expectations of performance of the professional role. As well as self-expectations, this may include the perceptions of others, such as patients and the general public. The investigator is not aware of any research about what students believe patients expect from pharmacists. Similarly, there is little qualitative evidence about how pharmacy students and staff view themselves in comparison to students or staff involved in other health care professional degrees, or their views on the status of pharmacy compared to other health care professions, or the contribution of pharmacy to health care and the place of pharmacists within the wider healthcare team. Deeper knowledge on these issues would contribute to building up an understanding of how students and staff perceive the professional identity of pharmacists.

### **Objectives**

- To determine what professional identities exist among undergraduate pharmacy students
- To identify factors which may contribute to the formation of this identity
- To determine what perceptions about professional identity exist among teaching staff in the School of Pharmacy

This research is intended to act as a pilot study. While it is hoped that the exercise will result in useful data, the primary aim is to pilot the topic guide, to enable further refinement of this if necessary to enable the investigator to ask valid questions during interviews. This is with a view to continuing the research with a larger sample in the future.

### **Method**

A series of qualitative interviews will be undertaken. The interviews will be semi-structured in nature. The researcher will use a topic guide covering the areas to be investigated. The interviews will be conducted in the manner of a 'structured conversation'(14) to allow the interviewee to introduce additional topics that the researcher may not have included.

The topic guide will contain open questions such as 'Describe what a pharmacist is and what they do',



'Where do pharmacists fit within the health care team?'. The investigator will also use terms from existing scales which have been used in the investigation of professional identity, for example Kumpusalo's scale, which includes descriptions such as 'healer', 'prescriber' 'listener', (15) and ask participants how well they think such expressions describe pharmacists.

The interviews will be audio-recorded with the participants' consent. The data will be transcribed and subjected to thematic analysis with the assistance of Nvivo v.7.

#### *Setting*

The interviews will be conducted in meeting rooms on the premises of the School of Pharmacy and Pharmaceutical Sciences at the University of Manchester.

#### *Sample*

Undergraduate students registered on the MPharm at the University of Manchester.

#### *Recruitment strategy*

The investigator (RE) will send, by email, an invitation to participate in the study to all undergraduate pharmacy students. (A copy of the wording for this email is attached.) The investigator will attend pharmacy undergraduate lectures to make an announcement about the study and invite students to volunteer to take part in interviews. Students will be asked to contact the investigator themselves by email or telephone if they are interested in taking part in the study. The investigator will respond to all students who make contact, to arrange a convenient time for them to come to the DUPPG offices for the interview. The researcher will attempt to answer any additional questions that potential participants have about the study.

We aim include students in all four years of the pharmacy degree in the research. The investigator appreciates that students in the earlier stages of the course, particularly first year students, will have less experience to draw on, both in terms of training, being newer to the degree, and possibly in terms of exposure to the practice of pharmacy. Therefore first year students may have less developed views and understandings of the profession. However, if there are indeed differences between students at different stages of the degree, collecting perspectives from students in all years will enable allow comparisons to be made which may enable the identification of specific, or critical, points in the formation of their professional identity and the factors that contribute to this identity.

To collect a wider range of views, teaching staff in the school of pharmacy will also be invited to participate in the study. To recruit these staff, the investigator will email potential participants asking them to respond if they would like to participate in the study. Those who express an interest in participating will then be contacted to arrange a convenient time to carry out the interview. Participants will be provided with copies of the information sheet and consent forms before the interview.

Participation in the study will be entirely voluntary and a students' decision to participate or not will have absolutely no bearing on their relationship with the supervisors, or their assessment for the degree. This is clearly stated on the information sheet and the investigator will endeavour to reassure all students who agree to participate of this. All participants will also be assured that they are free to withdraw from the study at any time and without giving a reason.

#### **Time scale**

I propose a start date of 30<sup>th</sup> October 2007 and an end date of 30<sup>th</sup> April 2008.

#### **Dissemination strategy**

Initial findings may be used in the preparation of the investigator's continuation report for presentation to the University of Manchester in December 2007. The wider dissemination of the findings at relevant conferences or in journals may also be considered.

#### Reference List

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- (4) Shuval JT. The Pharmacist: Processes of becoming. In: Wertheimer AI, Smith MC, ., editors. *Pharmacy Practice: Social and Behavior Aspects*. 2nd ed. Baltimore MD: University Park Press; 1981. p. 27-36.
- (5) American Pharmaceutical Association Academy of Students of Pharmacy - American Association of Colleges of Pharmacy Council of Deans Task Force of Professionalism, Benner J, Beardsley R. White Paper on Pharmacy Student Professionalism. *J Am Pharm Assoc (Wash)* 2000;40(1):96-102.
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- (9) Wilson K, Jesson J, Langley C, Hatfield K, Clarke L. *Pharmacy undergraduate students: Career choices and expectations across a four-year degree programme*. Final project report. Aston University Pharmacy Practice Research Group; 2005.
- (10) Willis S, Shann P, Hassell K. Who will be tomorrow's pharmacists and why did they study pharmacy? *The Pharmaceutical Journal* 2006;277(7410):107-8.
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## CONSENT FORM

Title of project: Professional identity in pharmacy

Researcher: Rebecca Elvey

Please initial each box

- 1 I confirm that I have read the information sheet dated (date) (version 2) for the above study and have had the opportunity to ask questions.
- 2 I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.
- 3 I understand that the interview will be audio-recorded and I give my permission for this to take place, and for anonymised quotes from my interview to be used in the reporting of this study.
- 4 I agree to take part in the study.


\_\_\_\_\_  
Name of participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of person taking consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

When completed, 1 copy for participant, 1 copy for researcher's file.

Subject: PhD research interviews - volunteers needed.

Dear (name)

I have sent you this email to invite you take part in a research study.

I am a PhD student, based in the Drug Usage and Pharmacy Practice group. My PhD topic is professional identity in pharmacy. One aim of my PhD is to investigate the views of pharmacy teaching staff on the pharmacy profession and how students are taught about professional issues and the professional role of pharmacists through the MPharm.

To meet this aim I intend to carry out some research interviews with members of teaching staff in the School of Pharmacy.

If you would like to contribute to this study, by taking part in an interview, please contact me, either by replying to this email, or on 0161 275 2415.

The interviews will take place at the School of Pharmacy and can be arranged at a convenient time. I have attached an information sheet, which provides more detail about the project and the interviews, to this email. If there is anything else you would like to know please ask me.

Thank you,

Rebecca Elvey

# INFORMATION SHEET

## **Professional identity in pharmacy**

You are being invited to take part in a research study. 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 (Rebecca Elvey) on 0161 275 2415 or [rebecca.elvey@manchester.ac.uk](mailto:rebecca.elvey@manchester.ac.uk).

Take time to decide whether or not you wish to take part.

Thank you for reading this information sheet.

### **Why is this research necessary?**

Professional identity relates to a person's sense of 'who they are' in relation to their professional role. Professional identity is related to, and can be influenced by other peoples' views and attitudes. Pharmacists' jobs have changed in recent years, with pharmacists being expected to take on new roles which require new skills and activities. In such a time of change, the professional identity of pharmacists, and other staff or patients' expectations of pharmacists, is likely to change. Consequently, it would be beneficial to identify how pharmacists see their own professional identity, and also how they are perceived by other healthcare professionals and by their patients, to identify to what extent different stakeholders share similar views, and find out what differences in opinion exist.

### **What is the purpose of the study?**

This postgraduate research project aims to use interviews to explore the idea of professional identity with pharmacists, doctors, nurses, plus associated staff (such as pharmacy technicians and practice managers) and also patients, to identify whether different stakeholders share similar or hold divergent views.

### **Why have I been chosen?**

You have been chosen to take part in this study as you have had recent contact with a pharmacist, either as a hospital patient, or as a patient or user of a community pharmacy. We therefore feel you have 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 an interview about your views on the professional identity and role of pharmacists. You will be provided with an outline of the topics that will be discussed so that you can think about them before you come to the interview.

The interview will be held close to where you live or work. It should take no longer than 30 minutes.

With your permission, the interview will be sound recorded, transcribed and analysed. On transcription, the information will be anonymised. If you do not wish to be sound recorded, please indicate this to the researcher, you can still participate and the researcher will take notes during the interview.

### **Will information about me remain confidential?**

All information obtained from the interviews and any other contact with you will be kept strictly confidential, except as described below. To ensure this, data will be anonymised and securely stored. Your personal details will not be used in the analysis. We may use quotes from your interview in reports or publications, but these will not be attributed to you. Audio-tapes of focus groups or interviews will be erased as soon as we have finished with them.

Information about your participation will only be available to the research team and staff responsible for monitoring the conduct of the study at the University and Trust. The study will respect patient confidentiality and you will be asked not to mention patients or colleagues by name. If any details of patients are mentioned they will be promptly removed from the transcripts of the interview data.

### **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 interview at any point, if you wish to. The information collected can be destroyed after your withdrawal if you prefer.

### **What if there is a problem?**

If you have any concerns about any aspect of this study, you should speak with the researchers who will do their best to answer your questions (see contact details).

If you remain unhappy and wish to complain formally, you can contact the University Research Office on 0161 275 7583. This contact is independent of the researcher and research supervisors.

### **What will happen to the results of the research study?**

The results of the study will be analysed and published in professional journals and at conferences. They will also contribute to the completion of a postgraduate thesis. You will not be identifiable from the data used and published.

### **Who has organised the study?**

The study has been organised and funded by the Centre for Pharmacy Workforce Studies at the University of Manchester.

### **Who has reviewed the study?**

This study has been approved by Oldham Research Ethics Committee.

### **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 for an interview.

### **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:

Rebecca Elvey  
Centre for Pharmacy Workforce Studies  
School of Pharmacy and Pharmaceutical Sciences  
University of Manchester  
1<sup>st</sup> Floor, Stopford Building  
Oxford Road  
Manchester  
M13 9PT

Telephone: 0161 275 2415  
Email: [rebecca.elvey@manchester.ac.uk](mailto:rebecca.elvey@manchester.ac.uk)

**Thank you once again for taking the time to read through this information and considering taking part in this study.**

# INFORMATION SHEET

## **Professional identity in pharmacy**

You are being invited to take part in a research study. 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.

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Thank you for reading this information sheet.

### **Why is this research necessary?**

Professional identity relates to a person's sense of 'who they are' in relation to their professional role. Professional identity is related to, and can be influenced by other peoples' views and attitudes. Pharmacists' jobs have changed in recent years, with pharmacists being expected to take on new roles which require new skills and activities. In such a time of change, the professional identity of pharmacists, and other staff or patients' expectations of pharmacists, is likely to change. Consequently, it would be beneficial to identify how pharmacists see their own professional identity, and also how they are perceived by other healthcare professionals and by their patients, to identify to what extent different stakeholders share similar views, and find out what differences in opinion exist.

### **What is the purpose of the study?**

This postgraduate research project aims to use interviews to explore the idea of professional identity with pharmacists, doctors, nurses, plus associated staff (such as pharmacy technicians and practice managers) and also patients, to identify whether different stakeholders share similar or hold divergent views.

### **Why have I been chosen?**

You have been chosen to take part in this study as you are a practising pharmacist, doctor, nurse or associated member of staff working within an NHS or primary care



trust. We therefore feel you have 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 an interview about your views on the professional identity and role of pharmacists. You will be provided with an outline of the topics that will be discussed so that you can think about them before you come to the interview.

The interview will be held close to where you live or work. It should take no longer than 1 hour.

With your permission, the interview will be sound recorded, transcribed and analysed. On transcription, the information will be anonymised. If you do not wish to be sound recorded, please indicate this to the researcher, you can still participate and the researcher will take notes during the interview.

### **Will information about me remain confidential?**

All information obtained from the interviews and any other contact with you will be kept strictly confidential, except as described below. To ensure this, data will be anonymised and securely stored. Your personal details will not be used in the analysis. We may use quotes from your interview in reports or publications, but these will not be attributed to you. Sound recordings of interviews will be erased as soon as we have finished with them.

Information about your participation will only be available to the research team and staff responsible for monitoring the conduct of the study at the University and Trust. The study will respect patient confidentiality and you will be asked not to mention patients or colleagues by name. If any details of patients are mentioned they will be promptly removed from the transcripts of the interview data.

In the interests of patients' safety, it may be deemed necessary to break this confidentiality if you describe some **seriously unsafe** practice of yours (e.g. prescribing a ten-fold overdose of warfarin for a patient) that you state as not having been previously reported through your Trust's usual clinical governance procedures (e.g. the completion of a critical incident report). We have a professional obligation to report this to the appropriate bodies. If this situation occurs, the interview will be stopped and the matter discussed with you, making it clear what is happening, before discharging that responsibility.

### **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 interview at any point, if you wish to. The information collected can be destroyed after your withdrawal if you prefer.

### **What if there is a problem?**

If you have any concerns about any aspect of this study, you should speak with the researchers who will do their best to answer your questions (see contact details).

If you remain unhappy and wish to complain formally, you can contact the University Research Office on 0161 275 7583. This contact is independent of the researcher and research supervisors.

### **What will happen to the results of the research study?**

The results of the study will be analysed and published in professional journals and at conferences. They will also contribute to the completion of a postgraduate thesis. You will not be identifiable from the data used and published.

### **Who has organised the study?**

The study has been organised and funded by the Centre for Pharmacy Workforce Studies at the University of Manchester.

### **Who has reviewed the study?**

This study has been approved by Oldham Research Ethics Committee.

### **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 for an interview.

### **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:

Rebecca Elvey  
Centre for Pharmacy Workforce Studies  
School of Pharmacy and Pharmaceutical Sciences  
University of Manchester  
1<sup>st</sup> Floor, Stopford Building  
Oxford Road  
Manchester  
M13 9PT

Telephone: 0161 275 2415  
Email: [rebecca.elvey@manchester.ac.uk](mailto:rebecca.elvey@manchester.ac.uk)

Thank you once again for taking the time to read through this information and considering taking part in this study.

# Pan-Manchester R&D Notification Form

This **three-page** form must be fully completed and used to inform The University and NHS Trust(s) of all research, whether internally or externally funded. It must be signed by:

- An R&D Office on behalf of the NHS Trust where staff are to be based and resources/facilities will be used<sup>1</sup>.
- ALL the Heads of Departments or an Authorised Signatory of each University Department or Division/ School to receive financial credit from such an award. The Faculty of Medical and Human Sciences Research Office will be unable to authorise any proposal in the absence of an appropriately completed Notification Form.



For help with information required in each field, click on relevant field and press F1 or refer to the guidance notes.

*Ethics Application*

1) Project Details			
Full Title of the Project:		Professional identity in pharmacy	
Please use the same title as used in ethics application form.			
Sponsor of Project:		The University of Manchester	
If 'Other' please specify:			
Funder of Project (if different to Sponsor):		Total Project Value (£s)	n/a
Name of Organisation receiving/ administering funds:		Is this a grant application?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		Has a grant been awarded?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Intended Start Date: (dd/mm/yy)		Intended End Date: (dd/mm/yy)	31/12/09

2) Location	
Sites (Facility and institution(s)) where the research will be conducted:	The University of Manchester

3) Ethics (For further information regarding NHS Research Ethics Committees, visit <a href="http://www.corec.org.uk">www.corec.org.uk</a> )	
Is a favourable ethics opinion required:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Date Submitted (dd/mm/yy):	29/01/09
If a favourable ethics opinion has already been obtained, please give:	
Committee Name:	Ref No:
LREC:	
MREC:	
University Ethics Committee:	<input type="checkbox"/> Yes <input type="checkbox"/> No

4) Type of research	
Is the research a multi-centre project?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If 'Yes' please specify name of Lead Organisation:	The University of Manchester
Name of Chief Investigator if different to Principal Investigator (given below)	Rebecca Elvey

5) Principal Investigator (PI)		
Name: Title Professor	Forename(s): Karen	Surname: Hassell
Tel: 0161 2752420	Fax: 0161 2752416	E-mail: karen.hasell@manchester.ac.uk
Job Title: Chair of Social Pharmacy	Employer Name: The University of Manchester If Other (please specify):	Honorary Contract held? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If 'Yes' name issuing organisation:
NHS Trust Department:	University Division/ School Research Group: Pharmacy	Credit share of funding (%): n/a

<sup>1</sup> Please note that some R&D offices may require additional information before Trust approval can be given.

University staff only: % of effort to be spent on this project: %

## Pan-Manchester R&D Notification Form

**6) Co-applicants** (If you need to add any further applicants please provide details on separate sheet.)

Co-applicant 1		
Name: Title Ms	Forename(s): Rebecca	Surname: Elvey
Tel: 0161 2752415	Fax: 0161 2752416	E-mail: rebecca.elvey@manchester.ac.uk
Job Title: PhD Student	Employer Name: The University of Manchester If Other (please specify):	Honorary Contract held? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'Yes' name issuing organisation:
NHS Trust Department:	University Division/ School Research Group: Please choose	Credit share of funding (%):
University staff only: % of effort to be spent on this project: %		

Co-applicant 2		
Name: Title Dr	Forename(s): Jason	Surname: Hall
Tel: 0161 2752720	Fax: 0161 2752416	E-mail: jason.hall@manchester.ac.uk
Job Title: Senior teaching fellow	Employer Name: The University of Manchester If Other (please specify):	Honorary Contract held? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'Yes' name issuing organisation:
NHS Trust Department:	University Division/ School Research Group: Please choose	Credit share of funding (%):
University staff only: % of effort to be spent on this project: %		

Co-applicant 3		
Name: Title Please choose	Forename(s):	Surname:
Tel:	Fax:	E-mail:
Job Title:	Employer Name: Please choose If Other (please specify):	Honorary Contract held? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'Yes' name issuing organisation:
NHS Trust Department:	University Division/ School Research Group: Please choose	Credit share of funding (%):
University staff only: % of effort to be spent on this project: %		

### 7) Declaration by Principal Investigator/ Researcher

***The Principal Investigator and/ or researchers confirm this project complies, where appropriate, with the DH Research Governance Framework for Health and Social Care<sup>2</sup> and/ or all legal and statutory requirements (e.g. licences, authorisations and approvals) applying to the proposed work are observed and complied with. Please refer to Section 7 of the Guidelines.***

Principal Investigator		
Name: Karen Hassell	Signature: <i>Karen Hassell</i>	Date (dd/mm/yy): 16/1/09

<sup>2</sup> DoH Research Governance Framework Version 2, 2005

# Pan-Manchester R&D Notification Form

## 8) Authorisation by University and/ or Trust (Official Use Only)

I/ we have reviewed the application, for which external funding is being sought or internal funding is available, and confirm that:

1. The project is acceptable to and can be accommodated within the space available to this University Division or School/ Trust;
2. If successful additional support from central funds, e.g. building alterations, running or maintenance costs or compensation for currency exchange fluctuation, or NHS Clinical service costs must have been agreed beforehand;
3. Within the terms and conditions, the University will recover costs in line with the Faculty's pricing policy.

**As Head of University Division/ School or Trust Authorised Signatory I accept that it is my responsibility to ensure that the University's/ Trust's Financial Regulations are adhered to in connection with any transactions charged to this project. I also accept that any deficits as a result of overspends against budget or ineligible expenditure which may arise will be recouped from other funds available to the University or Trust's Clinical Department, or at School level as appropriate.**

### 8a) University Authorisation:

Division/ School Leader/ Authorised Signatory for <b>Principal Investigator</b> :	Name: <u>David Clarke</u> Signature: <u>[Signature]</u>	Date (dd/mm/yy): <u>20/1/09</u>
Division/ School Leader/ Authorised Signatory for <b>Co-applicant 1</b> :	Name: <u>David Clarke</u> Signature: <u>[Signature]</u>	Date (dd/mm/yy): <u>20/1/09</u>
Division/ School Leader/ Authorised Signatory for <b>Co-applicant 2</b> :	Name: <u>David Clarke</u> Signature: <u>[Signature]</u>	Date (dd/mm/yy): <u>20/1/09</u>
Division/ School Leader/ Authorised Signatory for <b>Co-applicant 3</b> :	Name: _____ Signature: _____	Date (dd/mm/yy): _____

### 8b) NHS Trust(s) Authorisation:

When presenting your application for Trust approval please ensure that you provide a copy of the following (please tick):

- Research funding application ☐
- Research protocol ☐
- Research ethics application ☐
- Favourable ethics opinion letter (if applicable) ☐
- Evidence of independent scientific or peer review ☐ *browse to **PReviewNow** for assistance*

Authorised Signatory for Trust:	Name: _____	Date (dd/mm/yy): _____
Trust Name: _____	Signature: _____	
Authorised Signatory for Trust:	Name: _____	Date (dd/mm/yy): _____
Trust Name: _____	Signature: _____	

### 9) Internal Review:

Has this proposal been subject to internal review by an authorised person within your School? ☐ Yes ☐ No

If 'Yes' please ask the relevant person to sign here:

Name: \_\_\_\_\_ Signature \_\_\_\_\_

N.B. This application cannot be submitted unless it has been internally reviewed by your School.

### 10) Institutional Commitment:

Will this project require any Institutional commitment, either during the award period itself or following its completion? ☐ Yes ☐ No

If 'Yes' please ask the appropriate person within your School authorised to make this commitment to sign here:

Name: \_\_\_\_\_ Signature \_\_\_\_\_

## **Protocol**

### **Professional identity, image and reputation in pharmacy**

**Rebecca Elvey MA**  
**PhD student**  
**Centre for Pharmacy Workforce Studies**  
**The University of Manchester**

## Introduction

Pharmacists' jobs have changed in recent years, with pharmacists being expected to take on new roles which require new skills and activities. UK government policy since 2000 has outlined a busy agenda for pharmacists. Pharmacists are being encouraged to develop both their clinical role, making full use of their clinical knowledge and skills, while also taking on greater responsibilities in public health and as medicines experts.(1) In such a time of change, the professional identity of pharmacists is likely to change.

Professional identity relates to a person's sense of 'who they are' in relation to their professional role. Professional identity refers to:

- Membership of professional or organisational groups
- Professional roles
- A range of elements by which people are defined as members of these groups and in these roles

Whether the focus is on groups, roles, or both, professional identity is generally perceived as being constructed of a number of components which define people as members of groups or in particular roles. Following definitions proposed in a number of studies, for the purposes of this project, professional identity is understood to include: the knowledge, skills, values, motivations, goals, orientations (preferences, attitudes), attributes, qualities, characteristics interests and working relationships in terms of which people define themselves as professionals. (2;3)

Professional identity is related to, and can be influenced by other peoples' views and attitudes. Therefore, in addition to professional identity, this project is concerned with the two related concepts of professional image and professional reputation. These three concepts are defined as follows:

- Professional identity – a person's own definition of themselves as a professional
- Professional image – the way in which a person believes others see them
- Professional reputation – how others actually see a person

Professional identity, image and reputation and the relationship between them are deemed to be important because research has suggested that identity can be affected by what outsiders think.(4)

Professional identity, image and reputation all exist at both an individual (personal) level and a collective level, that is, the collective identity of a professional group or an organisation.

There is an ongoing focus in health policy on interprofessional learning and working, however, recent reports suggest that in primary care particularly, professional relationships between pharmacists and GPs were strained (5)and that integrated care needs closer professional co-operation than currently exists.(6) The white paper also suggests that there is a need to raise awareness of the services and benefits offered by pharmacists. To address some of these issues, the white paper proposes that a communications programme should be developed to 'support the delivery of key messages to patients, the public, the NHS and others to improve awareness and understanding of the role of pharmacy in providing services.' (7)

Professional identity can be affected by changes to professional roles. In times of change, individuals may be prompted to question their identity. Transition or change, either due to an individual taking on a different social position, or the position itself, or people's expectations for that position, changing, can also cause strain. This is important because studies of formal organisations have shown role conflict to be associated with stress, poor job performance, lower commitment to the organisation and higher rates of accidents and resignations.

A literature review of electronic databases (e.g. PubMed, International Pharmaceutical Abstracts) was conducted to identify internationally published research investigating the professional identity, image and reputation of pharmacists. In terms of *identity*, the review

found a number of studies that investigated pharmacy students' perceptions of their professional identity in relation to other health care professions.(8-10) Other studies have investigated pharmacists' orientations to new roles.(11) Two studies which used quantitative methods to measure pharmacists' *image* were identified. In terms of pharmacist' reputation, literature from a range of standpoints has informed this project. One study found that pharmacists, along with doctors, were rated lowest out of 10 health professions on interpersonal skills. A focus group study of general practitioners found that a 'shopkeeper' image of community pharmacists prevailed amongst this professional group.(12) A recent study of stakeholders' views towards supplementary prescribing by nurses and pharmacists found that pharmacists were perceived to be competent in pharmacology, but lacked counselling and diagnostic skills.(13) In terms of public views of pharmacists, public support for the role of the pharmacist has been found to be high, however, there are also contradictory ideas about the functions of the pharmacist; primary health care roles have been seen to result from counterbalancing perceived deficiencies from other health care professionals such as doctors, and the 'commercialism image' of community pharmacies has been noted as a point of concern. Findings from questionnaire studies on the public perceptions of pharmacists suggested a lack of a distinct 'identity', for example over 40 percent of respondents said they could not distinguish a pharmacy from a pharmacy attendant. A number of opinion pieces in the Pharmaceutical Journal have claimed that pharmacists' reputation with the public has declined and that they should work to increase public awareness of their extended roles.(14;15)

The literature on professional identity, image and reputation of pharmacy includes studies undertaken from a range of perspectives and using various research methods. However, the issues warrants further research for several reasons. Many of the studies were conducted decades ago, and some were conducted outside the UK, in different healthcare contexts. The majority of studies used quantitative methods and many were based on research tools originally developed for use with different occupations and which have not been validated for use with pharmacists today. Furthermore, there is a particular lack of qualitative research on hospital pharmacists within this area. In 2001, Hassell et al argued that the 'raison d'être' of the pharmacy profession, and its' place and contribution to the NHS has been ambiguous and unpredictable.(16) Three years later, Shann and Hassell identified a need to validate the existence of different 'types' of pharmacist and to clearly identify the characteristics that define them.(17)

In 2008, a focus group study was undertaken by the CI with practising pharmacists connected to the pharmacy practice research group at the university, with pharmacists employed in the community, hospital and primary care sectors. The data was analysed and a preliminary 'typology' of pharmacists was produced. The main limitation of the focus group study, was that all the participants were connected to the university, therefore they may have a different perspective from other practicing pharmacists. Therefore, it is considered that further work is needed to validate the findings with a sample of 'grassroots' pharmacists practising in a variety of healthcare settings. Considering the research evidence described above suggesting that image and reputation are important when investigating professional identity it will also be beneficial to capture the views of other health care professionals and patients who interact with pharmacists.

All of these factors suggested a need for fresh, qualitative research to address the issue of professional identity across the pharmacy profession in the UK today.

## **Methodology**

### ***Aims and objectives of the research***

The overall aim of this project is to use interviews to explore the notion of professional identity with pharmacists, doctors, nurses, plus associated staff (such as pharmacy technicians and practice managers) and also patients, to identify whether different stakeholders share similar or hold divergent views.

### ***Sample***



Interviews will be conducted with pharmacists working in the hospital, community and primary care sectors. Other health care professionals who regularly interact with pharmacists such as doctors and nurses, working in the primary and secondary care sectors, associated staff such as pharmacy technicians and general practice receptionists and also with patients and other users of pharmacies.

Pharmacists, nurses, doctors and associated staff will be identified via contacts known to the investigator, either personally or through members of the Pharmacy Practice research group at the University of Manchester and working in the collaboration of the investigator. These contacts are employed within NHS trusts and primary care trusts (PCTs).

Patients will be identified by their use of hospital or community pharmacy services at the sites where the professional participants are located.

### **Setting**

The interviews will be conducted by the investigator at selected venues that are convenient to participants and the investigator. Venues may include offices in the University of Manchester, primary care trust, community pharmacy, NHS hospital, conference centre premises or participants' own homes if required.

### **Interviews**

Due to the broad scope and complex nature of the subject matter, and because some elements were not well defined, a qualitative approach, using focus groups, was considered appropriate for the pilot study. Focus groups and interviews are used when it is necessary to explore concepts and can be particularly useful when there is limited research in the area of interest.(18) The life story approach is a qualitative narrative research approach for gathering information on the subjective essence of one person's life. The life story approach has been used across various disciplines to gain detailed understanding of people's lives and how the individual plays various roles in society. An interview that focuses on a specific aspect of a person's life, such as their work life, is called an oral history. This approach has been found to be useful in gaining clarity on a person's self-image and identity, and can help researchers to define an individual's place in the social order. (19) For these reasons, an oral history approach was considered appropriate for the pharmacist interviews.

Participants will be invited to take part in one to one interviews. Interviews will be conducted using a topic guide. For professional staff, the interviews will be between 30 minutes and one hour in duration, for associated staff and patients or users of pharmacy services, the interviews will last a maximum of 30 minutes. Interviews will be audio-recorded with the permission of the participants and will be transcribed verbatim.

Participants will be asked to provide brief demographic details. These details will be studied to ensure a range of views are being captured.

### **Interview schedule**

Informal, semi-structured interviews will allow flexibility and increase trust between the participants and the researcher. Interviews will follow a semi-structured schedule and will include 'probes' to encourage fuller responses where needed.(20) Oral history interviews are conducted using an open-ended interview approach, with specific questions ready to ask when needed. Table 1 below outlines the main questions and prompts that may be used during the interviews.

**Table 1: Schedule for semi-structured one to one interviews**

<b>Stakeholders: Pharmacists</b>	
<b>Area of concern</b>	<b>Questions</b>
Educational and professional background	<p>What school of pharmacy did you go to?</p> <p>When did you qualify?</p> <p>Did you do work placements?</p>

	What did you enjoy most and least during your time at university?
Views on career and current role	<p>What is your current job title?</p> <p>How long have you been doing this job?</p> <p>Which areas of pharmacy have you worked in?</p> <p>Did you always know you wanted to work in this sector?</p> <p>Are there any key events that stand out?</p> <p>Did these change your perspective?</p>
The elements that make up the professional identity of pharmacists	<p>What do you think makes a good pharmacist? (<i>Prompts – do you need specific knowledge, skills, a certain type of personality?</i>)</p> <p>How do you think your patients/customers would answer this question?</p> <p>How would other health care professionals you work with answer this question?</p>
Professional identity and group identification	<p>Do you think all pharmacists are alike?</p> <p>Is there such a thing as the typical pharmacist?</p> <p>What are they like?</p> <p>Do you see yourself as this person?</p> <p>What is unique about pharmacists?</p> <p>How are they different from doctors and from nurses?</p>
Pharmacists' professional roles	Are there things that you are required to do that you do not think pharmacists should be doing?
Role models	Is there a particular person who has made an impression on you or influenced you during your career so far? ( <i>Prompts - this could be someone you would like to be, or someone you want to avoid becoming.</i> )
Media representation of pharmacy and pharmacists.	What representation of pharmacists have you seen in the media? ( <i>Prompts - Can you think of any recent news stories about pharmacists? Can you think of any examples of pharmacists in novels or other popular culture – on TV programmes, in films?</i> )
Future roles	<p>What are your goals as you move forward in your career?</p> <p>Are there more services that you would like to provide/get involved with in the future?</p>
<b>Stakeholders: Doctors, nurses and associated staff</b>	
<b>Area of concern</b>	<b>Questions</b>
Current role	<p>What is your current job title?</p> <p>How long have you been doing this job?</p>
Contact and working relationships with pharmacists	What type of contact do you have with pharmacists? ( <i>Prompts – Is this in person? Over the phone? For what reasons? How frequently?</i> )
Working relationships	Can you give me an example of a positive and/or negative interaction with a pharmacist?
Identity of the pharmacist	Can you tell who is a pharmacist and who is a technician?
Identity and role of	What types of pharmacists have you come across? ( <i>Prompts –</i>

pharmacists	<i>Perhaps working in different sectors, or in different jobs.)</i>
Status/prestige of pharmacy	What are your views on the status of pharmacists compared to other members of the health care team?
Pharmacists' training and knowledge.	Do you know anything about the training that pharmacists undergo? <i>(Prompt – e.g. how long this takes.)</i>
Perceptions of pharmacists	How would you sum up in a few words what pharmacists do, or are like?
Future roles	Are there services that you would like the pharmacist to provide that they don't currently?
Media representation of pharmacy and pharmacists.	What representation of pharmacists have you seen in the media? <i>(Prompts - Can you think of any recent news stories about pharmacists? Can you think of any examples of pharmacists in novels or other popular culture – on TV programmes, in films?)</i>
<b>Stakeholders: Patients and users of pharmacy services</b>	
<b>Area of concern</b>	<b>Questions</b>
Participants' use and experience of pharmacy services.	What did you use the pharmacy for today? <i>(Prompts – to collect a prescription? To buy something? To get advice? Something else)</i>  Do you tend to use the same pharmacy? Why/why not?
Identity of the pharmacist	Have you ever spoken to a pharmacist?  Do you tend to ask for the pharmacist when you use a pharmacy?  Do you know who the pharmacist is when you visit the pharmacy? (If so, how?)
The role of the pharmacist	What do pharmacists do?
Pharmacists' training and knowledge.	Do you know anything about the training that pharmacists undergo? <i>(Prompt – e.g. how long this takes.)</i>
Professional identity, professional groups and roles	What is the difference between a doctor and a pharmacist?
Perceptions of pharmacists	How would you sum up in a few words what pharmacists do, or are like?
Views about entrepreneurial nature of community pharmacy	Would you say that pharmacists are health care professionals?  Considering the fact that community pharmacists are employed in private businesses, does this make them different to other health care professionals?
Media representation of pharmacists	What representation of pharmacists have you seen in the media? <i>(Prompts - Can you think of any recent news stories about pharmacists? Can you think of any examples of pharmacists in novels or other popular culture – on TV programmes, in films?)</i>
Future roles	Are there services that you would like the pharmacist to provide that they don't currently?

### **Analysis of qualitative data**

While there are a range of approaches to analysing qualitative data, a method deemed particularly suitable for this project is the framework approach developed by Ritchie and Spencer (ref). This approach involves the development of a structured hierarchical thematic framework which is used to classify and organise data according to key themes and concepts which have emerged from the interviews. To assist in analysing the data following this approach, the computer software package Nvivo will be used, which was specifically designed for managing qualitative data.

### **Validity of qualitative research**

King (1994) states validity in qualitative research is achieved if the research explored what it claims to have explored.(21) However, there are arguments in the literature about the validity of qualitative research in terms of whether qualitative research should be judged according to

the same criteria as quantitative research.(22) Atkinson explains that it is not necessary to try to interpret the findings from oral history interviews against qualitative standards of analysis. An oral history interviewer seeks the insider's viewpoint on the particular aspect of their life that is being discussed and the storyteller should be considered both the expert and the authority on his or her own life. However, while the oral history interview is a subjective process, internal consistency can be used as a 'primary quality check' to clarify early comments if they appear to be different or to contradict something that is said later in the interview.(19) In addition, for the purposes of this study, validity of the researcher's interpretation will be assessed through the involvement and judgements of other more experienced researchers.

### **Recruitment**

Emails or letters of invitation will be sent to pharmacists, doctors and nurses working in NHS hospitals, primary care trusts, general practices and community pharmacies. This letter/email will also include an interview information sheet and a consent form. Those who are willing to participate will be asked to contact the investigator via telephone or email to arrange a meeting at a suitable time and venue and clarify any questions they may have. The overall recruitment strategy will also include the technique of snowballing. This will involve requesting participants to suggest peers who may be willing to take part in the study. Participants if willing would then pass details of the study (participant information leaflets and letters of invitation) to suitable colleagues. These people would then contact the chief investigator if they were interested in taking part in the study.

For users of pharmacy services, details of the study (participant information leaflets and letters of invitation) would be provided to hospital patients by the CI's contacts in the hospital, and to users of community pharmacies by contacts in those pharmacies. Patients and service users would also be asked by these contacts whether they were willing to provide their contact details (name and telephone number or email address). These people would then contact the investigator if they were interested in taking part in the study, or, where they had provided their contact details, the investigator would then contact them to arrange an interview at a suitable time and venue. If necessary, the investigator may visit community pharmacies and/or hospital clinics to approach patients and pharmacy users to inform them about the study, provide information to those who may be willing to participate in the study (participant information leaflets and letters of invitation), and collect contact details (name and telephone number or email address). These people would then contact the investigator if they were interested in taking part in the study, or, where they had provided their contact details, the investigator would then contact them to arrange an interview at a suitable time and venue.

### **Data collection**

Participants who agree to be involved in the study will be invited to attend a one to one interview during the study period. Before the interview, the investigator will explain the necessity for the research and assure confidentiality. The same investigator will conduct all interviews, which will last up to approximately one hour. A topic guide will be used in all cases. All interviews will be audio-recorded with the permission of the participants and transcribed verbatim. Audio files and anonymised transcripts will be stored securely, accessible only by the investigator.

### **Dissemination strategy**

Participants will be provided with a summary of the main findings of the interviews if they wish to be informed of these. The findings of the study will be published in peer-reviewed journals and the presentation of findings at appropriate conferences will be considered.

### **Timescale**

I propose a start date of 16<sup>th</sup> Feb 2009 and propose an end date of 31<sup>st</sup> December 2009.

## Reference List

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- (22) Rolfe G. Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Methodological Issues in Nursing Research* 2004;53(3):304-10.

## Welcome to the Integrated Research Application System

## IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

**Please enter a short title for this project** (maximum 70 characters)  
Professional identity in pharmacy

**1. Is your project an audit or service evaluation?**

☐ Yes ☒ No

**2. Select one category from the list below:**

- ☐ Clinical trial of an investigational medicinal product
- ☐ Clinical investigation or other study of a medical device
- ☐ Combined trial of an investigational medicinal product and an investigational medical device
- ☐ Other clinical trial or clinical investigation
- ☐ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
- ☒ Study involving qualitative methods only
- ☐ Study limited to working with human tissue samples, other human biological samples and/or data (*specific project only*)
- ☐ Research tissue bank
- ☐ Research database

**If your work does not fit any of these categories, select the option below:**

☐ Other study

**2a. Please answer the following question(s):**

- a) Does the study involve the use of any ionising radiation? ☐ Yes ☒ No
- b) Will you be taking new human tissue samples (or other human biological samples)? ☐ Yes ☒ No
- c) Will you be using existing human tissue samples (or other human biological samples)? ☐ Yes ☒ No

**3. In which countries of the UK will the research sites be located? (Tick all that apply)**

- ☒ England
- ☐ Scotland
- ☐ Wales
- ☐ Northern Ireland

**3a. In which country of the UK will the lead R&D office be located?**

- ☐ England  
☐ Scotland  
☐ Wales  
☐ Northern Ireland

**4. Which review bodies are you applying to?**

- ☐ NHS/HSC Research and Development offices  
☒ Research Ethics Committee  
☐ Patient Information Advisory Group (PIAG)  
☐ Ministry of Justice (MoJ)

**5. Will any research sites in this study be NHS organisations?**

- ☒ Yes ☐ No

**6. Do you plan to include any participants who are children?**

- ☐ Yes ☒ No

**7. Do you plan to include any participants who are adults unable to consent for themselves through physical or mental incapacity?** *The guidance notes explain how an adult is defined for this purpose.*

- ☐ Yes ☒ No

**8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service in England or Wales?**

- ☐ Yes ☒ No

**9. Is the study, or any part of the study, being undertaken as an educational project?**

- ☒ Yes ☐ No

**9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?**

- ☒ Yes ☐ No

**10. Is this project financially supported by the United States Department for Health and Human Services?**

- ☐ Yes ☒ No

**11. Will identifiable patient data be accessed outside the clinical care team without prior consent at any stage of the project (including identification of potential participants)?**

- ☐ Yes ☒ No



**Integrated Research Application System**  
**Application Form for Research involving qualitative methods only****Application to NHS/HSC Research Ethics Committee**

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting [Help](#).

**Short title and version number:** (maximum 70 characters – this will be inserted as header on all forms)  
Professional identity in pharmacy

*Please complete these details after you have booked the REC application for review.*

**REC Name:**  
Oldham

**REC Reference Number:**  
09/H1011?8

**Submission date:**  
29/01/2009

**PART A: Core study information****1. ADMINISTRATIVE DETAILS****A1. Full title of the research:**

Professional identity, image and reputation in pharmacy

**A2–1. Give details of the educational course or degree for which this research is being undertaken:**

Name and level of course/ degree:  
PhD Pharmacy Practice

Name of educational establishment:  
The University of Manchester

Name and contact details of academic supervisor:

Title	Forename/Initials	Surname
Prof.	Karen	Hassell
Address	The University of Manchester	
	Stopford Building, 1st floor	
	Oxford Road	

Post Code M13 9PT  
 E-mail karen.hassell@manchester.ac.uk  
 Telephone 0161 275 2422  
 Fax 0161 275 2416

Name and contact details of student:

	Title	Forename/Initials	Surname
	Ms	Rebecca	Elvey
Address	Centre Pharmacy Workforce Studies		
	The University of Manchester		
	Stopford Building 1st floor		
Post Code	M13 9PT		
E-mail	rebecca.elvey@manchester.ac.uk		
Telephone	0161 275 2415		
Fax	0161 275 2416		

*A copy of a current CV for the student (maximum 2 pages of A4) must be submitted with the application.*

**A2-2. Who will act as Chief Investigator for this study?**

- ☒ Student  
☐ Academic supervisor  
☐ Other

**A3. Chief Investigator:**

	Title	Forename/Initials	Surname
	Ms	Rebecca	Elvey
Post	PhD student		
Qualifications	MA (Econ) Applied Social Research BA (Hons) Politics		
Employer	The University of Manchester		
Work Address	Centre Pharmacy Workforce Studies		
	The University of Manchester		
	Stopford Building 1st floor		
Post Code	M13 9PT		
Work E-mail	rebecca.elvey@manchester.ac.uk		
* Personal E-mail			
Work Telephone	0161 275 2415		
* Personal Telephone/Mobile	07917831910		
Fax	0161 275 2416		

*\* This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*

*A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.*

**A4. Is there a central study co-ordinator for this research?**

☐ Yes ☒ No

Title Forename/Initials Surname

Address

Post Code

E-mail

Telephone

Fax

**A5-1. Research reference numbers. Please give any relevant references for your study:**

Applicant's/organisation's own reference number, e.g. R & D (if available): N/A

Sponsor's/protocol number: N/A

Funder's reference number: N/A

International Standard Randomised Controlled Trial Number (ISRCTN): N/A

ClinicalTrials.gov Identifier (NCT number): N/A

European Clinical Trials Database (EudraCT) number: N/A

Project website: N/A

Ref.Number	Description	Reference Number
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**A5-2. Is this application linked to a previous study or another current application?**

☐ Yes ☒ No

*Please give brief details and reference numbers.*

**2. OVERVIEW OF THE RESEARCH**

*To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.*

**A6-1. Summary of the study. Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. This summary will be published on the website of the National Research Ethics Service following the ethical review.**

The main purpose of this research is to gain insight, using qualitative methods, into professional identity, image and reputation in pharmacy. Pharmacists' jobs have changed in recent years, with pharmacists being expected to take on new roles which require new skills and activities. In such a time of change, the professional identity of pharmacists, and other staff or patients' expectations of pharmacists, is likely to change. Consequently, it would be beneficial to identify how pharmacists see their own professional identity, and also how they are perceived by other healthcare professionals and by their patients, to identify to what extent different stakeholders share similar views, and find out what differences in opinion exist. The study will use qualitative interviews with pharmacists to explore their perceptions of their own professional identity and image, i.e. how they define themselves in their professional roles and how they believe others see them. Interviews will also be undertaken with pharmacy support staff, doctors, nurses and patients and other users of community pharmacies, to investigate the professional reputation of pharmacists, that is, how these 'others' perceive pharmacists.

**A6-2. Summary of main issues.** *Please summarise the main ethical and design issues arising from the study and say how you have addressed them.*

The main ethical issues are: informing the participant of their right to withdraw, informed consent, discussing issues which may be of a sensitive nature and debriefing.

The CI will ensure from the first contact that interviewees are aware of their right to withdraw at any time. The CI will comply with requests by participants who are withdrawing from research that any data they have contributed, including recordings, be destroyed.

The CI will ensure that participants are given ample opportunity to understand the nature, purpose, and anticipated consequences of their involvement in the research so that they may give informed consent. Participants will be given an opportunity to ask questions about the research before giving their consent to participate. The CI will obtain the informed consent of all participants and keep adequate records of when, how and from whom consent was obtained.

Participants will be asked during interviews to talk about their professional identity (pharmacists), or their perceptions of and views about pharmacists (other health care professionals and patients). The interview schedule does not contain sensitive questions or probes. However, potentially, participants may spontaneously comment on an issue that was distressing for them, if this happens the interviewer will not probe unnecessarily. The CI, who will be undertaking all the interviews, has been trained in interview techniques and has experience of conducting over eighty one-to-one interviews and several focus groups. Furthermore, participants will be reminded that interviews are anonymous and confidential, that their participation is entirely voluntary and that they can withdraw at any time.

The CI will debrief research participants at the conclusion of their participation, in order to: verify that the interviewer's interpretation of their responses has not been misinterpreted, to inform them of the anticipated outcomes and nature of the research, to identify any unforeseen outcomes or misconceptions, to answer any questions that they may have about the research and in order to arrange for any assistance as needed.

**3. PURPOSE AND DESIGN OF THE RESEARCH****A7. Select the appropriate methodology description for this research.** *Please tick all that apply:*

- ☐ Case series/ case note review
- ☐ Case control
- ☐ Cohort observation
- ☐ Controlled trial without randomisation
- ☐ Cross-sectional study
- ☐ Database analysis
- ☐ Epidemiology
- ☐ Feasibility/ pilot study
- ☐ Laboratory study
- ☐ Metanalysis
- ☐ Qualitative research
- ☒ Questionnaire, interview or observation study
- ☐ Randomised controlled trial
- ☐ Other (please specify)

**A10. What is the principal research question/objective? Please put this in language comprehensible to a lay person.**

The principal aim of this study is to explore the professional identity, image and reputation of pharmacists.

**A11. What are the secondary research questions/objectives if applicable? Please put this in language comprehensible to a lay person.**

n/a

**A12. What is the scientific justification for the research? Please put this in language comprehensible to a lay person.**

Professional identity is a key concept within research on careers and occupations generally. Professional identity refers to:

- Membership of professional or organisational groups
- Professional roles
- A range of elements by which people are defined as members of these groups and in these roles

Whether the focus is on groups, roles, or both, professional identity is generally perceived as being constructed of a number of components which define people as members of groups or in particular roles. Professional identity includes: the knowledge, skills, values, motivations, goals, orientations (preferences, attitudes), attributes, qualities, characteristics interests and working relationships in terms of which people define themselves as professionals. In addition to professional identity, this project is concerned with the two related concepts of professional image and professional reputation. These three concepts are defined as follows:

- Professional identity – a person's own definition of themselves as a professional
- Professional image – the way in which a person believes others see them
- Professional reputation – how others actually see a person

Professional identity, image and reputation and the relationship between them are deemed to be important because research has suggested that identity can be affected by what outsiders think. Identity shapes how people act and how they interpret things, which affects what outsiders think of them and how they treat them, which in turn affects peoples' identity. Similarly, research investigating the effect of stereotypes has suggested that the stereotypes held of one group by another can have an impact on identity. Negative perceptions of the public stereotyping of nursing, for example, has been thought to influence the development of poor collective self-esteem, job satisfaction and performance in nurses.

UK government policy since 2000 has outlined a busy agenda for pharmacists. Pharmacists are being encouraged to develop both their clinical role, making full use of their clinical knowledge and skills, while also taking on greater responsibilities in public health and as medicines experts. The latest pharmacy white paper contends that pharmacists remain a 'significant untapped resource' in health care. There is also an ongoing focus in health policy on interprofessional learning and working, however, recent reports suggest that in primary care particularly, professional relationships between pharmacists and GPs were strained and that integrated care needs closer professional co-operation than currently exists.

Professional identity can be affected by changes to professional roles. In times of change, individuals may be prompted to question their identity. Transition or change, either due to an individual taking on a different social position, or the position itself, or people's expectations for that position, changing, can also cause strain. This is important because studies of formal organisations have shown role conflict to be associated with stress, poor job performance, lower commitment to the organisation and higher rates of accidents and resignations.

A literature review of electronic databases (e.g. PubMed, International Pharmaceutical Abstracts) was conducted to identify internationally published research investigating the professional identity, image and reputation of pharmacists. In terms of identity, the review found a number of studies that investigated pharmacy students' perceptions of their professional identity in relation to other health care professions. Other studies have investigated pharmacists' orientations to new roles. Two studies which used quantitative methods to measure pharmacists' image were identified. In terms of pharmacist reputation, literature from a range of standpoints has informed this project. One study found that pharmacists, along with doctors, were rated lowest out of 10 health professions on interpersonal skills. A focus group study of general practitioners found that a 'shopkeeper' image of community pharmacists prevailed amongst this professional group. A recent study of stakeholders' views towards supplementary prescribing by nurses and pharmacists found that pharmacists were perceived to be competent in pharmacology, but lacked counselling and diagnostic skills. In terms of public views of pharmacists, public support for the role of the pharmacist has been found to be high, however, there are also contradictory ideas about the functions of the pharmacist; primary health care roles have been seen to result from counterbalancing perceived deficiencies from other health care professionals such as doctors, and the 'commercialism image' of community pharmacies has been noted as a point of concern. Findings from questionnaire studies on the public perceptions of pharmacists suggested a lack of a distinct 'identity', for example over 40 percent of respondents said they could not

distinguish a pharmacy from a pharmacy attendant. A number of opinion pieces in the Pharmaceutical Journal have claimed that pharmacists' reputation with the public has declined and that they should work to increase public awareness of their extended roles.

The literature on professional identity, image and reputation of pharmacy includes studies undertaken from a range of perspectives and using various research methods. However, the issues warrants further research for several reasons. Many of the studies were conducted decades ago, and some were conducted outside the UK, in different healthcare contexts. The majority of studies used quantitative methods and many were based on research tools originally developed for use with different occupations and which have not been validated for use with pharmacists today. Furthermore, there is a particular lack of qualitative research on hospital pharmacists within this area. In 2001, Hassell et al argued that the 'raison d'être' of the pharmacy profession, and its place and contribution to the NHS has been ambiguous and unpredictable. Three years later, Shann and Hassell identified a need to validate the existence of different 'types' of pharmacist and to clearly identify the characteristics that define them.

In 2008, a focus group study was undertaken by the CI with practising pharmacists connected to the pharmacy practice research group at the university, with pharmacists employed in the community, hospital and primary care sectors. The data was analysed and a preliminary 'typology' of pharmacists was produced. The main limitation of the focus group study, was that all the participants were connected to the university, therefore they may have a different perspective from other practicing pharmacists. Therefore, it is considered that further work is needed to validate the findings with a larger sample of practising pharmacists. Considering the research evidence described above suggesting that image and reputation are important when investigating professional identity it will also be beneficial to capture the views of other health care professionals and patients who interact with pharmacists.

All of these factors suggested a need for fresh, qualitative research to address the issue of professional identity across the pharmacy profession in the UK today.

**A13. Please give a full summary of your design and methodology.** *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

The aim of this research is to gain insight, using qualitative methods, into professional identity, image and reputation in pharmacy. The study will use qualitative interviews with pharmacists to explore their perceptions of their own professional identity and image, i.e. how they define themselves in their professional roles and how they believe others see them. Interviews will also be undertaken with pharmacy support staff, doctors, nurses and patients and other users of community pharmacies, to investigate the professional reputation of pharmacists, that is, how these 'others' perceive pharmacists.

Qualitative methods such as interviews are used when it is necessary to explore concepts and can be particularly useful when there is limited research in the area of interest. Participants will be invited to take part in one interview. Participants will be asked to provide brief demographic details. These details will be studied to ensure a range of views are being captured. If necessary, further interviews will be conducted with additional participants.

Pharmacists participating in one to one interviews will be asked about their professional roles using open ended questions about their career history, their motivations for joining the profession of pharmacy, their career goals, preferences for different aspects of their role and professional relationships with other staff and with their patients. Participants will be asked whether they perceive a 'collective' professional identity for pharmacists, or whether they perceive differences between individual pharmacists generally, between different sectors of the profession, and between pharmacists and other health care professionals. Participants will also be asked how they are perceived by other health care professionals and by patients.

Nurses, doctors and other associated staff (such as pharmacy support staff or general practice receptionists) participating in interviews will be asked about their working relationships with pharmacists, their interpretation of the role of pharmacists and their perceptions on pharmacists' knowledge and characteristics.

Patients participating in interviews will be asked about their experiences of any interaction they have had with pharmacists, as patients or users of pharmacy services or community pharmacies. They will be asked about their general perceptions of pharmacists, including in comparison to other health care professionals such as nurses and doctors.

**A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, or members of the public?**

- ☐ Design of the research  
☐ Management of the research  
☐ Undertaking the research  
☐ Analysis of results  
☐ Dissemination of findings  
☒ None of the above

*Give details of involvement, or if none please justify the absence of involvement.*

This study is being undertaken as part of an educational qualification, as training for the researcher, and is exploratory in nature.

**4. RISKS AND ETHICAL ISSUES****RESEARCH PARTICIPANTS****A17. Please list the principal inclusion and exclusion criteria.**

The CI is interested in community, hospital and primary care pharmacists because they represent the majority of the pharmacy profession. The CI is also interested in the views of other health care professionals and associated support staff who have regular contact with pharmacists as part of their work. Additionally, the CI is interested in the recipients of health care, advice or other services from pharmacists. Therefore, the inclusion/exclusion criteria are:

- Pharmacists currently practising within the community, hospital or primary care sectors
- Nurses currently practising within hospitals and the community
- Doctors currently practising within hospitals and the community
- Associated staff such as pharmacy technicians and administrative staff who have contact with pharmacists through their work
- Hospital patients
- Users of community pharmacies

Exclusion criteria: Those who do not meet the inclusion criteria.

**RESEARCH PROCEDURES, RISKS AND BENEFITS****A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. These include seeking consent, interviews, non-clinical observations and use of questionnaires.**

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Seeking informed consent	1	N/A	5 minutes	Informed consent will be sought by the CI (Rebecca Elvey). Participants will complete the consent form at a time and place convenient to them.
One-to-one interview	1	N/A	1 hour	Interviews will be conducted by the CI (Rebecca Elvey). Interviews will be held in locations and venues convenient to participants throughout the north

				west of England.
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**A19. Give details of any clinical intervention(s) or procedure(s) to be received by participants as part of the research protocol.** *These include uses of medicinal products or devices, other medical treatments or assessments, mental health interventions, imaging investigations and taking samples of human biological material. Include procedures which might be received as routine clinical care outside of the research.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days).
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
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**A21. How long do you expect each participant to be in the study in total?**

Each consenting participant will take part in one interview. Involvement in the study, or the time from giving consent to time of last contact with the researcher is expected to be approximately one month. This is because this is how long it may take for the participant to find a time that is convenient for them to take part in an interview. Interviews will be conducted using a topic guide, and will be up to one hour in duration. After the interview, no further contact will be made, except where the participant wishes to be made aware of the results.

**A22. What are the potential risks and burdens for research participants and how will you minimise them?**

*For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.*

Potential inconveniences to participants include the amount of time they have to spend taking part in the study and also the potential risk that they may recount distressing issues during the interview.

To minimise the time inconvenience for participants in the study interviews will take place at times and places convenient to participants and has been limited to one hour in duration.

If participants raise sensitive or distressing issues, as a result of natural discourse, the interviewer, who is experienced in conducting interviews and has received the relevant training, will handle this as sensitively as possible and stop the interview if deemed necessary. Participants will also be assured of their confidentiality at all times. They will also be reminded that their participation is entirely voluntary and also that they can withdraw at any time.

**A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?**

☐ Yes ☒ No

*If Yes, please give details of procedures in place to deal with these issues:*



**A24. What is the potential for benefit to research participants?**

There is no direct benefit to the individual participants in the study. However, the study may benefit the pharmacy profession as a whole in the future, as it will identify the different types of pharmacists that exist within the profession, as well as to what extent the way that pharmacists see themselves matches how they are perceived by other members of the healthcare team and patients. This could in turn be used to inform and guide recruitment strategies for the profession, in terms of identifying the particular types of roles that may be attractive to potential entrants to the profession. The data collected may also help to inform policy in the pharmacy profession by highlighting any inconsistencies between the expectations of different stakeholder groups.

**A26. What are the potential risks for the researchers themselves? (if any)**

For lone working activity (i.e. carrying out interviews), the CI will not leave campus without informing the Supervisor (or School) of her destination, nature of the work, estimated time of return, location and the contact details of the interviewee. The CI will then advise the School upon return.

If the CI departs for the field directly from home, the supervisor or School will be given the relevant information by telephone and appropriate emergency plans will be in place should the lone worker fail to check in at the arranged time.

The CI will be traveling by public transport. The CI will endeavour to conduct interviews during daylight hours to avoid travelling alone at night.

**RECRUITMENT AND INFORMED CONSENT**

*In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.*

**A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used?** *For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).*

Pharmacists, nurses, doctors and associated staff will be identified via contacts known to the CI through members of the Pharmacy Practice research group in the School of Pharmacy and working in the collaboration of the CI. These contacts are employed within NHS trusts and primary care trusts (PCTs).

The CI will provide letters and/or emails of invitation to the contacts, who will forward these to colleagues at their place of work, inviting them to participate in the study. These letters or emails will also include a participant information sheet. Potential participants will be asked to contact the investigator via telephone or email to arrange a meeting and clarify any questions they may have.

Patients will be identified by their use of hospital or community pharmacy services at the sites where the professional participants are located. Pharmacists and pharmacy support staff will be asked to distribute 'recruitment packs' containing letters of invitation, information sheets and consent forms to patients and other users of pharmacy services. A pack will be provided to any patient or service user who is willing to receive one.

**A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?**

☐ Yes ☒ No

*Please give details below:*

**A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?**

☐ Yes ☒ No

*If Yes, please give details of how and where publicity will be conducted, and enclose copy of all advertising material (with version numbers and dates).*

**A29. How and by whom will potential participants first be approached?**

The CI will provide letters and/or emails of invitation to the contacts, who will forward these to colleagues at their place of work, inviting them to participate in the study. These letters or emails will also include a participant information sheet. Potential participants will be asked to contact the investigator via telephone or email to arrange a meeting and clarify any questions they may have.

Pharmacists will be asked to distribute 'recruitment packs' containing letters of invitation, information sheets and consent forms to users of pharmacy services.

**A30-1. Will you obtain informed consent from or on behalf of research participants?**

☒ Yes ☐ No

*If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.*

*If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.*

Written consent will be obtained from all participants involved in interviews. Before interviews begin, participants will be asked to confirm that they agree to take part in the interview and that they are willing for the discussion to be audio-recorded and will be asked to complete and sign a consent form.

*If you are not obtaining consent, please explain why not.*

*Please enclose a copy of the information sheet(s) and consent form(s).*

**A30-2. Will you record informed consent (or advice from consultees) in writing?**

☒ Yes ☐ No

*If No, how will it be recorded?*

**A31. How long will you allow potential participants to decide whether or not to take part?**

Patients and pharmacy users will be given a minimum of 24 hours to consider whether or not they would like to participate in the study.

**A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? (e.g. translation, use of interpreters)**

Proficiency in English is a requirement for all participants in the study.

**A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study?** *Tick one option only.*

- ☒ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.
- ☐ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.
- ☐ The participant would continue to be included in the study.
- ☐ Not applicable – informed consent will not be sought from any participants in this research.

*Further details:*

## CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

### Storage and use of personal data during the study

**A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?** *(Tick as appropriate)*

- ☐ Access to medical records by those outside the direct healthcare team
- ☒ Electronic transfer by magnetic or optical media, email or computer networks
- ☐ Sharing of personal data with other organisations
- ☐ Export of personal data outside the EEA
- ☒ Use of personal addresses, postcodes, faxes, emails or telephone numbers
- ☒ Publication of direct quotations from respondents
- ☐ Publication of data that might allow identification of individuals
- ☒ Use of audio/visual recording devices
- ☒ Storage of personal data on any of the following:
- ☒ Manual files including X-rays
  - ☐ NHS computers
  - ☐ Home or other personal computers
  - ☒ University computers
  - ☐ Private company computers
  - ☒ Laptop computers

*Further details:*

It is anticipated that participants will supply personal telephone numbers and email addresses to the CI for the purpose of arranging times and venues. Personal data about participants will be held on university computer databases. Databases will be password protected at both computer and file level. Personal data held on paper will be stored in a locked filing cabinet within the Centre for Pharmacy Workforce Studies (CPWS) office. The office is locked when there are no members of the research team present. Access to the School of Pharmacy, where the CPWS office is sited, is via swipe card entry only.

Data may be held on home or personal computers for the purposes of data analysis and writing up of the project. Where this is the case, all data will be completely anonymised, and no personal identifiers will be held on personal computers,

laptops or paper records outside the university. The CI will take the advice of the University IT services to ensure that the appropriate security measures are in place.

**A38. How will you ensure the confidentiality of personal data?** *Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

Personal data about participants will be held on university computer databases. Databases will be password protected at both computer and file level. Personal data held on paper will be stored in a locked filing cabinet within the Centre for Pharmacy Workforce Studies (CPWS) office. The office is locked when there are no members of the research team present. Access to the School of Pharmacy, where the CPWS office is sited, is via swipe card entry only.

All participants will be allocated reference numbers and data will be handled using these reference numbers wherever possible.

No personal identifiers (names, addresses, email addresses, telephone numbers) will be held on personal computers or laptops (or on paper) outside the University.

**A40. Who will have access to participants' personal data during the study?** *Where access is by individuals outside the direct healthcare team, please justify and say whether consent will be sought.*

The CI and the PI will have access to personal data for the purposes of contacting the participants when arranging interviews. For the purposes of the research, participants will be invited to provide basic demographic details (excluding name or contact details) as thoroughly as they choose. These details will be used for purposes of the project, such as data analysis, only.

Auditors from the University or Trust will have access to monitor the conduct of the study if required.

**Storage and use of data after the end of the study**

**A43. How long will personal data be stored or accessed after the study has ended?**

- ☐ Less than 3 months
- ☐ 3 – 6 months
- ☐ 6 – 12 months
- ☐ 12 months – 3 years
- ☒ Over 3 years

*If longer than 12 months, please justify:*

Research governance and PhD requirements recommend data be kept for the purposes of checking, validating and future analysis of the data.

**INCENTIVES AND PAYMENTS**

**A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?**

- ☐ Yes ☒ No

*If Yes, please give details. For monetary payments, indicate how much and on what basis this has been determined.*

**A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?**

☐ Yes ☒ No

*If Yes, please indicate how much and on what basis this has been decided:*

**A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?**

☐ Yes ☒ No

*If yes, please give details including the amount of any monetary payment or the basis on which this will be calculated:*

#### NOTIFICATION OF OTHER PROFESSIONALS

**A49-1. Will you inform the participants' General Practitioners (and/or any other health professional responsible for their care) that they are taking part in the study?**

☐ Yes ☒ No

*If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.*

#### PUBLICATION AND DISSEMINATION

**A50. Will the research be registered on a public database?**

☐ Yes ☒ No

*Please give details, or justify if not registering the research.*  
There is no appropriate database for the study.

**A51. How do you intend to report and disseminate the results of the study? Tick as appropriate:**

- ☒ Peer reviewed scientific journals
- ☒ Internal report
- ☒ Conference presentation
- ☒ Publication on website
- ☒ Other publication
- ☐ Submission to regulatory authorities
- ☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
- ☐ No plans to report or disseminate the results
- ☒ Other (please specify)

Results will be reported in published conference proceedings. A copy of the final thesis will be held in the university library.

**A53. Will you inform participants of the results?**

☒ Yes ☐ No

*Please give details of how you will inform participants or justify if not doing so.*

Results will be made available to participants, who wish to receive written feedback on findings, in the form of an executive summary report.

**5. Scientific and Statistical Review****A54. How has the scientific quality of the research been assessed? Tick as appropriate:**

- ☐ Independent external review
- ☐ Review within a company
- ☐ Review within a multi-centre research group
- ☒ Review within the Chief Investigator's institution or host organisation
- ☒ Review within the research team
- ☒ Review by educational supervisor
- ☐ Other

*Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:*

Two academic supervisors, who are also part of the research team, have assessed the scientific quality of the research. Professor Hassell and Dr Hall have extensive experience in conducting qualitative research as well as research that is designed to inform and guide policy within the pharmacy profession.

The PhD process also involves a review after the first year, in the form of a viva, carried out by a senior academic who is not directly involved in supervision, and this was successfully completed by the researcher.

*For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.*

*For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.*

**A59. What is the sample size for the research? How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.**

Total UK sample size: 90

Total international sample size (including UK):

*Further details:*

Pharmacists, nurses, doctors and associated staff – up to 60 interviews.

Patients and pharmacy service users – up to 30 interviews.

**A60. How was the sample size decided upon? If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.**

Interviews will be conducted until theoretical saturation of data is achieved, i.e. until no new themes emerge from the data. The figures provided above represent an estimate of the maximum number of interviews that will potentially be undertaken.

**A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.**

Qualitative data from interviews will be audio recorded, with the permission of the participants, and transcribed verbatim. Transcripts will be anonymised and data collected subject to a thematic analysis. Transcripts will be read independently by two members of the research team to identify key themes. Analysis will be aided by the use of Nvivo, a software package designed for use with qualitative data.

**6. MANAGEMENT OF THE RESEARCH**

**A63. Other key investigators/collaborators.** *Please include all grant co-applicants, protocol co-authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

	Title	Forename/Initials	Surname
	Prof.	Karen	Hassell
Post	Professor of Social Pharmacy and School Research Director		
Qualifications	PhD, MA (Econ), BSc, DipMRS, Cert.		
Employer	The University of Manchester		
Work Address	The University of Manchester Stopford Building, 1st floor Oxford Road		
Post Code	M13 9PT		
Telephone	0161 275 2422		
Fax	0161 275 2416		
Mobile			
Work Email	karen.hassell@manchester.ac.uk		

	Title	Forename/Initials	Surname
	Dr	Jason	Hall
Post	Senior teaching fellow		
Qualifications	PhD, BSc, MSc, MRPharmS, PGCE, MCPP		
Employer	The University of Manchester		
Work Address	Stopford Building, 1st Floor Oxford Road Manchester		
Post Code	M139PT		
Telephone	0161 275 2720		
Fax	01612752416		
Mobile			
Work Email	jason.hall@manchester.ac.uk		

**A64. Details of research sponsor(s)**

**A64-1. Lead sponsor** *(must be completed in all cases)*

Name of organisation which will act as the lead sponsor for the research:

University of Manchester

Status:

☐ NHS or HSC care organisation ☒ Academic ☐ Pharmaceutical industry ☐ Medical device industry ☐ Other*If Other, please specify:*

Address The University of Manchester  
Oxford Road  
Manchester

Post Code M13 9PL

Country UK

Telephone 01612758795

Fax

Mobile

E-mail research-governance@manchester.ac.uk

**A64-2. Sponsor's UK contact point for correspondence** *(must be completed in all cases)*

	Title	Forename/Initials	Surname
	Dr	Karen	Shaw
Post	Head of the Research Office		
Work Address	Stopford Building 1st Floor		
	Oxford Road		
	Manchester		
Post Code	M13 9PL		
Telephone	01612758795		
Fax			
Mobile			
E-mail	research-governance@manchester.ac.uk		

**A64-3. Are there any co-sponsors for this research?**☐ Yes ☒ No**A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?**☐ Yes ☒ No*If Yes, please give details of each rejected application:*

*Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.*



**A68. Give details of the lead NHS R&D contact for this research:**

Title	Forename/Initials	Surname
Dr	Andrew	Maines
Organisation	South Manchester University Hospitals NHS Trust	
Address	R&D Directorate, Ground Floor	
	Wythenshawe Hospital, Southmoor Road	
	Manchester	
Post Code	M23 9LT	
Work Email	andrew.maines@manchester.ac.uk	
Telephone	0161 291 5775	
Fax	0161 291 5771	
Mobile		

*Details can be obtained from the NHS R&D Forum website: [www.rdforum.nhs.uk](http://www.rdforum.nhs.uk)*

**A69. How long do you expect the study to last?**

Planned start date: 12/01/2009

Planned end date: 11/01/2010

Duration:

Years: 1

Months: 0

**A71-1. Is this a single centre study?**

☐ Yes ☐ No

**A71-2. Where will the research take place? (Tick as appropriate)**

- ☒ England
- ☐ Scotland
- ☐ Wales
- ☐ Northern Ireland
- ☐ Other states in European Union
- ☐ Other countries in European Economic Area
- ☐ USA
- ☐ Other international (please specify)

**A72. What host organisations (NHS or other) in the UK will be responsible for the research sites? Please indicate the type of organisation by ticking the box and give approximate numbers of planned research sites:**

- |  |    |
|--|----|
| <input checked="" type="checkbox"/> NHS organisations in England | 10 |
| <input type="checkbox"/> NHS organisations in Wales              |    |
| <input type="checkbox"/> NHS organisations in Scotland           |    |
| <input type="checkbox"/> HSC organisations in Northern Ireland   |    |
| <input checked="" type="checkbox"/> GP practices in England      | 5  |
| <input type="checkbox"/> GP practices in Wales                   | 0  |
| <input type="checkbox"/> GP practices in Scotland                | 0  |

<input type="checkbox"/> GP practices in Northern Ireland	0
<input type="checkbox"/> Social care organisations	0
<input type="checkbox"/> Phase 1 trial units	0
<input type="checkbox"/> Prison establishments	0
<input type="checkbox"/> Probation areas	0
<input type="checkbox"/> Independent hospitals	0
<input checked="" type="checkbox"/> Educational establishments	1
<input type="checkbox"/> Independent research units	0
<input checked="" type="checkbox"/> Other (give details)	8
Community pharmacies	

Total UK sites in study: 24

#### A76. Insurance/ indemnity to meet potential legal liabilities

*Note: in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland*

**A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research?** Please tick box(es) as applicable.

*Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.*

- ☐ NHS indemnity scheme will apply (NHS sponsors only)
- ☒ Other insurance or indemnity arrangements will apply (give details below)

The research will be covered by the Public, Products and Employer's Liability Policy held by the University of Manchester

Please enclose a copy of relevant documents.

**A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research?** Please tick box(es) as applicable.

*Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.*

- ☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)
- ☒ Other insurance or indemnity arrangements will apply (give details below)

The research will be covered by the Public, Products and Employer's Liability Policy held by the University of Manchester

Please enclose a copy of relevant documents.

**A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?**

*Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.*

- ☐ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)
- ☒ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

The research will be covered by the Public, Products and Employer's Liability Policy held by the University of Manchester

*Please enclose a copy of relevant documents.*

DRAFT

PART C: Overview of research sites

Please enter details of the host organisations (NHS or other) in the UK that will be responsible for the research sites.

Research site	PI/ local collaborator
---------------	------------------------

**PART D: Declarations****D1. Declaration by Chief Investigator**

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
3. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.
4. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.
5. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.
6. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.
7. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.
8. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 1998.
9. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:
  - ◆ Will be held by the main REC or the GTAC (as applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
  - ◆ May be disclosed to the operational managers of review bodies, or the appointing authority for the main REC, in order to check that the application has been processed correctly or to investigate any complaint.
  - ◆ May be seen by auditors appointed to undertake accreditation of RECs.
  - ◆ Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
10. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.
11. I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

**Contact point for publication**

*NRES would like to include a contact point with the published summary of the study for those wishing to seek further information. We would be grateful if you would indicate one of the contact points below.*

- ☒ Chief Investigator  
☐ Sponsor's UK contact point  
☐ Study co-ordinator  
☐ Student  
☐ Other – please give details  
☐ None

Title:

Forename / Initials:

Surname:

Post:

Work address:

Work email:

Work telephone:

**Access to application for training purposes**

*Optional – please tick as appropriate:*

☒ I would be content for members of other  
RECs to have access to the information in the  
application in confidence for training purposes.  
All personal identifiers and references to  
sponsors, funders and research units would be  
removed.

Signature: .....

Print Name: Rebecca Elvey

Date: 28/01/2009 (dd/mm/yyyy)

**D2. Declaration by the sponsor's representative**

*If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the lead sponsor named at A64-1.*

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. The duties of sponsors set out in the Research Governance Framework for Health and Social Care will be undertaken in relation to this research.
7. I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Signature: .....

Print Name:

Date: (dd/mm/yyyy)

**D3. Declaration for student projects by academic supervisor**

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the Chief Investigator and the supervisor for this study as set out in the Research Governance Framework for Health and Social Care.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Signature: .....

Print Name:

Date: (dd/mm/yyyy)

Post:

Organisation:



## CONSENT FORM

### Professional identity in pharmacy

If you agree with the statements below please initial the box provided:

I have read and understood the information sheet..... ☐

I have had an opportunity to ask questions and discuss this study..... ☐

I have received satisfactory answers to all my questions..... ☐

I give permission for the researcher to use direct, anonymised quotes in publications..... ☐

I understand that I am free to withdraw from the study:

at any time..... ☐

without giving a reason for withdrawing..... ☐

I give my permission for this interview to be digitally recorded..... ☐

I agree to take part in the study..... ☐

Name (PLEASE PRINT).....

Signed.....Date.....

**Please indicate how you would prefer to be contacted to arrange your participation in an interview. Please provide your telephone number / email address:**

☐ Telephone:.....

☐ Email:.....

Please return this consent form using the stamped address envelope provided, thank you.

## Appendix C

### Topic guide – Pharmacist persona group interviews

#### 1. *Introductions:*

Collect consent forms from all participants and answer any questions  
Introduce project and self  
Assure that data will be handled confidentially etc  
Ask others to introduce themselves

#### 2. *Activity and discussion:*

Introduce profiles of pharmacy profession  
Present other pharmacy sector personas x 3

Ask participants whether they recognise these 'characters'?  
Do equivalent characters exist within their sector of work?  
Bring out prepared sheets with headings ready to complete and decide  
Ask participants whether they would prefer to work as a group, doing personas one at a time, or individually

Work through headings, filling them in  
Probe on interesting points raised  
Give group 10 key roles for pharmacy and the code of ethics to comment on – question?

Are there differences between people that work in your sector and other sectors?

Name:

Age:

Ethnic group:

Job title and grade:

Organisation:

Location:

Working hours:

Family/living arrangements:

Lives:

What they wear to work:

What newspaper they read:

Hobbies/interests:

Where they shop:

Skills/personal qualities:

Knowledge/expertise:

Values/motivations:

Goals/aspirations:

Key working relationships:

Most likely to say:

## Appendix D

### Interview topic guides

#### Interview schedule pharmacists

- Describe a pharmacist in five words

#### Contextual questions

- Can you tell me a bit about your career to date – what you do now and how you arrived at this point?
- Why did you choose to study pharmacy?
- What school of pharmacy did you go to?
- Why did you choose that school?
- When did you qualify?
- What did you enjoy most and least?
- Did you do work placements?
- Did you do any work experience?
- How did you choose the job you have now?
- Why this – sector? Organisation? Area?
- Which sectors of pharmacy have you worked in?

#### Current job

- Can you tell me a bit more about your current role?
- Describe a typical day
- The organisation
- Describe your role here. How long been here? Grade?
- How is your time split? on wards and elsewhere, dispensary?
- What types of wards and patients – emergency, surgical etc
- What contact do you have with patients – for what?
- What contact do you have with other staff. About what?
- What do you enjoy most about your job? What do you find most interesting? Is there anything that makes your job difficult?

#### Pharmacists

- What is your general view of pharmacists, what they do and what they're like?
- Do you think they are similar – is there such a thing as the typical pharmacist? Or core traits/values/skills?

#### *SHOW PICTURES*

#### Role models

- Can you think of anyone who has influenced you or made a particular impression on your career?
- Anyone you've been impressed/inspired by in general? Any examples of someone to *avoid* becoming?
- Did you know any pharmacists before you went to study pharmacy?
- While studying or working?

#### Further pharmacist questions

- What makes a good pharmacist? (knowledge, personality)

- What do you think your patients would say? What do they want from you? Do you think they are aware of your training? Do they see the value of pharmacists?
- Do you think they know who pharmacists are when they see them? Do you know?
- How do doctors and nurses see pharmacists?
- Would you say that there are differences between hospital pharmacists and those in other sectors?
- How do other pharmacists see hospital pharmacists?
- What do you think makes pharmacists different from other health professionals? Unique?
- Do you think pharmacists' roles have changed since you first qualified/recently? Good or bad?
- What does clinical mean to you?
- Locums – work with many, worked as a locum?
- Where do you see pharmacists fitting within the healthcare system/team? Is there a particular role that they fulfil?
- Do you perceive any status differences between different professions?
- Can you sum up the overall role – label?

### **Public image**

- Can you name me a famous pharmacist?
- Can you remember seeing any pharmacists in the media – news or fictional?
- Have you seen doctors or nurses in these?
- What sort of coverage do you think pharmacy gets?
- Does this make a difference? Does it matter? Should anything be done about it?

### **Interview schedule support staff**

- Describe a pharmacist in five words

### **Contextual questions**

Can you tell me a little bit about your job – what you do now and how you arrived at this point?

- Why did you choose to come and work in pharmacy?
- What training have you undertaken?
- What did this consist of?
- Did you get to do practical work/placements
- How did you choose the job you have now?
- Why this sector? Organisation? Area?
- Which sectors of pharmacy have you worked in?

### **Current job**

Can you tell me a bit more about your **current role**?

- Describe a typical day
- The organisation
- The local area and clientele
- Health issues you are dealing with
- Do you have regular patients?
- Who do you work with – pharmacists/other staff?
- What do you enjoy most about your job? What do you find most interesting? Is there anything that makes your job difficult?

**Scenario 1** - If a patient comes in to fill a prescription, can you describe the interaction for me, from the time person enters the pharmacy to the time they leave. (How it proceeds, who talks to them, who does each part of the process, how long they are there for.)

- Is there a gap between the reality and what would be your ideal?

Scenario 2 – and for advice or a minor ailment?

Tell me about an **interesting recent patient encounter**

### **Pharmacists**

So you work with pharmacists in (appropriate setting) Where else do pharmacists work? What types of pharmacist have you come across?

- Are they similar as a group (the whole profession) – can we talk of the ‘**typical pharmacist**’?
- Are there common traits, skills or values that pharmacists share?
- What different types might exist?

### ***SHOW PICTURES***

- These are pictures of pharmacists, can you tell me your thoughts on each picture?
- What areas might they work in?
- What sort of traits would they have?
- Are these pictures realistic?
- Is there anyone missing?

(These were the result of focus groups – they are summaries, may look stereotypical. These are the roles they were designed to represent. And to put it another way, they were given animal names – metaphorically. Don't know if these make sense or ring any bells. Do you recognise any of these characters, have you come across pharmacists like this?)

### **People**

Can you think of **anyone who has influenced you** or made a particular impression on your career?

- Did you know anyone who worked in pharmacy before you went into it?
- Anyone who made an impression while you were studying? Since you've been working?
- Anyone you've been impressed/inspired by in general – pharmacists or other?
- Any examples of someone to avoid becoming?

### **Further questions**

- What makes a good pharmacist in your view?
- And a bad one?
- What do you think patients would say – what do they want from pharmacists?
- What's the difference between you and a pharmacist?
- What can the pharmacist do that you can't?
- Would you consider qualifying as a pharmacist?
- What do you know about the training of pharmacists? (Length, type)
- Are there things that pharmacists can do that no other professional can? Or areas of knowledge that only pharmacists have?
- Do you think the way pharmacists work has changed since you have been working as a technician (or appropriate job title)/recently?
- Do we need pharmacists? Could technicians run pharmacies without them?
- What sort of status do you think pharmacists have compared to nurses? Doctors?
- Do you have much contact with doctors or other staff at the surgery? What for?
- Can they tell the difference between you and a pharmacist?
- Do you think patients can tell the difference between you (and other support staff) and pharmacists?
- Do they ask for the pharmacist when they come to the pharmacy?

### **Public image**

- Can you name me a famous pharmacist – real or fictional?
- What do you think the media presence/coverage of pharmacists is like in general?

### **SHOW EXAMPLES**

- Do you think public perceptions of pharmacists are affected by the media?
- Does this matter? If it needs to change, what should be done? Who should lead on this?
- What should pharmacy's 'selling point'/key message be?
- Anything I've not covered?
- Anything you want to ask me?

*Thanks and close*

### **Interview schedule patients**

- What did you come to the pharmacy for today – a prescription/to buy something/something else? For yourself or someone else?
- Do you use this pharmacy regularly?
- Do you use any others?
- Describe a pharmacist in five words
- What usually happens when you visit the pharmacy?
- Who do you talk to?
- Have you ever spoken to a pharmacist?
- Do you know who the pharmacist is when you go into a pharmacy? How?
- What do pharmacists do?
- What are they like? What do they know about? What are the main parts of their role?
- How can pharmacists help you?
- What sort of services can they deliver?
- What do they know about?
- Do you know anything about the training of pharmacists? (Length, type)
- You've come into this pharmacy today – where else do you think pharmacists work? Have you come across pharmacists in other settings/places?
- What types of pharmacist might you come across

### **SHOW PICTURES**

- What makes a good pharmacist in your view?
- Can you give me an example of a good encounter with a pharmacist?
- Or a bad one?
- Are there things that pharmacists can do that no other professional can? Or areas of knowledge that only pharmacists have?
- Do we need pharmacists?
- What would you have done today if the pharmacy was not here?
- What's the difference between a pharmacist and a doctor?
- Can you name me a famous pharmacists – real or fictional?
- Can you remember seeing any pharmacists in the news, or in TV dramas, films, books etc?
- Have you seen doctors or nurses in these?
- Probe on any key topics they bring up
- Anything else you would like to say about pharmacists?
- Anything you would like to ask me?



## **Interview schedule nurses and doctors**

- Describe a pharmacist in five words

## **Context and current job**

- Can you tell me a little bit about your job
- What type of contact do you have with pharmacists? Type (face to face or otherwise), frequency, for what reasons?
- What usually happens when you interact with pharmacists?

## **Pharmacists**

- What are pharmacists like?
- What do pharmacists do? - What are the main parts of their role?
- What do they know about?
- Do you know that a pharmacist is a pharmacist when you see one? How?
- How do you differentiate them from pharmacy technicians/other support staff?
- Do you think patients know who they are?

So you work with pharmacists in (appropriate setting) Where else do pharmacists work?  
What types of pharmacist have you come across?

- Are they similar as a group (the whole profession) – can we talk of the **‘typical pharmacist’**?
- Are there common traits, skills or values that pharmacists share?
- What different types might exist?

## ***SHOW PICTURES***

- These are pictures of pharmacists, can you tell me your thoughts on each picture?
- What areas might they work in?
- What sort of traits would they have?
- Are these pictures realistic?
- Is there anyone missing?

(These were the result of focus groups – they are summaries, may look stereotypical. These are the roles they were designed to represent. And to put it another way, they were given animal names – metaphorically. Don't know if these make sense or ring any bells. Do you recognise any of these characters, have you come across pharmacists like this?)

- What makes a good pharmacist in your view?
- Can you give me an example of a good interaction with a pharmacist – or a good pharmacist that you've met?
- And a bad one/bad example of person or occasion?
- How can pharmacists help you in your job?
- And how can they help other health care professionals?
- And patients?
- What sort of services can they deliver? Anything else that would be useful if they did?
- Do you perceive any changes in pharmacists' roles since you have been working as a nurse/recently?
- What do you know about the training of pharmacists? (Length, type)

- Are there things that pharmacists can do that no other professional can? Or areas of knowledge that only pharmacists have?
- Do we need pharmacists?
- Where do they fit within the healthcare team?
- What's the difference between a pharmacist and a nurse?
- What sort of status do think pharmacists have compared to nurses? Doctors?

### **Public image**

- Can you name me a famous pharmacist – real or fictional?
- Can you remember seeing any pharmacists in the news, or in TV dramas, films, books etc?
- Have you seen doctors or nurses in these?

.....

- Probe on any key topics they bring up
  - Anything I've not covered or that you would like to add?
  - Anything you want to ask me?

*Thanks and close*



Appendix E  
Pictures 1 to 8

