SELF-PERCEIVED PROFESSIONAL IDENTITY OF PHARMACY EDUCATORS

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Now I become myself. It's taken
Time, many years and places;
I have been dissolved and shaken,
Worn other people's faces …

May Sarton

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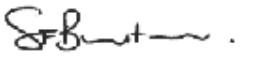
SIGNATURE: 

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ABBREVIATIONS

AACP	American Association of Colleges of Pharmacy
Academy	South African Academy of Pharmaceutical Sciences
ACCP	American College of Clinical Pharmacy
ACPE	American Council of Pharmaceutical Education
APhA	American Pharmaceutical Association
BPCS	Behavioural Pharmaceutical Care Scale
CAI	Caring Ability Inventory
DoH	National Department of Health
EDQM	European Directorate for the Quality of Medicines & Health Care
FIP	International Pharmaceutical Federation
ISPOR	International Society for Pharmacoeconomics and Outcomes Research
MCC	Medicines Control Council
MSH	Management Sciences for Health
MTM	Medication Therapy Management
NACDS	National Association of Chain Drugstores
NCPA	National Community Pharmacists Association
PharmD	Doctor of Pharmacy
PSSA	Pharmaceutical Society of South Africa
SAPC	South African Pharmacy Council
SPS	Strengthening Pharmaceutical Systems
UK	United Kingdom
UNESCO	United Nations Educational, Scientific and Cultural Organisation
US	United States
WHO	World Health Organisation

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ABSTRACT

The philosophy of pharmaceutical care, which defines a patient-centred approach to practice, has been embraced and upheld by national and international pharmaceutical organisations for two decades. However, pharmacists have been slow to change their practice and implement a pharmaceutical care approach. It has been suggested that amongst other factors, short-comings in pharmaceutical education have contributed to this reluctance of the profession to transform practice. Efforts to address these short-comings in pharmaceutical education have focused on the curriculum and pedagogic practices, and not on the pharmacy educators themselves. Palmer (1998) asserts that “good teaching cannot be reduced to technique; good teaching comes from the identity and integrity of the teacher”. In essence, "we teach who we are" and good teachers have one common trait: “a strong sense of personal identity that infuses their work”.

This study identified, described and analysed the self-perceived professional identities of pharmacy educators within the South African context. This included ascertaining factors and contexts which contributed to participants’ self-perception of their professional identity. In an effort to understand the influence the educators have on practice and on changing practice and *vice-versa*, the attitudes, beliefs and behaviours of participants regarding the philosophy and practice of pharmaceutical care, and pharmaceutical education were also explored.

Situated within a constructivist-interpretive, qualitative paradigm and making use of methodological triangulation, this study was conducted in three phases, each employing a different qualitative method to collect data. The first phase made use of narrative analysis to gain an in-depth understanding of pharmacy educators’ perceived professional identities and to explore how their experiences, across various contexts, have formed their professional identities. In-depth individual narrative interviews were used to provide a forum in which the participants could reflect upon and tell their professional life-story. This phase of the study also made use of the exploration of metaphors to further investigate the participants’ professional identity and, more particularly, their images of themselves as “teacher” and role model for students. A maximum variation, purposeful sampling approach was used to recruit eight pharmacy academics - one from each school or faculty of pharmacy in South Africa, as participants in this phase of the study.

The second and third phases explored more widely, the insights gained from the first phase and the formation of professional identity, attitudes, beliefs and practices of pharmacy educators in South Africa. Two focus groups were employed during the second phase and the study sample was broadened to include a further ten pharmacy educators. In the third phase, a purpose-designed, qualitative questionnaire was used to extend the study sample to all pharmacy educators in South Africa. A convenience sampling approach was used in both the second and third phases of the study. Thematic analysis and interpretation of the narrative interview and focus group transcripts and the questionnaire responses were conducted using qualitative data analysis software – Atlas.ti®.

A multiplicity of self-perceived professional identities was described. However, all of these were multi-faceted and could be situated on a continuum between pharmacist identity on one end and academic identity on the other. In addition, six key determinants were recognised as underpinning the participants' self-perception of their professional identity. These included three structural determinants: expected role; knowledge base; and practice, and three determinants relating to the emotional dimensions and agency of professional identity: professional status; passions; and satisfiers. The professional identity of the participants had been formed through membership of multiple pharmacy-related communities of practice and continued to be sustained through a nexus of multi-membership.

There was extensive support by the participants for the concept of pharmaceutical care; however, it did not impact extensively on their role as pharmacy educators. Furthermore, many expressed concern around the use of the term 'pharmaceutical care': its definition; its lack of penetration into, and implementation within the practice environment; and even its relevance to the South African healthcare context.

Many of the participants perceived the professional development of future pharmacists to be integral to their role as educators, and was often their source of greatest professional satisfaction. However, concern was also expressed at the dissonance that students were perceived to experience, sometimes, because of the incongruities that they are taught and what they experience in practice.

This study has afforded pharmacy educators in South Africa an opportunity to understand better "who" they are as professionals, and to reflect on their role as educators and as role models for future pharmacist. Moreover, the findings contribute to a collective understanding of the professional identity of pharmacy educators and socialisation of pharmacy students into the profession. The insights and recommendations emerging from

the study have the potential to make academic pharmacy a more attractive career choice which may have positive implications for the future attraction and retention of pharmacists to academic posts within universities.

KEYWORDS:

Academic identity, communities of practice; identity; narrative inquiry; pharmaceutical care; pharmaceutical education; pharmacy; professional identity.

CHAPTER 1

INTRODUCTION

After decades of unsettling change within the pharmacy profession and its educational institutions, many pharmacy educational institutions and educators are struggling with issues of identity and meaning (Duncan-Hewitt & Austin, 2005). The profession has sought unity under the ideology of pharmaceutical care, a patient-centred approach to practice, which pharmaceutical professional organisations, both nationally and internationally, contend should be the defining philosophy of pharmacy practice (Williams, 2005).

Research has, however, demonstrated a seeming opposition or resistance by pharmacists in South Africa, and the rest of the world, to adopt pharmaceutical care, as both a philosophy and an approach to practice (Lubbe, Serfontein, Futter, Steyn, & Serfontein, 2000). Williams (2005, p. 123) citing several studies, suggests that short-comings in pharmacy education internationally contribute to the "reluctant take-up of, and apparent lack of understanding of the urgency for, pharmaceutical care". Furthermore, he cites a substantial body of international literature that contends that changes in pharmacy practice need to be both "preceded and supported by changes in the approach to pharmacy education" (Williams, 2005, pp. 123-124). The majority of these proposed changes in pharmacy education have focussed on changes to the curriculum content – "*what* we teach" - and to pedagogic practice – "*how* we teach". Smith (2000, p. 100) argues, however, that pharmaceutical educational reforms which have "focused on the what, how and why questions", and not the "who" question, have produced only "limited successful results" and not the outcome that was hoped for.

Central to the practice of pharmaceutical care are caring attitudes and behaviours, the development of which can take place during pharmacy education. Fjortoft (2004) suggests that both the culture as well as what is modelled within the educational environment can make a difference in the development of pharmacy students' caring behaviour and skills, and that it is the attitudes of the educators, towards this aspect of the profession, which are highly instrumental in the formation of students' behaviour. She further suggests that "it is not so much what we teach and how we teach, but who we are as teachers that affects students' caring abilities" (Fjortoft, 2004, p. 68).

Arguing for greater attention to be given to the "inner landscape" of teachers, Palmer (1998) suggests that teaching arises from one's inwardness, and that good teaching cannot be reduced to knowledge and technique; good teaching comes from the identity and integrity of the teacher. He, furthermore, proposes that good teaching is located in the ability of the teacher to create connections between student, subject and self, and for teachers to do this successfully, it is not sufficient for them to be the knowledge experts in their academic discipline or to merely employ new techniques to impart that knowledge to students. Good teaching requires and is dependent on self-knowledge, without which teachers cannot know their subjects or understand their students. Good teachers therefore have a strong sense of personal and professional identity and integrity that infuses their work (Palmer, 1998).

Identity seeks to answer the question "Who am I?", and is an on-going "process of development" with the purpose of making sense of the question in the context of past, present and future lived experiences (Billot, 2010, p. 713). Professional identity specifically answers the question of "Who am I?" within the context of work or vocation. Acknowledgement of the influence of professional identity on teaching practice, as described by Palmer (1998) has given rise to a vast body of literature around the concept of teacher, professional and academic identities in higher education (Archer, 2008; Clegg, 2008; Hockings, Cooke, Yamashita, McGinty, & Bowl, 2009; James, 2005; Trede, Macklin, & Bridges, 2012). Personal adequacy, satisfaction, career success and sense of agency have all been related to professional identity (Oliver, 2007; Slay & Smith, 2010; Trede *et al.*, 2012). Furthermore, a well-formed sense of professional identity has also been demonstrated to contribute to individuals' understanding of their profession and their ability to communicate and model their professional role, philosophy, and approach to others (Healey & Hays, 2011).

This supports the notion that the professional identity of educators not only influences their effectiveness as teachers, but within a vocational programme, such as pharmacy, it has the potential to impact on their influence as professional role models. It follows, therefore that the professional identity of pharmacy educators may contribute to shaping and forming the professional identity of the students, and may impact on their attitudes towards pharmaceutical care and the practice thereof. Therefore, in an effort to deepen understanding of the potential for pharmacy education to impact on change within the practice domain, particularly with regards moving practice toward a pharmaceutical care approach, the focus of this study is on "*Who* it is that teaches". The study seeks to explore, understand, and describe the self-perceived professional identities of pharmacy educators within the current South African context.

1.1 Background to the study

The idea for this study emerged through personal reflections on my role as a pharmacy educator and on the pharmacy profession as I experienced it. In particular, I desired to make sense of the multiple identities I possessed and to learn how to move towards an integrated, holistic notion of myself as a pharmacy educator. I sought to understand better how my identities were related to what I did and the impact I had on preparing students for the pharmacy profession. These questions and the reflective process that gave rise to the study developed from deep questioning of my own professional identity. Nearly 25 years after graduating with a Diploma in Pharmacy and being registered with the South African Pharmacy Council as a pharmacist, which also encompassed fifteen years in pharmacy education, I found myself unable to answer the question "Who am I?" with respect to my profession.

Four pivotal, converging incidents gave rise to this questioning of my professional identity. The first was an innocent question from my daughter who, at the time of exploring her own study choices and career options, asked me "What is it like to spend so long studying for a profession, and then not to practice it?" My initial response had been that of course I was practicing; it was just that my practice was within the university environment and not in a traditional practice setting. Furthermore, I argued, although with some self-awareness of a lack of confidence, that to teach within the discipline of pharmacy practice required a qualification in pharmacy, and thus I was using my qualifications. At the time when this conversation occurred, it had been about eight years since I had worked in any other pharmacy sector beyond the academic sector. This conversation initiated a process of self-reflection in which I started to question if I should still be identifying myself a pharmacist, or if "teacher" or 'educator" did not better describe my professional practice.

The second incident which deepened my personal reflection and questioning occurred when I completed the South African Pharmacy Council's Continuing Professional Development (CPD) Annual Declaration Practice Profile questions. In order to assess the practice status of pharmacists registered with Council, the annual declaration requires pharmacists to respond to a set of eighteen statements related to aspects of pharmacy practice, by selecting a response from three options: "I never do this"; "I spend some of my time doing this"; or "I spend most of my time doing this (see Appendix A for a full list of the statements). Since I was only practicing within the university environment at the time, completing the questions honestly involved responding with "I never do this" to almost all the questions except two: "Providing information and education relating to medicine", and "Training and human resource development". On submission of my responses my practice status was

automatically returned: “According to your practice profile you are a non-practicing member of the South African Pharmacy Council”! This served to strengthen my internal argument for leaning toward identifying myself as a teacher or educator, rather than as a pharmacist.

It was after I had become aware of these unresolved nuances in issues of my identity, that a third incident occurred which left me with some doubt about my effectiveness as a pharmacy educator or teacher and questioning my ability to significantly influence the future practice of my students in a meaningful manner. I was an unnoticed witness in a community pharmacy where I observed a pharmacist inappropriately sell medicines to a client, without asking a single question, or offering any advice, in a situation which, in my opinion, obviously called for pharmaceutical care intervention.[1] Unfortunately, this was not an isolated incident and was similar to others which I had often observed. However, this pharmacist, only three years previously, had been one of my most enthusiastic students who had been passionate about patient centeredness and pharmaceutical care, and determined to change the world of pharmacy practice!

In the fourth awareness moment, in the context of deepening confusion and quest for answers, I returned to a book which I had first encountered a few years earlier, entitled “The courage to teach” by author and educationalist Parker Palmer. Confronted by the notion asserted by Palmer (1998) that good teachers have a well formed sense of personal and professional identity and integrity that permeates their work and is dependent upon teacher self-knowledge, I specifically began to struggle with questions related to my identity as an educator. More specifically, I began to dwell on the question of how, as a pharmacy educator and pharmacist, I could hold multiple identities together in an integrated manner that would impact positively on my teaching and the future practice of my students.

Moreover, discussions with some of my colleagues suggested that I was not alone in this questioning process and that perhaps as a community of pharmacy educators we could benefit from answers to some of the questions around professional identity which I and others were asking. So, although this study emerged as a personal journey and a quest toward a deeper understanding of myself as a professional, a pharmacist and an educator, and toward enhanced effectiveness as a teacher, it has the potential to create a wider awareness of the importance of professional identity and integrity on the effectiveness of pharmacy educators. Furthermore, it has the potential to provide opportunities for others to

[1] The client who was obviously not known to the pharmacist requested three salbutamol inhalers, which the pharmacist took off the shelf, handed to the client and indicated the cash register at which they could pay. The excessive use of inhaled salbutamol (using one inhaler in less than three months) is suggestive of uncontrolled asthma.

engage in a reflective process which may lead to better understanding of themselves and their sense of personal and professional identity.

1.1.1 My story

In light of the very personal context from which this study emerged, and in accordance with the subjective, constructivist-interpretive, qualitative paradigm (see Section 4.2.1.3.1) in which this study is situated, it seems appropriate that I be reflexive concerning my own story; that I be upfront with regard to my own personal experiences, beliefs and attitudes, and make my own stance and subjectivities explicit. In the same manner that participants' reconstructed stories are provided in Chapter 5, I offer a reconstruction of my own story. It is told in response to the question: "Tell me the story of your career thus far; from what first attracted you to pharmacy to where you find yourself now". Furthermore my feelings, attitudes and beliefs regarding pharmaceutical care, the profession, and pharmacy education are also interwoven into the story.

Born into a family of pharmacists – my father, grandfather and several uncles were all community pharmacists - I grew up in pharmacies and around pharmacists. From an early age I spent hours in the pharmacy at weekends, and while my parents "did the books" or caught up on administrative work, I was making potions and mixtures and dreaming of how these would be future cures and remedies for illnesses; and my means of "making people better". My father was also involved in various pharmacy organisations, at all levels – local and national – so I grew up amongst much pharmaceutical talk about the profession, which was not always positive. As long as I can remember, pharmacy was at a "crossroads" and the only thing that seemed to change was the nature of the issues which threatened the profession. Over the years, these issues included dispensing doctors, extended services, pharmacy ownership, mail-order pharmacy and the threat of corporatisation of pharmacy.

Despite this talk, all through my childhood and adolescence, there was never any doubt in my mind that one day I would be a pharmacist. However, during my last few years of schooling the idea of becoming a doctor started to hold greater appeal and I applied for, and was accepted into, medical school. But the need for my own surgery for a longstanding medical condition intervened and necessitated that I remained in my hometown - Durban – and prevented me from proceeding with medical studies. Since pharmacy studies were

offered at the Natal Technikon in Durban, registering for a diploma in pharmacy[2] became the logical choice.

Four years later I graduated with a diploma in pharmacy and thereafter completed an internship in community pharmacy, with an uncle as my mentor. It was an extremely fulfilling year and I was well mentored in patient-centred community pharmacy practice. As a consequence of my positive internship experience, I embarked on what at the time I believed would be a long career in community pharmacy. I thoroughly enjoyed every aspect of community pharmacy and particularly appreciated the patient contact; being convinced that through patient education and counselling I was able to make a substantial difference to the healthcare of patients. However, I was also disappointed in what I perceived as an inability to apply my knowledge, in particular my pharmacology knowledge, to my everyday practice. Interpreting this as a lack in the more clinical aspects of pharmacology, I enrolled for a part-time Honours programme at a local university. Having completed my undergraduate programme at a Technikon[3], where there was very little focus on research, my experience of the Honours programme was also my first exposure to the research aspects of academia. It was a very positive experience and resulted in me registering for a Master's degree in pharmacology at Rhodes University.

This was in itself a fulfilling experience and a great opportunity to be exposed to academia in all its dimensions; however, my primary purpose for doing the Master's degree had been the desire to deepen my knowledge and ability to apply pharmacology to the patient care situation. With a research Master's study which focussed on a very limited aspect of neuropharmacology, I soon recognised that this was not preparing me for enhanced practice as a pharmacist, but was preparation rather for the research aspects of an academic career, which, at that time, I had no intention of pursuing. Nonetheless, I completed the Master's degree and the following year I was offered a temporary junior lectureship and the opportunity to teach pharmacy administration. For several reasons, including a lack of familiarity with, and expertise in the subject area; complete under-preparedness for teaching; and no real mentorship in the process, it was a very difficult year for me. I did, however, discover an affinity for teaching. I thoroughly enjoyed the student contact and particularly the opportunity to share my experience and passion for pharmacy with the students. It was also during this year that I was first exposed to the concept of pharmaceutical care, through the writings of Charles Hepler (1987). The patient-centred care emphasis of the concept

[2] Prior to 1986 the South African Pharmacy Board, which became the South African Pharmacy Council accredited a diploma in pharmacy which was offered at Technikons throughout the country.
[3] Technikons in South Africa, were at that time (early 1980s) colleges providing vocational education on a tertiary level

immediately captured my attention and I believed that it would finally be pharmacy's means to move beyond the "crossroads" which it seemed the profession had always been.

However, family commitments saw me moving away from the university environment and for about five years I worked in various other pharmacy domains, including community psychiatric services, managing a dispensary within a private hospital and a drug utilisation review unit within a mail-order pharmacy business. I truly enjoyed my experiences within each of those domains; however, direct patient contact and particularly the opportunities to make a contribution to patient care through the rationalisation of their pharmacotherapeutic regimens remained, for me, the most satisfying aspect of pharmacy work.

I returned to the university in 1996 and had the opportunity of developing and implementing the community experience programme and the vocational externship programme. These two programmes, which were both experiential in nature, provided me with an opportunity to combine my passion for pharmacy and my sense of self as a pharmacist, with my growing affinity for teaching and my identity as an educator, in a very fulfilling manner. This period at Rhodes University was also focussed on exploring, developing and teaching theoretical models of pharmaceutical care. In addition, it was a time when, confronted by my under-preparedness for teaching, I grasped every possible opportunity to develop my pedagogical knowledge. I attended a series of courses offered by the Academic Development Centre, including modules on teaching and teaching methods, assessment and evaluation, and curriculum development and course design. In addition to frequenting pharmacy-related conferences, I also began attending educational conferences; both nationally and internationally. All of these workshops and conferences fuelled my growing passion for and interest in education - and experiential pharmacy education in particular.

A family move, to the United Kingdom (UK) in 1999, saw a further shift in focus. I worked for the School of Pharmacy at the University of Nottingham on the development and implementation of an internet-based, postgraduate programme in pharmacy practice. However, it did mean that I remained in pharmaceutical education even though my focus and educational interests moved to issues of internet-based delivery of programmes and to life-long learning. Although it was a rich time of learning about education, and particularly the delivery of distance-education, I missed direct student contact and interaction and also experienced a sense of loss at not being able to practice in other pharmacy domains.

During this period in the UK, I was not able to register, and therefore practice as a pharmacist, and for the first time in my working life began to realise how important that aspect of my professional identity was to me. Furthermore, it was the first time in my career

that I did not know how to self-label myself professionally, which was perhaps indicative of a more deep rooted confusion over my professional identity. Even though I had been in pharmacy education for about five years, and had attended many courses and workshops, I still felt inadequate and under-qualified as a teacher or educator and therefore was hesitant to identify myself as such. I was employed as a “special lecturer”, but that for me was simply a title and one I could never identity with. Although my job title in higher education has always included the term “lecturer” it has remained one that I am uncomfortable with. I do not “deliver lectures” in the traditional sense and have always preferred an interactive teaching style; consequently I have always thought of myself as a teacher rather than a lecturer.

Furthermore, even though I have sought out opportunities for development as an educator, and participated in many educational conferences and forums, I have always felt on the fringes of these communities. While there was sometimes a sense of shared practice with others in the communities – teaching within the higher education environment - my lack of formal training in education has always left me feeling inadequate in terms of being able to engage deeply in issues of pedagogy.

A move back to South Africa in 2003 saw me taking up my current post as a lecturer in pharmacy practice at the Nelson Mandela Metropolitan University (which at the time was the University of Port Elizabeth). Inherent in my motivation for returning to South Africa was the notion of regaining my professional status as a registered pharmacist and the freedom to be able to practice in other domains beyond pharmacy education. However, even though by virtue of being registered as a pharmacist, I was free to practice outside of the university environment, for reasons of health, I was prevented from doing this for many years. Thus, although I was really rooted only in academia, I felt as if I had regained my status as a healthcare professional and I recognised how this gave me a renewed sense of belonging and identification with a profession. It also gave me access to participation within communities of pharmacy practice outside of the university environment, for example: I was able to participate in the community of assessors of intern portfolios for the South African Pharmacy Council (SAPC).

Notwithstanding my renewed sense of identification with the pharmacy profession and my feelings of belonging within pharmacy communities, and by contrast my sense of being on the fringes of educational communities, my tendency at that time was toward calling myself a teacher rather than a pharmacist. This could possibly have been attributed to my practice as an educator or teacher and my lack of practice as a pharmacist outside of the university domain; suggesting that my practice was a determining factor in my professional identity. This became even more evident when, on returning to locum work in community pharmacy

two years ago, I found myself once again questioning whether I was a pharmacist or educator – or a combination of both. What did become clear for me, however, was that even within the community pharmacy environment I had a propensity toward teaching; constantly seeking out opportunities to teach others on the staff such as pharmacy assistants, students, interns and even patients about health and medicines.

On the other hand, it is perhaps also noteworthy that my particular focus in education has always been on positively socialising the students into the pharmacy profession and has therefore been closely related to both my passion for pharmacy and my identity as a pharmacist. As an educator I have always sought to facilitate learning experiences which provided opportunities for the students to construct not only a sound knowledge base, but to develop attitudes and values which are consistent with the pharmacy profession, and which empower students to be patient-focused, caring practitioners. The metaphor I use to describe myself as a professional is that of a “fire lighter”. It originates from the maxim commonly attributed to William Yeats: “Education is not filling a bucket, but lighting a fire”, which for many years now has underpinned my teaching philosophy. As a pharmacy educator I view my specific role as enflaming, within the students, fervour for pharmacy and a desire to serve both the profession and society through the provision of quality patient-centred pharmaceutical care services. I also seek to awaken within them a zeal for learning and the ability to engage in self-directed, life-long learning.

I have often been disillusioned by the manner in which I see pharmacy being practiced, particularly by a perceived lack of care and patient focus on the part of pharmacists and a seeming unwillingness, or perhaps inability, to make the interventions necessary to ensure the best possible pharmacotherapeutic outcomes for patients. It was my own sense of inadequacy in this regard and my zeal to change practice, which had initially been the impetus for pursuing postgraduate studies. The disparities between what we teach the students and what they encounter in practice have also often been evident to me. Even though I have always tried to address these in my teaching, by drawing attention to them and suggesting ways of overcoming them, I have doubts about how effective I have been. Although, on reflection, I have had a long standing disquiet about my professional identity, it was only when the four instances described in the background to the study converged, that I became consciously aware of it and started to ask questions such as: “Does holding an appropriate qualification make me a pharmacist or teacher?”; “Can my professional identity as a teacher grow out of regular practice and a responsibility for teaching?”; and furthermore, “Does my being a pharmacist make any difference to my effectiveness as an educator?” Similarly, I began wondering whether my pharmacy educator colleagues had comparable

struggles with clarity regarding their professional identities. I was driven to ask the same questions of them; in particular to question what is it about us as pharmacy educators that we are seemingly unable to empower graduates adequately to practice pharmaceutical care.

It is questions of this nature, and the longing to see pharmacy education and pharmacy educators being instrumental in changing professional practice, that led me to ask: "How can we be effective teachers?" Prompted by the writings of Parker Palmer and the notion that good teaching is rooted in the identity and integrity of the teachers themselves, these questions became concerned with "Who am I?" and "Who are we?" as pharmacy educators, and consequently gave rise to this study.

1.2 Study aim and questions

The primary aim of this research study was to identify, describe and analyse the self-perceived professional identities of pharmacy educators within the South African context. To this end, with respect to pharmacy educators in South Africa, this study sought to answer the following questions:

1. What are the self-perceived, professional identities of pharmacy educators in South Africa?
2. What are the key factors which contribute to participants' self-perception of their professional identity?
3. How has membership across multiple communities of practice contributed to the development of their professional identities?
4. What are their attitudes, beliefs and behaviours regarding the philosophy and practice of pharmacy, pharmaceutical care and pharmaceutical education?
5. What is the perceived mutual impact of their professional identity, and participation in multiple communities of practice, on teaching and, more particularly, the beliefs, attitudes and behaviours modelled to students?

1.3 Structure of the thesis

In order to situate this study within the context of the existing knowledge and understanding in the field, an overview of the literature pertaining to pharmaceutical care, pharmaceutical education and professional identity is provided. Chapter 2 is a review of the literature pertaining to pharmaceutical care and describes how the changing role of the pharmacist, and the shifting status of the profession in society, gave rise to the concept of pharmaceutical care. It describes the nature of the concept and, in particular, the patient-

centred focus and caring aspects, and its relationship to other forms of practice such as clinical pharmacy and medicines management. Furthermore, the impact of the concept on the practice of pharmacy, and the perceived barriers to its implementation, are reviewed. The second half of the chapter provides an overview of the evolving nature of pharmacy education relative to practice, and then specifically focuses on pharmaceutical care education. Lastly, literature regarding socialisation of students into the profession and, in particular, the role of pharmacy educators in the process is reviewed.

In Chapter 3, literature pertaining to identity, professional identity and academic identity are reviewed using a framework derived by Rodgers and Scott (2008) that views all contemporary theories of identity as underpinned by four common themes: identity as contextual; identity as relational; identity as dynamic; and identity as constructed through narrative. The chapter concludes with a review of specific academic identity issues related to teaching on a vocational programme such as pharmacy.

The research methodology and process is described in Chapter 4. The chapter begins with an overview of research approaches and paradigms, and specifically locates this study within a constructivist-interpretive paradigm. Thereafter, the research methods used in the three phases of the study are described, and the chapter concludes by elaborating how ethical issues and concerns of trustworthiness of data were addressed.

The results of the first phase of the study – the narrative analysis phase - are both presented and discussed in Chapter 5. The in-depth accounts of the narratives of each of the eight participants in this phase of the study, together with my interpretation of them, are provided. A synthesis of the interpretations is also presented. The sixth chapter reports the results from the second and third phases of the study – the focus groups and the questionnaire survey. These results are also discussed in the context of the reviewed literature and the findings of the first phase of the study.

In the final chapter – Chapter 7 – conclusions addressing the specific study questions are offered. In addition, I provide personal reflections on the research process. The chapter concludes with a discussion of the study limitations, and offers recommendations arising out of the study and possible directions for future research.

CHAPTER 2

THE PHARMACY PROFESSION PHARMACEUTICAL CARE AND EDUCATION

2.1 Introduction

In order to appreciate the context in which this study is being undertaken it is necessary to understand how the concept of pharmaceutical care emerged as a consequence of the evolving nature of the pharmacy profession and its dynamic status as a profession in society. In this literature review the emergence and the nature of the concept of pharmaceutical care and in particular the patient-centred focus and caring aspects and its relationship to other forms of practice such as clinical pharmacy and medicines management will be explored. Furthermore, the penetration and impact of the concept on the practice of pharmacy and the perceived barriers to its implementation will be reviewed. In the latter half of the chapter, the developing nature of pharmacy education relative to practice will be considered. In particular the efforts that have been made to adapt pharmaceutical education to a pharmaceutical care context will be explored. The chapter ends with a review of literature regarding the socialisation of students into the pharmacy profession and in particular the role of pharmacy educators in the socialisation process.

2.2 Changing role of the pharmacist

Over the past few decades, the practice of pharmacy has progressed through many phases. According to Daughton and Ruhoy (2009), these phases mirror periods of constraint and expansion in the role of the pharmacist, relative to their relationship with society and patients. More specifically the phases are aligned with changes in role orientation between what can be described as a business or product orientation and a professional or patient orientation. Consequently the phases also reflect fluctuations in the professional status of pharmacy.

For purposes of clarity it would be useful before giving consideration to the changing role of the pharmacist and the professional status to define what is meant by professional status in this context. Although it has been suggested that there are various ways in which the terms

"profession" and "professional" can be both understood and defined (Institute for Learning, 2009), for the purposes of this study they will be defined using a trait approach suggested by Lester (2007).

A profession can be considered to be a fairly well delineated occupation whose characteristics include: having and using a body of expert or specialist knowledge; exercising autonomous and independent thought and judgement; and, being responsible to clients and society at large through deliberate and voluntary commitment to a set of standards, ethics and principles. Professional when used as a noun to refer to a person can be considered as one who embodies the characteristics used to describe a profession and when used as an adjective refers to this set of characteristics (Lester, 2007).

2.2.1 The apothecary role

Traditionally, pharmacy was considered as an intermediary profession situated at the interface between the medical and the chemical sciences, and as a profession was charged with ensuring the safe preparation and use of medicines. Pearson (2007, p. 1295) describes pharmacists of the early 1900s, as apothecaries: "preparing drug products *secundum artem* (according to the art) for medicinal use". The role of pharmacists during this period included, drug procurement, storage and compounding (Hepler & Strand, 1990; Mrtek & Catizone, 1989). According to Holland and Nimmo (1999, p. 1759), during this phase, there was no clear distinction between prescription and non-prescription drugs and the choice of appropriate medicines for patients lay with pharmacists who made use of their own "recipes" to create medicines on an individual basis for patients. Giam, McLachlan, and Krass (2011, p. 178) propose that it was the role as "compounder of medicines"- with the recognition of the value and the unique body of knowledge involved in fulfilling this role, that served as a basis for the professional status afforded the profession by society. Pharmacists had a clearly defined societal role and both "product and process were valued" (Holland & Nimmo, 1999, p. 1759). However although society acknowledged and valued the professional role of pharmacists as compounders of medicines, they also recognised and accepted that these professional services were often subsidised by the sale of both health-related and unrelated products within the pharmacy (Giam *et al.*, 2011).

2.2.2 The mercantile role

By the 1950s, with the development of industrialisation and advances in medical technology, medicines were mostly being manufactured on a large-scale, by the pharmaceutical industry. During this period, as Abramowitz (2009, p. 1437) noted: “the pharmacy practice model focused heavily on the distribution of medications” with many pharmacists enhancing their product lines with non-prescription healthcare and non-healthcare products, becoming retail establishments, which also dispensed medications. Throughout recorded pharmacy history the dual mercantile and professional roles of pharmacy have been a source of tension and created role confusion. With the emphasis of pharmacy, during this phase, being predominantly product focussed, the role of the pharmacist was strongly oriented towards that of a merchant or trader. As a consequence pharmacy was all but marginalised as a profession (McCormack, 1956).

In the United States (US), the passing of the Durham-Humphrey Amendment to the Food, Drug, and Cosmetic Act in 1951 created a prescription only category of drugs, which pharmacists could only dispense on the instruction of a medical doctor or licensed prescriber (Desselle, 2009). Consequently, the responsibility for the choice of medicines for a patient shifted from the pharmacist to the doctor. Ironically, at the same time the American Pharmaceutical Association (APhA), promulgated a Code of Ethics, which prohibited pharmacists discussing the composition or therapeutic effects of a prescription with a patient (Desselle, 2009). This effectively diminished the healthcare professional role of the pharmacist and enhanced the product-focus of the profession. According to Higby (1996, p. 39) this was the “count and pour” era of pharmacy with pharmacists being restricted to performing “machine-like” tasks.

Changes within the pharmacy profession in South Africa were very similar to those that took place globally, but occurred about ten years later. The pharmacists’ “authority to compound and sell medicines with virtually no restriction” (Gilbert, 1998b, p. 155), ceased in 1965 with the introduction of the Medicines and Related Substances Control Act (Act 101), which limited the sale of medicines without a prescription by a pharmacist, to medicines in schedules 1 and 2 of the Act. Similarly pharmacists were legally prevented from disclosing and discussing the clinical indications of dispensed medicines with patients.

The role of the pharmacist thus became narrowly constrained, largely limited to the compounding, dispensing and labelling of mass-produced medicines according to a prescription; a role for which pharmacists were over-trained, and in relation to which, their

knowledge was under-utilised (Gilbert, 1998b; Holland & Nimmo, 1999; Mrtek & Catizone, 1989; Pearson, 2007). Mrtek and Catizone (1989, p. 31) maintain that within 50 years the pharmacy profession lost three of the four primary functions – drug procurement, storage and compounding - which had been central to the work of pharmacists since about the 8th century, the loss of which "endangered the identity of the entire profession".

The profession's response to this loss of function and the resultant confusion and role ambiguity, was as Gilbert (1998b, p. 153), citing Birenbaum (1990) maintains: "a movement toward 're-professionalisation'". The re-professionalisation process took various forms, which for the most part included a move away from the more technical focus on the drugs and the distribution of drugs, toward an increased focus on the disease and the patient.

2.2.3 The clinical role

By the mid-1960s, frustrated with their constrained role and loss of professional identity, "pharmacists steeped in knowledge about drugs stepped out of the shackles of 'count and pour' practice and asserted themselves as 'drug information experts'" (Higby, 1996, pp. 40-41). In the US, clinical pharmacy emerged and the pharmacy profession was transforming itself (Zeind & McCloskey, 2006). The American College of Clinical Pharmacy (ACCP) defines clinical pharmacy as "that area of pharmacy concerned with the science and practice of rational medication use" (American College of Clinical Pharmacy, 2008, p. 816). It is the application of pharmaceutical expertise to activities and services which are aimed at maximising drug efficacy and minimising medication related problems (Lampert, Krähenbühl, Hersberger, & Schlienger, 2006).

According to Pearson (2007), with the emergence of clinical pharmacy there was a rapid move to extend and integrate new and diverse services, such as therapeutic drug monitoring services, into the pharmacist's scope of practice. There was also a shift toward increased and closer interaction with the medical and other health care professions. Hepler and Strand (1990, p. 534) argued that this was an "introspective transitional stage, in which pharmacy pursued professional identity and legitimation", and was characterised by pharmacists innovating and performing new functions and making "original contributions to the literature". They further suggested that it was "an unavoidable response to the disappearance of the apothecary role and a necessary forerunner of professional maturation" (Hepler & Strand, 1990, p. 534).

Although this evolution toward clinical pharmacy started in the US in the 1960s, it was slower to occur in other regions of the world, only emerging in the 1970s in the United Kingdom (UK) (Walker, 1996) and only in the 1980s in South Africa (Summers, Summers, Rawnsley, & Hurwitz, 1987). Writing in 1987, Dowse and Kanfer (1987, p. 181) expressed the opinion that “Hospital pharmacy could be regarded as the embryonic stage of clinical pharmacy and in some of our hospitals today, the innovative hospital pharmacist may even be considered to be a prototype clinical pharmacist”.

Clinical pharmacy concepts and practices were largely developed within institutional pharmacy, where hospital pharmacists, who had previously been on considered to be on the margins of the profession, took the lead (Higby, 1996). Consequently the shift toward greater patient-focus and extended clinical roles was significantly less within community pharmacy settings (Gilbert, 1998b; Wiedenmayer, Summers, Mackie *et al.*, 2006). A report by the US Department of Health and Human Services (1990), stated that despite much evidence that pharmacist provided clinical interventions, reduced health costs and improved clinical outcomes, “clinical pharmacy practice has remained largely within the purview of institutional settings” (p. 8), and that evidence indicated that “provision of clinical services outside of institutional settings is uneven and often inadequate” (p. 9). The report further suggested that the reasons for this included: a product-based reimbursement structure; underutilisation of pharmacy support personnel; inter-professional barriers, including a struggle for power and autonomy with doctors; lack of access to patient medical information; inadequate training; and a lack of patient demand for the services. Mrtek and Catizone (1989) argued that the lack of access to patient medical records and information was the primary barrier to provision of clinical services outside of a hospital environment.

Hepler and Strand (1990, p. 534) noted that the clinical role was slow to penetrate the profession, being unevenly adopted by pharmacists and pharmaceutical organisations, resulting in the profession becoming what they described as: “a collection of disputatious factions and splinter groups … a profession in search of a role … still unable to choose from a bewildering variety of functions and unable to overcome a variety of barriers to clinical practice”. This “uneven pace of change” within the profession was not unexpected, since in a consideration of role theory, as it relates to the health professions, Pendergast, Kimberlin, Berardo, and McKenzie (1995, p. 558) citing Lum (1978) noted that "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." Furthermore Pendergast and colleagues (1995, p. 558) also suggested that an “inconsistent and conflict-ridden sense of identity among persons undergoing a significant shift in societal or personal

roles" is common and that in a profession which is in as much transition as pharmacy, "the variability in how pharmacists conceptualise their role is potentially great as is the range of role behaviours exhibited by members of the profession".

2.2.4 Transition to pharmaceutical care

It was within this milieu of role confusion and dividedness that Hepler and Strand (1990) argued that as a profession, pharmacy would not find a common purpose and mission by clarifying, listing or defining new clinical functions but rather by conceptualising and identifying their patient-care responsibilities. They further argued that even the most sophisticated clinical functions, unless performed in the context of professional accountability and responsibility for the wellbeing of the patient cannot be considered as professional functions. Additionally they stressed that the practice of pharmacy needs to revive what it had lost: "… a clear emphasis on the patient's welfare, a patient advocacy role with a clear ethical mandate to protect the patient from the harmful effects of … drug misadventuring.'" (Hepler & Strand, 1990, p. 534).

Early in the 1990s, this major shift in the philosophy of pharmacy practice, which Hepler and Strand (1990) had argued for, began to materialise. This shift was described by the term "pharmaceutical care", defined by Hepler and Strand (1990, p. 535) as "the direct, responsible provision of medication-related care for the purpose of achieving definite outcomes that improve a patient's quality of life". The outcomes referred to by Hepler and Strand (1990) in the definition include: 1. cure of a disease, 2. elimination or reduction of a patient's symptomatology, 3. arresting or slowing of a disease process, and 4. preventing a disease or symptomatology.

2.3 Pharmaceutical care

2.3.1 Defining pharmaceutical care

The concept of pharmaceutical care materialised within clinical pharmacy, and the first description of it, by Mikeal, Brown, Lazarus, and Vinson (1975, p. 567) - "the care that a given patient requires and receives which assures safe and rational drug usage", encompassed the concept of rational drug use and was more product-focused. In 1980, Brodie, Parish and Poston adopted a more social and outcomes oriented approach to defining pharmaceutical care when they stated that: "Pharmaceutical care includes the determination of the drug needs for a given individual and the provision not only of the drugs

required, but also of the necessary services to assure optimally safe and effective therapy. It includes a feedback mechanism as a means of facilitating continuity of care by those who provide it" (p. 276). With the Hepler and Strand (1990, p. 535) definition, the responsibility of the pharmacist within the context of a patient and outcomes focus, became the central theme.

According to Deselle (2009, p. 8) Hepler and Strand zealously stressed that pharmaceutical care was not simply comprised of a list of extended of clinical functions to be performed for every patient but that it was:

> … a new mission and way of thinking that takes advantage of pharmacists' accessibility and the frequency to which they are engaged by patients – a way of thinking that engenders the pharmacist to take responsibility for managing a patient's pharmacotherapy to resolve current and prevent future problems related to their medications.

As Oltmann (2009, p. 18) states, pharmaceutical care thus implies "caring 'about' and 'for' clients/patients and involves commitment, concern and responsibility for outcomes". This changes the focus of pharmacists away from a drug or product-oriented business and management role, towards a patient–centred care role.

The concept of pharmaceutical care therefore describes a social need and a patient-centred approach to meeting this need, through the development of a caring therapeutic relationship. It also provides a description of the practitioner's specific responsibilities. Hepler and Strand (1990) suggested that the therapeutic relationship, central to pharmaceutical care, was based on a covenant between the patient, who grants authority to the provider, and the provider, who undertakes to exercise competence and commitment to the patient in meeting the patient's medication related needs. This aspect of pharmaceutical care was later encapsulated in a definition by Cipolle, Strand, and Morley (2004) when they defined pharmaceutical care as: "a patient-centred practice in which the practitioner assumes responsibility for a patient's drug-related needs and is held accountable for this commitment" Furthermore they suggested that:

> Pharmaceutical care practitioners accept responsibility for optimising all of a patient's drug therapy, regardless of the source (prescription, non-prescription, alternative, or traditional medicines), to achieve better patient outcomes and to improve the quality of each patient's life. This occurs with

> the patient's cooperation and in coordination with the patient's other health care providers. (Cipolle *et al.*, 2004)

By the late 1990s the philosophy of pharmaceutical care had been accepted and adopted as the mandate for practice by numerous pharmacy organisations worldwide, including South Africa (Dunlop & Shaw, 2002; Farris, Fernandez-Llimos, & Benrimoj, 2005; Fjortoft & Zgarrick, 2001; van Mil, 2005; Williams, 2005). Subsequently, over the past two decades pharmacists, the pharmacy profession and pharmaceutical associations and organisations have worked to implement pharmaceutical care practice. Citing several authors, Daughton and Ruhoy (2009) suggested that worldwide, the history and evolution of pharmaceutical care and the approaches to the implementation thereof, have been very diverse and varied. Even the use of the term pharmaceutical care has been wide-ranging. Some authors, such as Kennie, Schuster, and Einarson (1998, p. 18) caution that "pharmacists must exercise discipline when using the term 'pharmaceutical care'". Arguing that it should not be used to describe pharmaceutical services, such as patient counselling, pharmacokinetic services, and medication review services, which they contend do not, on their own, constitute pharmaceutical care services. However, others, for example Farris and co-authors (2005, p. 1539) suggest that "in practical terms, pharmaceutical care means that pharmacists promise to do whatever possible to make sure the patient achieves positive outcomes from drug therapy".

Austin, Gregory, and Martin (2006) assert that despite many diverse local and national adaptations on the concept and implementation of pharmaceutical care, specific core concepts of pharmaceutical care have been widely accepted and adopted. Central to these concepts is the "special and covenantal nature of the 'patient-pharmacist' relationship" (Austin *et al.*, 2006, p. 534). The relationship is built upon the pharmacist's duty to serve the patient and an ethical responsibility to act in the patient's best interests and forms the foundation of the profession. The practice of pharmaceutical care makes explicit the pharmacist's responsibility to the patient for the prevention of medicine-related illness (Austin *et al.*, 2006; Cipolle *et al.*, 2004).

It needs to be noted that confusion still exists around pharmaceutical care and pharmacy practice terminology. The International Pharmaceutical Federation (FIP) Pharmacy Education Taskforce, whose role it is to develop and guide pharmacy education globally, as recently as 2010, found themselves "ensnared in the tangled web of pharmaceutical care terminology" and suggested that the discussion to which this entanglement gave rise perhaps "mirrors a much larger, often intense debate among the wider profession over

terminology" (Whitmarsh, Futter, Rouse, Bates, & Anderson, 2010, p. 134). Therefore, the terms clinical pharmacy and medicines management, in relation to pharmaceutical care will be discussed, before giving consideration to the drivers for and implications of pharmaceutical care.

2.3.1.1 Pharmaceutical care and clinical pharmacy

"Clinical pharmacy" is still a commonly used term in both pharmacy practice and in the related literature. It is used to describe the services performed by pharmacists in all practice settings, where medicines are prescribed, dispensed or used and describes the activities "oriented to the analysis of population and individual needs of medicines, ways of administration, patterns of use and effects of drug therapy" (Lampert *et al.*, 2006, p. 59). The European Society of Clinical Pharmacy (2010) defines clinical pharmacy as a health specialty that describes the activities and services of the clinical pharmacist in developing and promoting the rational and appropriate use of medicinal products and devices. Whilst the United Kingdom Clinical Pharmacy Association (2009) describes clinical pharmacy as encompassing the knowledge, skills, and attitudes required by pharmacists to contribute to patient care. By describing clinical pharmacy as "an area of pharmacy involved with the science, practice, activity and service to develop and promote the rational and appropriate use of medicines, in the interest of the patient and community" the South African Society of Clinical Pharmacy (South African Society of Clinical Pharmacy, 2012) also include a patient focus in their definition of clinical pharmacy.

Following the emergence of the concept and philosophy of pharmaceutical care, the American College of Clinical Pharmacy (2008, p. 816) redefined clinical pharmacy as:

> …. a health science discipline in which pharmacists provide patient care that optimises medication therapy and promotes health, wellness, and disease prevention. The practice of clinical pharmacy embraces the philosophy of pharmaceutical care; it blends a caring orientation with specialised therapeutic knowledge, experience, and judgment for the purpose of ensuring optimal patient outcomes.

This definition specifically encompasses the philosophy of pharmaceutical care, includes a "care" as an aspect and focuses on patient outcomes. Ahmed (2010) argues that no matter how clinical pharmacy is defined, in essence, it is about the provision of pharmaceutical care

to the patient. Clinical pharmacy therefore embraces the pharmaceutical care philosophy and merges a caring patient-orientation with specialised medication and therapeutic knowledge, experience, and professional judgment for the purpose of ensuring optimal patient outcomes. Thus, the clinical movement of the 1960's which attempted to secure greater legitimation and identity for pharmacy as a profession, through the identification and development of new clinical functions, can be seen as having both, given birth to the pharmaceutical care movement and in the process, found its own greater purpose through an enhanced patient focus.

2.3.1.2 Pharmaceutical care and medicines management

In the UK, medicines management is defined by the National Prescribing Centre as "the entire process by which medicines are selected, procured, delivered, prescribed, administered and reviewed to optimise the contribution they make to produce informed and desired outcomes of patient care" (Anon, 2002). Although the term is often used interchangeably with pharmaceutical care (Whitmarsh *et al.*, 2010), Simpson (2001, p. 150) suggested that the terms are not synonymous, and that medicines management is broader in scope than pharmaceutical care: ''Pharmaceutical care is a type of medicines management …but medicines management is not pharmaceutical care."

Barber (2001, p. 210) proposed that the medicines management concept originated within organisations responsible for the payment for medicines and consequently sought to "manage them". He further suggested that in this context "management" refers to rationalising the use of medicines primarily for the benefit of the organisation, rather than for the patient. He did, however, acknowledge that despite its origins, newer definitions of the concept, such as the definition of the National Prescribing Centre, have a greater patient focus.

In the US the concept of medication therapy management (MTM), defined as: "a distinct service or group of services that optimise therapeutic outcomes for individual patients that are independent of, but can occur in conjunction with, the provision of a drug product" (Bluml, 2005, p. 566) also has its origins in funding organisations. Medication therapy management was first introduced in the Medicare Prescription Drug, Improvement, and Modernisation Act of 2003. The Act makes provision for both the compulsory development and provision of MTM programs for eligible beneficiaries of Medicare Prescription Medication Benefits as part of their benefits, and also payment to the service providers of such programs. MTM programs are aimed at optimising therapeutic outcomes through improved medication use

and thereby reducing the risk of adverse events, including adverse drug reactions.(Ramalho de Oliveira, Brummel, & Miller, 2010)

With the emphasis on services and medication it would appear that MTM is almost a departure from the emphasis on the patient-pharmacist relationship and the patient-focus, central to pharmaceutical care. However, McGivney, Meyer, Duncan-Hewitt *et al.* (2007, p. 620) proposed that MTM, as intended in the Medicare Prescription Medication Benefit, may be seen as a means of implementing the philosophy of pharmaceutical care in practice, albeit for a defined patient population. They argued that MTM is underpinned by the concept of pharmaceutical care, which requires that pharmacists accept responsibility and accountability for the medication-related needs of patients. Furthermore MTM includes a variety of strategies, such as patient counselling, motivational interviewing, patient assessment, patient education, documentation, follow-up, and inter-professional collaboration in order to adequately meet the specific medication therapy needs of patients. (McGivney *et al.*, 2007)

Ramaldo de Oliveira and co-authors (2010) also support the opinion that MTM is the provision of pharmaceutical care services to a defined group of patients. Furthermore they suggest that "programs of this kind represent the pharmacy profession's shift from a product focused to patient-centred practice " (Ramalho de Oliveira *et al.*, 2010, p. 187).

2.3.2 Drive for pharmaceutical care

The transition to pharmaceutical care has been driven by many factors including influences both external and internal to pharmacy and arising from within the profession. Knowlton and Penna (1996a) describe the external forces as:

1. Epidemiologic, including an increasingly aging and culturally diverse patient population and an increasing average number of multiple chronic diseases per patient, resulting in healthcare being sought from a variety of practitioners who prescribe medication as part of their therapeutic treatments.
2. Communication and technological advances which are: increasing the nature, scope and availability of medication and healthcare information to patients; improving the facilities available to healthcare professionals for the storage, transfer, access and analysis of patient data; and expanding the variety of medications available and the efficacy, potency and risk profiles of available medications.
3. Ethical changes associated with shifts from "provider paternalism to informed consent" (p. xiv), and greater patient autonomy and empowerment.

4. Economic: the increased utilisation of costly medication has resulted in third party payors attempting to limit healthcare spending by increased control over the use of medication.

They suggest that "this combination of externalities is creating health care situations in which patients are being treated by multiple prescribers with highly potent and risky medications within an anachronistic drug use system" (Knowlton & Penna, 1996a, p. xiv). Furthermore, they argue that situations such as this are responsible for the rise in mortality and morbidity indicators resulting from adverse pharmacotherapeutic outcomes and an increase in healthcare expenditure (Knowlton & Penna, 1996a).

There is much evidence in the literature to support this argument. Classen, Pestotnik, Scott Evans, Lloyd, and Burke (1997) demonstrated that the occurrence of medicine-related adverse events significantly prolonged the length of hospital stay and increased costs. A meta-analysis of prospective studies concerned with the incidence of medicine-related adverse reactions resulting in hospital admissions was undertaken by Lazarou, Pomeranz, and Corey (1998) who concluded that medicine-related drug reactions could constitute the sixth leading cause of death in the US. In the US ambulatory healthcare setting in 2000, an estimated US$177.4 billion was spent on the management of medicine-related morbidity, and medicine-related hospital admissions accounted for approximately 70% of these costs (Ernst & Grizzle, 2001). Based on studies published worldwide between 1966 and 1999, Winterstein, Sauer, Hepler, and Poole (2002) estimated that approximately 7.1% (range, 2.5–25%) of hospital admissions could be considered drug-related, of which an estimated 58.9% (range, 32 to 86%) were preventable.

In summary, society has experienced a rise in mortality and morbidity associated with increased medicine use and related adverse reactions, which has prompted a call for an enhanced role for pharmacists in ensuring effective medicine use and enhanced patient safety (McGivney *et al.*, 2007). Pharmacists in all care settings are well situated in relation to the medication-use process to influence patient outcomes from drug therapy. They are often the last healthcare provider with whom the patient has contact prior to using medicine. In addition, pharmacists are readily accessible to patients, and often seen by patients several times between routine medical-practitioner visits. Pharmacists have the knowledge and expertise to help optimise patient outcomes by identifying, resolving, and most importantly, preventing medicine-related problems. (Planas, Kimberlin, Segal *et al.*, 2005)

As Varela Dupotey and Ramalho de Oliveira (2009, p. 610) postulated, pharmaceutical care could be an appropriate professional response to improving the use of medicine in society,

since it offers a philosophy of practice and a process that provides “pharmacists with a rational thought process to make the best decisions about drug therapy”. Central to pharmaceutical care is the patient-pharmacist relationship and partnership with other practitioners, both aimed at ensuring the best possible pharmacotherapeutic outcomes for the patient.

Pharmaceutical care also appears to be a fitting response to the profession’s need to identify a common mission and redefine itself as a profession. The tasks of repackaging and distributing which dominated during the mercantile phase of pharmacy and persisted, certainly in community and other ambulatory pharmacy settings, during the clinical era, were insufficient as a professional calling and kept the profession in search of a professional identity and legitimation (Hepler & Strand, 1990; Knowlton & Penna, 1996a). With its patient focus and goal of optimising patient outcomes through the medication use process, delivering pharmaceutical care offers pharmacists a genuine foundation for personal and professional satisfaction (Knowlton & Penna, 1996a).

Pharmaceutical care is a means to fulfil and meet the challenges of what Manasse (2011) described as the drivers for new models of pharmacy practice. Manasse argued that central to pharmacy’s professional ethos is care: “caring about - not just providing services to - patients” and suggested that there are were at least four drivers in pharmacy’s ethical, moral, and social imperatives for new practice models. Manasse described the first driver as “the sacred vessel”, suggesting that “every human’s body for which we care is a sacred vessel in which we place toxic and otherwise dangerous chemicals and biological agents” (p. 1098). He argued that as a profession it is pharmacy’s ethical and moral obligation to act effectively and safely, with compassion, to care for this “sacred vessel”. The second driver Manasse termed “the concept of franchise”, describing pharmacy’s franchise as the special privileges that result through licensure based on a unique education and knowledge of medicines. This franchise however carries an ethical and moral responsibility for the members of the profession to both deepen and maintain their knowledge and to apply their knowledge in the care of patients. The third driver Manasse described as the notion of “being your brothers’ and sisters’ keeper”, suggesting that pharmacists have a responsibility to assist in protecting patients from potential and preventable medicine-related adverse events. The fourth driver for change was pharmacy’s “professional covenant”. Manasse argued that as a profession “we are subject to the ethical imperative passed down by Hippocrates: not just to *do no harm,* but to continuously strive to *do only good”* (Manasse, 2011, p. 1098). However he did suggest that because pharmacy was “constantly tested by forces that focus on profit, speed,

and corporate growth" it was not always easy to act in the best interests of the patient and of society (Manasse, 2011, p. 1098).

2.3.3 Pharmaceutical care model

In the traditional dispensing role of pharmacy, the primary responsibility and focus of the pharmacist was to get the right product to the right patient, and pharmacists were primarily focused on medicines and medicine-delivery systems. Within a pharmaceutical care approach, the focus moves from medicines to patients. The primary concern of the pharmacist is the well-being of the patient and meeting the medicine-related needs of the patient. Furthermore, the patient is no longer considered as a passive recipient of medicines but rather as an active partner in the planning process and as "the ultimate decision maker". (Cipolle *et al.*, 2004)

In the pharmaceutical care role, pharmacists should engage in a systematic, comprehensive process with the aim of accomplishing three primary functions: 1. identifying actual and potential medicine-related problems of patients; 2. resolving the problems; and 3. preventing potential problems from becoming actual problems (Cipolle *et al.*, 2004). Fundamental to the process is the therapeutic relationship between the pharmacist and the patient. Hepler and Strand (1990) described the relationship as being based on a covenant between the two parties in which the patient grants authority to the pharmacist and the pharmacist undertakes to provide competence and commitment to the patient (Section 2.3.1). Within the context of the pharmacist - patient relationship, it is the responsibility of the pharmacist to: 1. assess the medicine-related therapeutic needs of the patient and identify potential medicine-related problems; 2. identify and establish pharmacotherapeutic goals and resolve and prevent potential medicine-related problems; and, 3. provide follow up to determine and evaluate patient outcomes in terms of both benefits and risks. It is the responsibility of the patient to: 1. provide accurate and complete information to the pharmacist; 2. actively engage with the pharmacist in setting pharmacotherapeutic goals; and 3. adhere to the agreed upon plan. (Cipolle *et al.*, 2004)

Despite a comprehensive process of pharmaceutical care having been identified and fully described (APhA Pharmaceutical Care Guidelines Advisory Committee, 1995; Cipolle *et al.*, 2004), different ways of practicing pharmaceutical care have developed. This would suggest that pharmaceutical care can be conceived in different ways and does not have the same meaning for all pharmacists (Björkman, Bernsten, & Sanner, 2008). In a summary of the major practice models that have engaged the pharmacy profession for the past four

decades, Holland and Nimmo (1999) pointed out that pharmacy's transition to a new patient-centred role "will not be instantaneous but will continue for an indefinite period to include a shifting balance of the practice models." The 1999 White Paper issued by the National Association of Chain Drugstores (NACDS), the American Pharmaceutical Association (APhA) and the National Community Pharmacists Association (NCPA) echoed this notion: "While some say that the pharmacist's role has been 'redefined' from medication dispenser to patient care provider, it is more accurate to say the role has been expanded" (National Association of Chain Drugstores, American Pharmaceutical Association, & National Community Pharmacists Association, 1999). Hence it would appear that the transition phase in the transformation of pharmacy from a product-oriented to a patient-oriented profession has necessitated the coexistence of several concurrent practice models. Although some, such as Maddux, Dong, Miller *et al.* (2000) have expressed the belief that the evolutionary phase would eventually result in the emergence of a single practice model, adapted for a variety of practice settings, one has yet to emerge.

The various cognitive and clinical services, associated with optimising medication use for improved patient outcomes in the provision of pharmaceutical care have been extensively described (Kelley, Vink, & Mark, 2010; Knowlton & Penna, 1996b; Snella, Trewyn, Hansen, & Bradberry, 2004). A cognitive service may be defined as, "a service provided by the pharmacist for the patient or healthcare professionals for the purposes of promoting optimal health and/or drug therapy; not necessarily drug-product-related" (Snella *et al.*, 2004, p. 390). These services primarily focus on optimising a patient's drug therapy and ensuring appropriateness, safety, and efficacy. (Snella *et al.*, 2004)

Exploring the care ideologies reflected in four conceptions of pharmaceutical care, Björkman and colleagues (2008) proposed that it was the understanding of the concept of pharmaceutical care that determined how such care was performed and what the intended purpose of the pharmaceutical care process was, in terms of patient outcomes. However, in a summary of the worldwide practice and research in pharmaceutical care in community pharmacies, Farris and colleagues (2005, p. 1539) concluded that because of a diversity in cultural, professional and healthcare contexts “each country has perspectives of pharmaceutical care and pharmacy practice that impact the implementation and practice model of pharmaceutical care”.

2.3.4 Impact of pharmaceutical care

While the concept of pharmaceutical care and its greater patient-centred role has been widely acknowledged and extensively accepted within the profession, the uptake and implementation of pharmaceutical care practice has been slow and the degree to which it has actually substantively changed pharmacy practice is questionable (Austin *et al.*, 2006; Droege & Baldwin, 2005; Hughes, Hawwa, Scullin *et al.*, 2010; Montgomery, Kälvemark-Sporrong, Henning, Tully, & Kettis-Lindblad, 2007; Williams, 2005).

A review of 22 randomised controlled trials of pharmaceutical care services, published between 1990 and 2003, provided evidence for the effectiveness of pharmaceutical care services provided by pharmacists in improving patient outcomes and medication use (Roughead, Semple, & Vitry, 2005). Although the review sought to include all international studies published in English, only studies located in North America, Europe and Australia were identified. The review demonstrated that pharmaceutical care services were effective in improving medication use and surrogate endpoints, such as blood pressure, cholesterol levels and glycosylated haemoglobin, although improvement in other outcomes, such as health-related quality of life measures, were less conclusive.

In a summary of 15 US studies that evaluated clinical pharmacy services, the pooled benefit-to-cost ratio was 4.81 to 1. Thus for every US$1 spent on clinical pharmacy services, the reductions in costs or other economic benefits were valued at US$4.81 (Perez, Doloresco, Hoffman *et al.*, 2008). In a systematic review of 36 peer-reviewed studies, published between 1985 and 2005 in English, Kaboli and co-authors demonstrated that clinical pharmacist services in the care of inpatients generally resulted in improved care, with no evidence of harm. (Kaboli, Hoth, McClimon, & Schnipper, 2006). Furthermore, in an observational study of almost 3 million patients in US hospitals, the provision of seven clinical services by pharmacists, including drug use evaluation, in-service education, adverse drug reaction management, drug protocol management, pharmacist participation on the cardiopulmonary resuscitation team (12 880 reduced deaths, p=0.009), pharmacist participation on medical rounds, and pharmacist-provided admission drug histories, were associated with significant reductions in mortality rate (Bond & Raehl, 2007).

In a review of the experience of developing and teaching the concept and practice of pharmaceutical care over a 25 year period, at the Peters Institute of Pharmaceutical Care, College of Pharmacy, University of Minnesota, Strand and colleagues (2004) described the impact on practitioners in the ambulatory setting and provided data that demonstrated the

clinical and economic impact of pharmaceutical care practice. The Institute trained 300 pharmacists who provided care to more than 25 000 patients. Pharmacists who participated in the training program reported that the average amount of time spent with patients increased three-fold. Data from 2 985 adult patients, who received pharmaceutical care from these trained practitioners, between January 2000 and December 2003, revealed that at the first assessment, the practitioners identified and resolved medication-related problems in 61% of the patients. An improvement in clinical status or maintenance of a stable status, as a result of the activities of the practitioners was demonstrated in 83% of the patients. The health care savings resulting from provision of pharmaceutical care for these patients, during this period was US$1134 162, representing a benefit to cost ratio of 2:1. Furthermore, in the review Strand and colleagues (2004, p. 3987) suggested that "physicians who collaborate with pharmaceutical care practitioners have validated the work of the practitioners, and patients are recognising the benefits of pharmaceutical care".

Although there is much published evidence to support the argument that pharmaceutical care services enhance quality and contain overall healthcare costs, to-date there have been limited published data on the extent to which pharmaceutical care has been adopted and implemented worldwide (Cohen, Nahata, Roche *et al.*, 2004). A pharmaceutical care survey was undertaken by the Committee of Experts CD-P-PH/PC coordinated by the European Directorate for the Quality of Medicines & Health Care (EDQM) (Council of Europe) in 2008 and 2009. The report that emerged from the survey analysed and presented the replies from 58 national public health authorities, doctors', pharmacists', nurses', and patients' associations from 17 countries in Europe, and concluded that although pharmaceutical care was increasingly being considered an important goal, it had not yet been implemented in practice. (Committee of Experts CD-P-PH/PC EDQM, 2009)

A recent study by Hughes and fellow researchers (2010) including 4696 pharmacies across 13 European countries, demonstrated that the provision of pharmaceutical care in Europe was limited. Many pharmacists offer some of the pharmaceutical care process elements to their clients, but relatively few practitioners integrated the entire process into their practice. Using an adapted version of the Behavioural Pharmaceutical Care Scale (BPCS) which is comprised of three main dimensions (direct patient care activities, referral and consultation activities and instrumental activities), the mean total score achieved by community pharmacists, expressed as a percentage of the total score achievable, ranged from 31.6% in Denmark to 52.2% in Ireland. Notwithstanding the fact that different aspects of pharmaceutical care were implemented to varying extents across Europe, the researchers noted that the scores in the direct patient care dimension were consistently poor.

In a study involving 81 pharmacies Ramaswamy-Krishnarajan and Hill (2005) also used the BPCS to measure the extent to which pharmaceutical care was being provided by pharmacists in community pharmacies in Canada. They concluded that although a segment of community pharmacists were involved in "pharmaceutical care–style" activities; many pharmacists in community settings had not been able to implement pharmaceutical care as part of their routine work activities.

In South Africa, despite a pressing need for the contribution that pharmaceutical care can make to the healthcare of patients, the concept and practice has not been widely adopted and implemented by pharmacists. As far back as 1998, Gilbert (1998a) contended that South African "pharmacists represent an untapped, and highly qualified resource that can be utilised more efficiently and appropriately to the benefit of the health-care system and the public". Although the SAPC (South African Pharmacy Council, 2008) and the Pharmaceutical Society of South Africa (PSSA) (Pharmaceutical Society of South Africa, 2010) have both embraced the philosophy of pharmaceutical care "the practice philosophy does not appear to have permeated to the majority of pharmacists in South Africa" (Williams, 2005, p. 144). Citing Lubbe and colleagues, Williams (2005, p. 145) further suggested that "South African pharmacists are either ignorant of the fundamental philosophy of pharmaceutical care, and view it as a simple algorithm, or they have chosen to disregard the more demanding elements of pharmaceutical care".

In a 2006 - 2009 audit of the activities in 133 community pharmacies in South Africa, Blignault (2010) demonstrated that approximately 70% of the pharmacies offered extended care services, such as blood glucose or cholesterol monitoring services, however, only one pharmacist interviewed indicated that he or she identified medicine related problems, established goals for addressing these problems in consultation with the patient and in addition, documented his or her efforts. Although the pharmacists interviewed in the study believed that pharmaceutical care services were important and indicated that they counselled patients on how to take their medication, the general public were not aware of the range of services offered and less than half the patients interviewed suggested that they were counselled. In addition, even though the participating pharmacists believed developing a pharmaceutical care plan was important, none of the patients interviewed indicated that they were involved in the development of a plan. Moreover, although 77% of the pharmacists considered the monitoring of outcomes and adherence to be important, only 4% of interviewed patients were aware of monitoring activities by the pharmacists. Although the results in Blignault's study suggest that pharmacists in South Africa consider pharmaceutical

care services to be important, the provision of such services is not being extensively recognised by patients (Blignault, 2010).

In many parts of Africa, especially sub-Saharan Africa a lack of pharmacists able to provide pharmaceutical care services is complicated by poor access to medicines, as King and Fomundam (2010, p. 30) write:

> The dearth of health care workers trained in pharmaceutical care coupled with inadequate access to medications creates multiple disease management challenges in Sub-Saharan Africa (SSA), which has 25% of the world's disease burden but only 1.3% of the world's health workforce. To prevent and treat HIV/AIDS, TB, malaria, and other maladies, the need is urgent to train and integrate the contributions of current workers who handle medications for major and minor health problems, especially those in licensed pharmacies and drug shops.

The potential benefits of pharmaceutical care services have been proven and pharmaceutical care would seemingly be an appropriate response to improving the use of medicine in society, and also to the pharmacy profession's need to identify a common purpose and redefine itself as a profession. However despite some pharmacists worldwide having adopted and incorporated aspects of the pharmaceutical care process and some of the associated services into their practices, relatively few have restructured or developed their entire practice around a pharmaceutical care model or process and it has yet to gain wide acceptance and implementation within pharmacy practice.

2.3.5 Barriers to pharmaceutical care

Concerned with the low rates of adoption of pharmaceutical care by the profession, several researchers worldwide have conducted studies and identified the barriers related to the provision of pharmaceutical care. The studies span about 15 years and although there are trends between countries, readiness to adopt and implement pharmaceutical care also differs between practitioners within countries (Odedina, Segal, & Hepler, 1995; van Mil, de Boer, & Tromp, 2001). Although the barriers do differ in various parts of the world and in different pharmacy sectors, the following compiled list reflects a comprehensive list of barriers which can be categorised as: resource-related constraints, system constraints and pharmacist and educational concerns.

Resource-related constraints:

- Time: a lack of time appears to be one of the most common major barriers perceived and cited. The lack of time is often attributed to a perceived excessive workload and the demands associated with dispensing medicines. (Amsler, Murray, Tierney *et al.*, 2001; Herbert, Urmie, Newland, & Farris, 2006; Kamal, Madhavan, & Maine, 2003; Law, Okamoto, & Chang, 2005; McDonough, Rovers, Currie *et al.*, 1998; O'Loughlin, Masson, Dery, & Fagnan, 1999; Sakthong, 2007; van Mil *et al.*, 2001; Venkataraman, Madhavan, & Bone, 1997)
- Space: Many researchers suggest that practitioners perceive an overall lack of space within the practice environment (Grindrod, Marra, Colley, Tsuyuki, & Lynd, 2010; Kamal *et al.*, 2003; McDonough *et al.*, 1998; O'Loughlin *et al.*, 1999). Other authors suggest that the major barrier associated with space is a lack of appropriate and adequate space for private patient counselling to be conducted, which is necessary in the provision of pharmaceutical care (Amsler *et al.*, 2001; Raisch, 1993; Sakthong, 2007)
- Personnel: worldwide there is a shortage of pharmacists and other support staff, contributing to the difficulty in providing labour-intensive pharmaceutical care services (Herbert *et al.*, 2006; Kamal *et al.*, 2003; Law *et al.*, 2005; McDonough *et al.*, 1998; McGivney *et al.*, 2007; O'Loughlin *et al.*, 1999; Venkataraman *et al.*, 1997).
- Funding: failure to address the other resource issues within the practice environment is often related to insufficient funding. This is also related to poor or no reimbursement or financial compensation for providing pharmaceutical care services (McDonough *et al.*, 1998; Sakthong, 2007; van Mil *et al.*, 2001).

System-related constraints

- Reimbursement: Traditionally pharmacists made profit from the sale of medicines and not from the provision of professional services. In the managed care environment however, many third party payers and governments have limited the profit that can be made on the sale of medicines and yet are reluctant to provide remuneration for professional services. This has led to pharmacists being reluctant to provide services for which they are not compensated (Barnes, Riedlinger, McCloskey, & Montagne, 1996; Herbert *et al.*, 2006; Kamal *et al.*, 2003; Law *et al.*, 2005; McDonough *et al.*, 1998; McGivney *et al.*, 2007; O'Loughlin *et al.*, 1999; Sakthong, 2007; Venkataraman *et al.*, 1997).

- Lack of business models to implement and maintain care services which might be financially viable (Farris *et al.*, 2005). Dugan (2006, p. 23) contends that "without a model to follow and a clear set of guidelines, community practitioners may find it easier to continue practicing within the existing framework".
- Physical organisation and workflow of community pharmacies. Many pharmacies are not designed for pharmacists to work alongside support staff and so the focus within many practice environments is still on pharmacists performing the technical functions associated with dispensing medicines, rather than on providing the professional services associated with pharmaceutical care (McGivney *et al.*, 2007).
- Lack of direct access to doctors. Pharmaceutical care requires co-operation with doctors and other healthcare practitioners and often, especially within community pharmacy this access is not possible or is difficult to achieve (Amsler *et al.*, 2001).
- Other healthcare provider acceptance, attitude, opinion and co-operation. Pharmacists often perceive that other healthcare providers do not understand or accept the value that they are able to bring to the healthcare of shared clients and therefore, are often resistant to co-operating with them (Grindrod *et al.*, 2010; McDonough *et al.*, 1998; Morak, Vogler, Walser, & Kijlstra, 2010; van Mil *et al.*, 2001).
- Patient demand and low expectation of the pharmacy profession. Patients have often experienced a low-level of service from pharmacists and therefore, resultantly demand and expect very little from them. When pharmacists attempt to provide a greater level of professional service to patients who have no previous experience of this, the patients often withdraw and are perceived as reluctant to give pharmacists the time and attention it requires (McDonough *et al.*, 1998; Sakthong, 2007).
- Access to patient clinical and laboratory data. The provision of pharmaceutical care requires access to client clinical and laboratory data – which is often in the possession of other healthcare professionals and inaccessible, or not easily accessible to pharmacists (Sakthong, 2007). Historically pharmacists practice in isolation, their practices mostly being separated physically from other healthcare providers (Dunlop & Shaw, 2002). This makes the sharing of patient records and collaborative patient care with other healthcare professionals difficult.
- Legal liability. In a litigious culture pharmacists are often reluctant to accept the legal liability associated with the provision of professional services (Kamal *et al.*, 2003; Rapport, Doel, & Jerzembek, 2009).
- Lack of legal basis for the implementation of pharmaceutical care. Although the concept is supported and promoted by many pharmaceutical organisations and also

by government pharmaceutical bodies worldwide, very few countries have a legal basis for the implementation of pharmaceutical care (Morak *et al.*, 2010).

Pharmacist concerns

- Lack of clinical knowledge and advanced practice skills: Pharmacists recognise the clinical knowledge and skills necessary to provide professional services and feel insecure in their knowledge and ability (McDonough *et al.*, 1998; Sakthong, 2007; van Mil *et al.*, 2001).
- Communications skills: Provision of pharmaceutical care requires effective communication with patients. Pharmacists have suggested that they do not have the patient communications skills necessary to obtain sufficient information from the patient or effectively convey pertinent information to the patient. (McDonough *et al.*, 1998; van Mil *et al.*, 2001)
- Pharmacists attitudes: In suggesting that "what some pharmacists perceive as a barrier to the provision of pharmaceutical care is not regarded as such by others or has been overcome", van Mil and colleagues (2001, p. 166) highlight the manner in which the attitude of the pharmacist can be a barrier to the provision of pharmaceutical care. Specific attitudes highlighted have included motivation (Farris *et al.*, 2005; Sakthong, 2007) and confidence (Blake & Madhavan, 2010; Venkataraman *et al.*, 1997).
- Fear of change: An unease or unfamiliarity with the new responsibilities associated with pharmaceutical care and a fear of change have also been cited as barriers to the provision of pharmaceutical care (Farris *et al.*, 2005; McDonough *et al.*, 1998). McDonough (1998, p. 94) states, ''Fear of change is a particularly important obstacle to pharmaceutical care because of the difficulty of implementing this philosophy in one's practice.''
- Reluctance to delegate technical tasks to others: Having not yet embraced the new responsibilities associated with pharmaceutical care, many pharmacists are hesitant to relinquish their traditional dispensing tasks and delegate these more technical aspects of their role to other support staff (Rapport *et al.*, 2009).
- Perceived value of pharmaceutical care to patients: Some pharmacists are not of the opinion that the provision of pharmaceutical care is actually of value to patients (Blake & Madhavan, 2010), whilst others suggest that this opinion may emerge from a perceived lack of data on the value of pharmaceutical care (Dunlop & Shaw, 2002).
- Attitude of pharmacy owners: It has been noted that the attitude of pharmacy owners often impacts on the extent to which pharmaceutical care provision is possible

(Dunlop & Shaw, 2002; van Mil *et al.*, 2001). Dunlop and Shaw (2002, p. 229) suggest a negative attitude of pharmacy owners to pharmaceutical care may be "largely attributable to their day-to-day focus on commercial matters in the operation of an increasingly complex retail business".

Educational concerns:

- Lack of pharmaceutical care related education: Some have cited the lack of suitable education, both at an undergraduate level and at a practitioner, continuing education level as a barrier to pharmaceutical care provision (Morak *et al.*, 2010). The different emphases necessary for the provision of pharmaceutical care, that are often lacking in education, include: training in clinical and advanced practice skills (McDonough *et al.*, 1998; Sakthong, 2007; van Mil *et al.*, 2001); communication skills and direct patient-care skills (McDonough *et al.*, 1998; van Mil *et al.*, 2001)
- Isolation of pharmaceutical education: Historically pharmacy education has not happened alongside the education of other healthcare professionals. This has resulted in misunderstandings and a lack of awareness about the role and abilities of the other professionals and has made inter-professional collaboration difficult. (Dunlop & Shaw, 2002)
- Change agents: Transitioning toward pharmaceutical care practice requires changing practice environments and processes and pharmaceutical education does not often teach students how to be agents of change (Berger, 2009).

In South Africa the implementation of pharmaceutical care as a philosophy of practice is also not without difficulties and constraints. The barriers to the implementation of pharmaceutical care that have been recognised mirror those identified worldwide. In 2000, Lubbe listed five sets of factors which mitigated against the implementation of pharmaceutical care in the South African context (Lubbe, 2000, p. 72). She categorised the factors as: attitudinal, educational, profession related, resource related and system related. A summary of the factors in each of these categories as identified by Lubbe (2000) is provided in Table 2.1.

In a more recent South African study Blignault (2010) identified the major barriers to practicing pharmaceutical care as: a lack of remuneration for services provided; the time consuming nature of the process; and, insufficient time to engage with patients. According to Lubbe's categorisations these would be resource and system related barriers.

Table 2.1: Barriers to the implementation of pharmaceutical care in South Africa (adapted from Lubbe, 2000, p. 72)

CATEGORY	BARRIER FACTORS

Attitudinal	• Resistance to change from pharmacists
	  ○ Lack of understanding of what is expected
	  ○ Lack of skills related to new roles
	  ○ Perceived threat to professional status of pharmacy
	• Patient attitudes
	  ○ Resistance to spending time in the pharmacy
	  ○ Resistance to additional expenses which might be incurred
	  ○ Concern about pharmacists duplicating the work of doctors
	• Attitudes of other healthcare professionals
	  ○ Concerns about pharmacists usurping their functions
	  ○ Lack of awareness of pharmacists skills and knowledge
	• Attitudes of third-party payers
	  ○ Lack of awareness of value of pharmaceutical care
	  ○ Concern about costs
	  ○ Resistance to challenge to authority

Educational	• Lack of education with regards clinical skills and pharmacotherapeutics • Inadequate training in communication • Lack of education in the systems and processes, such as documentation • Failure of academic institutions to value pharmaceutical care • Lack of adequate pharmaceutical care research
Profession-related	• Weak and unsupportive professional relationships
Resource related	• Time – due to increased patient numbers and pressure from patients • Lack of space for private consultations • Lack of evidence of cost-benefit • Lack of management support
System related	• Lack of reimbursement and financial incentives • Unsupportive, fragmented health care system.

Williams (2005, p. 146) argued that although the categories identified by Lubbe, appear at times to be "somewhat artificial", there are three themes that emerge and these are those corresponding to issues of: professional identity, which includes relationships with other healthcare professions, patient attitudes and financial incentives; education, including both undergraduate and continuing professional development, and; system related issues including lack of resources, professional territorial conflicts, government interventions and fragmented healthcare system. Furthermore Williams (2005, p. 146) contended that underpinning all of the factors which may be considered as barriers to pharmaceutical provision was the profession's "tenuous professional identity, which continues to exhibit the failure to understand the nature of covenantal relationship", in other words to understand the commitment and responsibility of the profession in the context of a patient or relationship-centred approach. With the transition to a patient-centred role pharmacists have to "change identities and learn new ways of being with their patients" (Sánchez, 2011, p. 55). This also supports the view of Maddux and colleagues (2000, p. 10) who argued that: "confidence level and self-image are important prerequisites for pharmacists who seek to perform health care functions that traditionally have been carried out by other health professionals".

2.3.6 Patient centeredness

As initially described by Hepler and Strand (1990, p. 537), the unique nature of the pharmacist-patient covenantal relationship is based upon both a "fiduciary" obligation to serve the patient, and an ethical responsibility to act in and work for the patient's best interest. This relationship forms both the basis of the profession and the foundation of practice. According to Zlatic (2000, p. 368) "a fiduciary relationship is a 'faith' relationship (fides = faith)". In such a relationship "a professional has special knowledge that he or she uses to touch the life of a person so intimately that that person must have complete trust, complete faith, in the professional; the client/patient must believe the professional will act in his or her best interest, not self-interest" (Zlatic, 2000, p. 368). Austin and colleagues (2006) argue that without this special relationship pharmacy would be little more than a technical occupation. This sentiment is echoed by Hepler (2010, p. 1322) who suggested that pharmaceutical care as the central function, purpose and responsibility of the entire pharmacy profession was "a dream deferred" and would remain such until the profession "puts the patient at the centre."

The patient-centred focus of pharmaceutical care provides the profession with an opportunity to "recreate" itself through the application of a consistent patient-care process and a clear definition of pharmacists' responsibilities in the health care system. According to Varela

Dupotey and Ramalho de Oliveira (2009, p. 610) the shift in focus with pharmaceutical care, from the product to the patient, restores the human aspect to pharmacy practice. It is this humanistic aspect for which Zellmer (1996, p. 1916) implored when he stated:

> I think we have greatly underestimated the magnitude of the paradigm shift that pharmaceutical care embodies. . . . let me remind you of Thomas Moore's definition of soul: 'It has to do with depth, value, relatedness, heart, and personal substance.' People want and need pharmacists with those characteristics - pharmacists with soul. Let's dedicate ourselves to remaking this occupation of ours into a profession that gives people what they want and need.

A patient-centred focus implies that the practitioner is consistently and undoubtedly focused on individual patients and is concerned with their health and well-being. Stewart (2001, p. 444) in an attempt to define a global concept of patient-centred care suggested that patients want patient-centred care which: 1. acknowledges and explores their experience of illness and their concerns and needs; 2. takes their "whole person" into account, including their needs and life issues; 3. seeks common ground on an understanding of what the problem is and mutual agreement on management thereof; 4. incorporates preventative and health promotion aspects into care; and, 5. enhances the continuing practitioner–patient relationship.

In a review of the conceptual and empirical literature regarding patient-centeredness of the doctor-patient relationship, Mead and Bower (2000) proposed five key dimensions to patient-centred health care. These dimensions each represent a specific aspect of the relationship between doctor and patient, and I propose have relevance to other practitioner-patient relationships and certainly to pharmacist-patient relationships. These include:

1. A biopsychosocial perspective in which disease and the patient's experience of it and the practitioner's approach to it is viewed as existing at a number of interacting levels, including biological, psychological and social.
2. The "patient as a person" – a patient's experience of illness is dependent on their biography and therefore the healthcare practitioner needs to understand the personal meaning of illness for the patient and acknowledge that "the patient is an experiencing individual rather than the object of some disease entity" (p. 1088).
3. Sharing power and responsibility – patient centred care depends on an "egalitarian" patient-practitioner relationship in which there is a shift from a "co-operation-

guidance" model to a "mutual participation model" and power and responsibility are shared with the patient (p. 1089).

4. Therapeutic alliance – in patient-centred care priority is given to the personal relationship between practitioner and patient, based on mutual empathy, congruence and unconditional positive regard. Therapeutic outcomes are acknowledged as depending on patients' experience of the practitioner as "caring, sensitive and sympathetic" (p. 1090). Although a function of the relationship, development of a therapeutic alliance depends on the skills of the practitioner to facilitate a supportive consultation context.
5. The practitioner as person. Patient centred care is dependent to a large extent on the personal qualities or "humanness" of the practitioner, including characteristics such as warmth, respect and empathy (p. 1090).

The practice of pharmaceutical care is by definition patient-centred (Sánchez, 2011). If this notion is taken seriously pharmaceutical care practitioners should seek to understand the patient as a whole person, acknowledging their feelings and experience of their illness, rather than simply viewing them as an object of a disease, to be treated. Attention needs to be given to the patient and to the meanings they ascribe to their illness as well as to their medications. The patient, rather than the disease or the product becomes the focus of the treatment and relationship with the patient is central to the process. It is important that pharmacists create an environment in which patients feel the respect and interest of the pharmacist and experience the pharmacist as "human".

In order to enhance understanding of patient-centred care, in particular as it is described by Mead and Bower (2000) it is helpful to give consideration to the concept within the broader context of relationship-centred care (Dobie, 2007). Relationship-centred care can be defined as "care in which all participants appreciate the importance of their relationships with one another" (Beach, Inui, & Relationship-Centered Care Research Network, 2006, p. S3). In relationship-centred care although the relationships between practitioners and patients remain central, the relationships of practitioners with themselves, with each other and also with the broader community are also acknowledged and emphasised (Beach *et al.*, 2006).

Beach and colleagues (2006) have identified and defined four principles underpinning relationship-centred care. Firstly, in relationship-centred care "dimensions of personhood" as well as "roles" are integral to all relationships and the practitioner also brings their "personhood" into the patient encounter (p. S4). Thus relationship-centred care emphasises the concept of practitioner "authenticity" developed through growing self-awareness.

Secondly, “affect and emotion” are recognised as central to the relationship process and the concept of “detached” care is challenged (p. S4). Alongside cognition, affect and emotion are fostered as important dimensions that enhance the empathetic capacity of the practitioner. Thirdly, “all health-care relationships occur in the context of reciprocal influence” and therefore although the patient’s needs are given priority it has to be acknowledged that the practitioner also benefits from the relationship (p. S4). Lastly, the formation and maintenance of relationships in health care have moral value. Beach and colleagues argue that “genuine relationships are morally desirable” since it is through such relationships that practitioners “are capable of generating the interest and investment that one must possess in order to serve others, and to be renewed from that serving” (2006, p. S4).

Relationship-centred care acknowledges that the practitioner-patient relationship is a “unique product of its participants and its context” and there is no single set of standards for practitioner behaviour (Beach *et al.*, 2006, p. S6). Rather practitioner behaviour is judged by the “extent that it emerges from and contributes to the relationship” between the practitioner and the patient (Beach *et al.*, 2006, p. S6). Relationship-centred care recognises that mutual respect and “sincere teamwork” between practitioners can also have a positive influence on the wellbeing of both the practitioners and their patients.

Building on the concept of relationship-centred care Dobie (2007, p. 423), contends that patient-centred care can best be provided when practitioners “know themselves, when they are truly present in the encounter, and when they are attentive to the collaboration between the patient and themselves”. Thus she proposed that central to the provision of relationship-centred care was practitioner self-awareness and mindfulness. She suggested that the practitioner brings to each patient encounter, their own culture and beliefs, assumptions – both conscious and unconscious, needs, feelings, passions, expectations, and skills. The better the practitioner knows themselves, the more they are able to give themselves attentively to the patient and to be able to truly hear the patient’s story. Giving themselves attentively to the patient is what is considered mindfulness.

According to Epstein (1999, p. 835) mindfulness is “attending to the ordinary, the obvious and the present”. It is “being present in everyday experience, in all of its manifestations, including actions, thoughts, sensations, images, interpretations, and emotions” (1999, p. 835). Mindfulness is a “logical extension of the concept of reflective practice” (1999, p. 835). The goals of mindful practice are to become increasingly aware of one’s own thought processes, to listen attentively to others, become adaptable and flexible and to be able to recognise biased and judgmental attitudes, so that one is able to act in a principled and

compassionate manner (1999, p. 835). Epstein (2003) suggested that mindfulness required that the practitioner develop four habits, namely: 1. attentive observation of the patient, the patient's problem, and of themselves; 2. a curiosity that encompasses the courage to see one's own weaknesses in a situation, 3. the ability to look and see with fresh eyes, without preconceived ideas, and with an openness and tolerance of contradiction; and 4. the ability to be present such that one can give undistracted attention to a person and or task, accompanied by both compassion and connection.

Ramalho de Oliveira and Shoemaker (2006) termed the natural tendency of pharmacists to provide product-centred services rather than patient-centred care as the "pharmacist's natural attitude" (p. 56). They further defined "natural attitude" as the manner in which people go about their everyday lives, suggesting that it is "the taken-for-granted approach to the world" and implying that "individuals do not reflect on their actions; rather they act according to their common sense pre-understandings, assumptions, or biases" (p. 57) They argued that pharmacists "like all people, have professional biases and pre-understandings, and they too, go through their workdays without questioning their professional assumptions and activities" and that the development of "openness" is necessary for pharmacists to move toward patient-centred practice. "Openness" involving both "open-heartedness" and "open-mindedness" is as they argued, achievable through "listening, acknowledging, and wondering in the moment the pharmacist is caring for the patient and recognising, questioning, and reflecting during self-analysis and interactions with colleagues" (p. 58). This can be seen as being akin to Epstein's (1999) concept of mindfulness which as Epstein (p. 834) contended is both a discipline and an attitude of "critical curiosity, openness and connection".

Williams (2005, p. 40), citing Archer (2003), describes a similar concept to mindfulness termed "reflexivity". Reflexivity can be considered as a deeper dimension of reflection, and is: "the practice of the internal dialogue through and in which we go about formulating a thought, questioning ourselves, clarifying our beliefs and inclinations, diagnosing our situations, deliberating about our concerns and defining our own projects" (Williams, 2005, p. 40). Reflexivity has also been described as having an "on-going conversation about experience" with oneself, "whilst at the same time living in the moment" (McIntosh & Webb, 2005). The term is often used more in the realms of knowledge production or research, to describe the process of having a "self-conscious account regarding the condition of knowledge production, as it is being produced" (Baarts, Tulinius, & Reventlow, 2000, p. 431). In other words it is concerned with the production of knowledge from experience, by the process of examination of the impact of one's position and actions. It is perhaps more introspective than

mindfulness, although it has been proposed as a strategy for developing a patient-centred approach to healthcare (Baarts *et al.*, 2000, p. 431).

It would appear that in the realm of healthcare, the practice of reflexivity, as a dimension of relationship-centred care, may lead to the development of an attitude of mindfulness and openness, which has the potential to deepen the patient-centred focus of the practitioner. The purpose and aim of mindfulness is “compassionate informed action in the world, to use a wide array of data, make correct decisions, understand the patient and relieve suffering” (Epstein, 1999, p. 838). Stated more simply one of the central goals of healthcare practitioner mindfulness is quality care of patients. Thus in order to fulfil its mission of pharmaceutical “care”, perhaps the pharmacy profession and pharmacists as individuals, need to give careful consideration to the concepts of relationship-centred care, reflexivity and mindfulness.

2.3.7 Caring aspects of pharmaceutical care

The phrase “pharmaceutical care” and its underlying meanings have been the primary focus of countless articles, discussions, mission statements, planning meetings, pharmacy lectures, and professional development programs for over a decade (Fjortoft & Zgarrick, 2003). Galt (2000, p. 224) however, advocated that although the term “care” is contained within the definition of pharmaceutical care, the values, attitudes and behaviours which characterise the care aspect are “assumed rather than overtly defined”.

According to Fjortoft and Zgarrick (2003), using phrases such as: "patient's welfare paramount"; "personal concern for the well-being of another person"; and "one-to-one relationship between a caregiver and a patient”, "caring" has been acknowledged as a dimension of pharmaceutical care by both the American Pharmacists Association and the American Society of Health-System Pharmacists. In 2006, the Accreditation Council for Pharmacy Education (ACPE) stated that in order to deliver patient-centred care, pharmacists must demonstrate empathy. The Accreditation Standards and Guidelines for the Professional Program in Pharmacy leading to the Doctor of Pharmacy degree, in the US, also identify empathy as a desirable quality which should be sought in new admissions, and that empathy, is an essential element for the development of pharmacists (Accreditation Council for Pharmacy Education, 2006a). In their positional statement on Professional Standards for the Provision of Pharmaceutical Care the International Pharmaceutical Federation (FIP) also states that pharmaceutical care must be provided in the context of a professional relationship between pharmacist and patient which is “established and maintained on the basis of caring,

trust, open communication and mutual decision making" and within the relationship pharmacists "give the patient's welfare priority" (International Pharmaceutical Federation, 1998).

Although in South Africa both the SAPC and the PSSA make reference to the provision of pharmaceutical care in their mission statements, neither of them define or describe the concept in terms of "caring" (Pharmaceutical Society of South Africa, 2010; South African Pharmacy Council, 2008). Notwithstanding the fact that the focus of Pharmacy Week 2011 in South Africa, which was supported and promoted by the SAPC, PSSA, National Department of Health (DoH) and Management Sciences for Health (MSH): Strengthening Pharmaceutical Systems (SPS), was "Pharmacy – toward quality care together", no mention was made in the campaign posters of the "caring" responsibility of pharmacists.

As Manasse (2011, p. 1098) suggested care, in the sense of "caring about" and "not just providing services to patients" is central to the professional ethos of pharmacy. Caring entails an "emotional commitment" to the well-being of the patient, and has been defined as the expression of "attitudes and actions of concern" for patients which foster and support their well-being, alleviates disease or distress, and is elicited in response to "obvious or anticipated needs" (Fjortoft & Zgarrick, 2001, p. 335). Caring behaviour is comprised of both attitudes and actions, underpinned by a sound knowledge base. According to Hawthorne and Yurkovich (1996), caring involves a connection between two people that encompasses "a sense of oneness, fulfilment, and growth, and assists each on his/her human journey", and it is "an act of accepting, enabling and encouraging an individual by honouring his [sic] uniqueness, his complexity, his feelings and needs; by believing that each person's life makes a difference; and by helping a person find his voice and be heard."

Integral to the concept of caring is the notion of empathy. Empathy has been described as the ability, through our understanding of mindfulness, to "vicariously" enter into and share the experiences of another person. It occurs when "I and you" develops into "I am you," or potentially "I might be you" (Spiro, 1992, p. 844). Drawing on published research Lonie (2006) identified several factors which are consistent with empathy, these include: expressive clarity in empathic communication; self-disclosure and the ability to honestly share of oneself with others; active listening; being able to ''read'' another person's nonverbal behaviours; the ability to use nonverbal behaviour to communicate understanding and concern; perceptual acuity, specifically the ability to become attuned to another's emotional states; and a positive self-concept and mature anger management skills.

In an examination of the concept of “care” in pharmaceutical care, across research, practice and education Galt (2000) argued that although debate and discussion around the concept of care and caring is meaningful, what is of true importance in healthcare is how these concepts or attitudes are translated into behaviours which are experienced by the patient. She contended that "care and caring are ultimately defined as acts or behaviours which are a response to the values and needs of the individual, with professional care specifically intended to improve or maintain a person's health" (2000, p. 224). Galt suggested a list of specific caring pharmacist behaviours that could be considered to demonstrate fulfilling or advocating for a patient’s needs. These behaviours are based on a set of ten carative factors identified in a model of caring dominant in nursing and described by Watson (cited by Galt, 2000). The model is known as the Carative factors of Watson and describes a set of factors relating to care which results in the satisfaction of certain human needs. These factors are summarised in Table 2.2

Table 2.2: Carative factors of Watson (adapted from Galt, 2000)

CARATIVE FACTORS
1. The formation of a humanistic-altruistic set of values.
2. The instillation of faith and hope.
3. The cultivation of sensitivity to one’s self and others.
4. The development of a helping-trust relationship.
5. The promotion and acceptance of the expression of positive and negative feelings.
6. The systematic use of the scientific problem-solving method for decision making.
7. The promotion of interpersonal teaching and learning.
8. The provision of supportive, protective and or corrective mental, physical, sociocultural, and spiritual environment.
9. Assistance with the gratification of human needs.
10. The allowance of existential-phenomenological forces.

The model is based on the assumptions that: caring is relationship centred and that it can only be effectively demonstrated and practiced interpersonally; effective caring promotes health and growth of individuals and families; the practice of caring is based upon the integration of biophysical, psychological and social knowledge; caring responses accept a

person as they are now and also for what they may become; and, a caring environment which supports the development of potential is necessary (Galt, 2000).

The pharmacist caring behaviours described by Galt range from personal behaviours, such as "praying for the patient," to professional responsibilities, such as "act to improve the patient's therapeutic regimen to better achieve desired outcomes." A full list of the caring behaviours and the Watson Carative factors which they encompass is provided in Table 2.3.

Table 2.3: A suggested list of pharmacist caring behaviours and the associated Carative factors of Watson (adapted from Galt, 2000)

SPECIFIC CARING BEHAVIOUR OF PHARMACIST	CARATIVE FACTOR[I]
Act directly to fulfil any health care related needs expressed by the patient.	1
Visit the patient in their home environment if this is a necessary step in order to assess, or serve meeting the patient's needs	1,2,4,7
Protect the patient from harmful treatments or decisions by informing the patient of this potential, and advocating for improved alternative approaches.	1,4,6,8
Provide privacy to a patient during sensitive and personal communications.	1,3,4,5
Take the time to observe the effects of a treatment on a patient.	1,2,36
Communicate the concerns of patients to other care givers, when appropriate and necessary.	1,4
Consult with other health professionals on behalf of the patient.	1,4,6
Inform the patient that you (the pharmacist) are available now, and in the future, for any health needs he or she may have	1,4,9
Act to resolve patient problems with medical care plans that are impeding access to needed treatments.	1,4,9
Include informing the patient that you will pray for them if this is within both of your health care concepts.	2,10
Employ effective listening skills with the patient and/or care providers to determine the patient's needs.	3,4,5
Communicate in an empathic manner toward patients	3,4
Respond to specific patient requests in a timely manner, and within an appropriate time frame based upon the urgency.	3,4,6,8
Educate the patient about how to provide self-care and self-assessment of his or her response to therapy.	3,4,7
Encourage the patient to become a partner in self-care.	4
Help patients to recognise that they need to participate in their care.	
Advocate for affordable medications specific to the patient's expressed needs and resources. This may be recommending the incorporation of less expensive alternatives, enrolment of patients in an indigent care pharmaceutical program, or discontinuing ineffective medications	3,4,6,8,9

SPECIFIC CARING BEHAVIOUR OF PHARMACIST	CARATIVE FACTOR[i]
Support the patient by assisting or advocating for obtaining adjunctive care services and/or resource which the patient needs to achieve health-related outcomes	4
Help patients find appropriate support groups.	4,10
Encourage the patient to express needs directly to you in order that you may act on behalf of these interests.	4
Provide education that is specific to a patient's needs.	4,7
Explain the proper use of a drug or device.	4,6,7
Provide answers which meet the needs underlying a patient's questions.	4,7
Act to improve a patient's treatment when they experience side effects.	4,6,8
Act to improve the patient's therapeutic regime to better achieve desired outcomes.	6
Monitor for whether a patient's desired outcomes are being achieved.	6
Maintain your professional competency through your professional life in order to fulfil caring acts on behalf of patients.	6
Identify, prevent and solve patient-specific medication-related problems.	6,7
Personalise counselling in order that it meets each patient's specific needs.	7
Confirm a patient's understanding of the essential information needed to fulfill their care needs.	7
Work with each patient to assure adherence to treatment regimens.	7
Follow-up with the patient through a variety of communication methods (interview, telephone, electronic communication, etc.) and based upon the patients specific problem, to determine how they are progressing toward achieving the desired outcomes.	7,8
Receive the prescription directly from the patient in order to encourage needed communication with the patient.	8
Deliver the prescription directly to the patient in order to encourage needed communication with the patient at the time of receiving treatments.	8
Document specific interventions in order to improve future care decision making.	8
Facilitate solutions to the patient's needs to improve the patient's well-being.	9
Act to obtain help from others who are most qualified to help a patient meet his or her specific expressed needs. These needs may be medical, social, economic or spiritual in nature.	8,9,10
Pray for the patient.	10
Maintain an up to date listing of medications that the patient uses in order to act responsibly to meet the patient's needs.	9

i The numbers relate to the carative factor listed in Table 2.2.

Galt (2000) further suggested that if caring behaviours were integral to practice, patient outcomes would improve and the impact of pharmaceutical care practice would be experienced. However, the degree to which pharmacists are exhibiting these behaviours and the effects engaging in these suggested caring behaviours have on patient well-being and

health outcomes, are as yet not fully known. Although it is apparent that the profession recognises that providing pharmaceutical care requires a commitment to the patient's health and well-being, it is not well understood how the "care" in pharmaceutical care is defined or what the current levels of pharmacists' caring abilities are (Fjortoft & Zgarrick, 2003).

Fjortoft and Zgarrick (2003) used the Caring Ability Inventory (CAI) to determine the caring ability of a random sample of 323 pharmacists registered in Illinois US. Pharmacists included in the study demonstrated a relatively high level of caring ability, and there were no significant differences in inventory score by gender, degree earned, or practice setting, although a significant and positive correlation was found between years in practice and caring ability score.

Although there has been published evidence on the impact of the provision of pharmaceutical care services on patient outcomes (Section 2.3.4), there do not appear to be any studies which directly demonstrate the impact of pharmacists' empathy specifically, on patients' health outcomes and wellbeing. Research has, however, proven that patients who interact with health care providers who have sensitivity toward their emotional states tend to have better health outcomes than those practitioners who focus exclusively on a patient's physical status (Hojat, Louis, Markham *et al.*, 2011; Mercer & Reynolds, 2002; Neumann, Edelhäuser, Tauschel *et al.*, 2011). Citing several authors, Fjortoft and colleagues (2011) suggest several instances where healthcare provider empathy has been associated with positive health outcomes, including: the degree of empathy having a direct link to positive clinical outcomes in diabetic patients; empathic engagement in patient care leading to better patient compliance; increased accuracy in diagnosis; increasing accuracy in identifying prognosis; increased patient satisfaction and; decreased likelihood of litigation against healthcare providers.

2.3.8 Pharmaceutical care into the future

While the concept of pharmaceutical care and its greater patient-centred role has been extensively accepted within the profession, and has become the central theme, the degree to which this has substantively changed pharmacy practice is questionable (Austin *et al.*, 2006; Droege & Baldwin, 2005; Hughes *et al.*, 2010; Williams, 2005). Austin and colleagues (2006, p. 536), go so far as to suggest that "although professional and corporate mission statements, academic standards, and regulatory requirements have all rapidly changed to embrace ''the patient-centred model'' of practice, the real-world experiences of pharmacists and of those who are served may be quite different and furthermore that this basic difference

can give rise to “misalignment of expectations, attitudes, and behaviours”. This sentiment is echoed by Hepler (2010, p. 1319) who suggested that although the dream of pharmaceutical care becoming “the central function, purpose, and responsibility” of the entire pharmacy profession was then “more than a generation old”, it remained “a dream deferred”.

Although several barriers to the implementation of pharmaceutical care have been identified (Section 2.3.5), I would agree with the observation made by Williams (2005, p. 146) that a “tenuous professional identity” which prevents the profession from comprehending it’s commitment and responsibility in the context of a patient or relationship-centred approach, may be at the foundation of all of the identified barriers. Hagemeier (2010, p. 133) contends that pharmacy has struggled “with an identity for many years” and argues that it is still struggling. This “tenuous professional identity” has implications for the profession and also for the socialisation of new pharmacists and students into the profession. As Hagemeier (2010, p. 137) further suggested:

> There is much to be accomplished with regard to the identity of the pharmacy profession. Academicians play a critical role in developing this identity….. If the profession desires to advance patient care, specifically in the community setting, pharmacy educators must nurture and develop student pharmacists into advocates who desire to enter academic and community pharmacy with the integrity and awareness necessary to stand firm in their primary responsibility to patients.

As some authors have suggested, pharmacy students and new graduates often find themselves disenchanted and frustrated with pharmacy as a career and disappointed with their education (Brown, Ferrill, Hinton, & Shek, 2001; Duncan-Hewitt & Austin, 2005). Although pharmacy students may have been taught the associated knowledge and required skills to deliver pharmaceutical care, they are often not adequately prepared to initiate and implement the process or provide the direct patient care dimension (Fjortoft & Zgarrick, 2001). The gap between the pharmaceutical care model of practice with its patient-centred philosophy taught in undergraduate schools, is often in stark contrast to the “technical, product-oriented, distributive practices” they encounter in practice (Brown *et al.*, 2001, p. 241).

This contrast often leads to internal feelings of conflict and confusion about one’s professional role and identity and an inability to be an agent of change, within the newly forming boundaries of integrity of one’s professional identity. According to Hagemeier (2010,

p. 133) “inconsistencies in the profession: the discontinuity between what is taught in pharmacy school and what is experienced in community practice, and the discontinuity between advancement of patient care and the retail, product focus of many community settings” have existed for years. Furthermore, he suggested that “academia has the potential to transform product-focused community settings through development of advocates for the profession” (Hagemeier, 2010, p. 133). The place of pharmacy education and its role in the formation of pharmacists capable of providing relationship-centred pharmaceutical care will be discussed in Section 2.4.

2.4 Pharmacy education

As Maddux and colleagues on the American College of Clinical Pharmacy’s Clinical Practice Affairs Subcommittee (2000, p. 13) suggested “Pharmacy education has a responsibility of preparing not only for the present but also for the future, even innovating for the future and guiding the course of the profession”. This notion is supported by Hudgens and Chirico (2010, p. 1) who assert that pharmacy educators have the task of educating future pharmacists with the prerequisite knowledge, skills and attitudes for practice “not only upon graduation, but for a 40-year career”. This would appear to be a formidable task as it seemingly requires educators to predict the nature of future practice. It would seem that perhaps there is a dual responsibility to both educate and prepare graduates for future practice in addition to the ability to practice in the context in which they find themselves whilst being able to recognise and respond appropriately to a changing practice environment.

Pharmacy education has a chequered history with regards practice, at times driving the profession forward to transform practice, and at other times lagging behind the profession in terms of adequately preparing students for a changed practice environment. This can perhaps be better understood by giving attention to the development of pharmacy education over time. In a consideration of the development of pharmacy education especially as it pertains to the preparation of students to practice patient-centred care, it would seem relevant to give attention to the US perspective; since it was there that the concept of pharmaceutical care emerged. Obviously specific focus will also be given to the South African context and to that in other countries, especially the UK, where pertinent.

2.4.1 The apprenticeship period

During the 19th century pharmacy education occurred primarily though apprenticeships. Apprenticeships were an “indentured servitude” and could last for up to seven years (Cohen,

2008, p. 103). Although some pharmacy colleges did exist in the US, with the first one being established in Philadelphia in 1821, and a further five by 1856, they commonly held night classes to facilitate apprentices being able to work during the day (Cohen, 2008; Higby, 1996). Cohen (2008) suggests that by 1896 only one in eight pharmacists had any formal pharmacy education and the colleges offered courses of varied length (between one and four years) and diverse content and quality. Around 1870, discussion with regards organised pharmacy education started to take place within the APhA and by the late 1890s the formation of what is now termed the American Association of Colleges of Pharmacy (AACP) transpired. By the start of the 20th century there were 55 colleges of pharmacy in the US. Although there was no consensus on syllabus or training methods, all taught aspects of chemistry, *materia medica* (the scientific study of medicinal drugs and their sources, preparation, and use) and pharmacy and business practice. There was also tension within the profession, with pharmacists in practice, particularly those in "chain stores", wanting to hold onto apprenticeships as the dominant training method, whilst a group of pharmacy educators insisted on the need for a "laboratory based scientific training … to put pharmacy on a full academic footing as an applied scientific discipline" (Cohen, 2008, p.104).

In the UK an apprenticeship model also dominated early education into the profession. The first school of pharmacy which offered "laboratory instruction for pharmacy students under proper guidance" was started by the Pharmaceutical Society in 1844 (Sonnedecker, 1963, p. 115). Similarly in South Africa, early pharmacy training also happened through apprenticeships, with no schools or colleges existing before 1900. In the 1880s in South Africa prospective pharmacists were required to serve a four-year apprenticeship with a pharmacist - or as they were then called – a chemist or druggist. According to Ryan (1986, p. 35) "the pharmacist agreed to teach his apprentice the chemist's trade and in some cases, supplied him with board, lodging, clothing and books necessary for his studies". In order to qualify they had to pass exams in five subjects, set by the Cape Medical Committee, namely: prescriptions; pharmacy; *materia medica*; botany and chemistry. Since no formal educational programmes including these subjects were available, apprentices had to depend on their apprenticeship "master" (Ryan, 1986, p. 35). Since all pharmacists during this period prepared or compounded medicines to their own formulae or "recipes", apprenticeship agreements prohibited the apprentice from "divulging the contents of their masters' mixtures" (Ryan, 1986, p. 37). As a consequence, the scope for development of general standards for education with respect to the practical aspects of pharmacy was limited.

In 1928, the Pharmacy Board of South Africa (the forerunner to the current SAPC) introduced a prescribed year of academic study and training at technical colleges (accredited

by the Board) and reduced the apprenticeship to three years. In 1954, the apprenticeship period was again reduced to two years, and the period of academic study was increased to three years. This was preceded by changes in the practice environment where the emphasis was shifting away from compounding of medicines to greater emphasis on the distribution of manufactured drug products. Prior to the introduction of the first degree in pharmacy, all pharmacists graduating in South Africa did so with a Pharmacy Board accredited diploma in pharmacy. The introduction of regulations relating to the minimum curriculum for a degree in pharmacy by the Pharmacy Board of South Africa, in 1955, was followed by the introduction of a degree programme at Potchefstroom University, in Afrikaans (1956), and a year later (1957) by a pharmacy degree, in English, at Rhodes University. (Ryan, 1986)

Clearly, during the apprenticeship period of pharmacy education, learning was predominantly experiential and education was driven by practice. As some authors have noted, new pharmacists were taught within a "community of practice" (Duncan-Hewitt & Austin, 2005; Vaillancourt, 2009). The term "community of practice" was coined by anthropologists Lave and Wenger (1991, p. 98), to describe a group of people "who share a concern or a passion for something they do and learn how to do better, as they interact regularly". Membership of a practice community provides opportunities for learning and for personal and professional growth. It is the milieu within which individuals acquire and develop the practices (including ideals, standards and relationships) appropriate to that community. It is also through participation in communities of practice that identity is negotiated (Wenger, 1998). The development of a practice-centred identity is one of the unique and defining characteristics of a community of practice that distinguishes it from other learning environments (Duncan-Hewitt & Austin, 2005).

The shift of the responsibility for pharmacy education away from the practice community to the university, overcame the problems of variation in quality in education and allowed for a "more uniform and efficient teaching of the sciences". However it created a gap between education and practice and a situation where students were not enabled to "develop an identity that is centred in their profession" and perhaps may be one of the factors contributing to the "perceived decline in professionalism". (Duncan-Hewitt & Austin, 2005, p. 373)

2.4.2 Period of educational reform

Throughout the early 20th century, with the advancement of technology and the subsequent increase in commercial manufacturing of medicines, pharmacy compounding decreased and the tension between the merchant or trader role and the professional role of pharmacy

became more pronounced (Section 2.3.2). This had a major impact on the discussion and development of pharmacy curricula. The pharmaceutical industry, interested in developing, mass producing and selling medicines, supported and encouraged drug and product oriented research, and some pharmacy educators took up this challenge. Other pharmacy educators, following the trends in practice, argued for greater emphasis on the business aspects of pharmacy, and yet a further group recognised the developing complexity of healthcare with the introduction of many new and often potentially more dangerous medicines. This last group of educators identified the possibilities that existed for pharmacists to work at the interface between doctors and patients and by preparing students for this more clinical role recognised the potential that existed for pharmacy to enhance its professional status in the healthcare environment. (Cohen, 2008; Sonnedecker, 1963)

During the 1920s in the US, a wide-ranging and inclusive assessment of the functions of a pharmacist helped ease the tension between the dual mercantile and professional roles of pharmacy, creating the opportunity for development of both of these roles and also the sciences underlying the manufacture of new drug products (Cohen, 2008). As Higby (1996, p. 33) suggested during the first half of the 20th century, pharmacists looked to changes in education as the "vehicle for professional improvement" and "the pursuit of professional status charged forward with the pharmacy curriculum as its standard". Furthermore, he noted the irony in this, since it was pharmacy education that advanced the pharmacy sciences to the point that manufacturers could "take over the art and science of pharmacy" (Higby, 1996, p. 34).

Toward the end of this period, in 1946, a joint effort of all major pharmacy organisations in the US and the American Council of Pharmaceutical Education (ACPE), saw the initiation of the Pharmacy Survey – "the most complete (self) study of an occupation ever undertaken" (Higby, 1996, p. 38). What emerged from the survey were action proposals making recommendations for changes in 11 different areas of pharmacy, including the pharmacy curriculum. It was suggested that pharmacy education strengthen the scientific components of the existing four year degree programme and begin looking toward the development and establishment of a six-year programme leading to the professional degree of Doctor of Pharmacy (PharmD) (Cohen, 2008; Higby, 1996). The rationale was that this would provide opportunity for a broader and more liberal education and that "pharmacists who followed this new course of study would be well educated and thereby, worthy of the respect of other professionals and of the public" (Higby, 1996, p. 39).

2.4.3 The science era

Pharmacy education across the US responded with the adoption of a five-year programme in 1954, and began to engage in the PharmD debate, about the same time that pharmacy in South Africa first moved toward degree status. It was also around this time that great strides in the pharmaceutical industry were being made and as Higby (1996, p. 39) noted, for the pharmaceutical manufacturers these were "boom times", with a multitude of new and effective drugs such as antibiotics, anti-hypertensives and antidepressants coming onto the market. It was however the mercantile or "count and pour" phase of pharmacy practice (Section 2.2.2) and although "pharmacists gained respect from their connection with the new, effective drugs coming on the market …. their new reputation came at the cost of being considered over-educated for a diminished professional function" Higby (1996, p. 39). Higby (1996, p. 40) furthermore noted the irony that "pharmacy students of the 1950s and 1960s spent longer and longer hours learning the scientific basis of the techniques industry used to eliminate compounding, a large part of the traditional *raison d'être* of "pharmacy practice". This therefore suggests that whilst changes in pharmacy education at this time may have "solidified the place of pharmacy within academia" they did little to raise the professional status of pharmacy within the healthcare system, or society at large (Higby, 1996, p. 40).

In the US, whilst the debate about the balance between scientific and business aspects of the curricula continued during the period between 1955 and 1975, most pharmacy schools "adopted relatively uniform curricula based on requisite accreditation standards which laid out guidelines in required disciplines and mandatory experiential education" and "basic science continued to evolve into discrete disciplines and most colleges were organised around these individual disciplines (departments) for both undergraduate and graduate education" (Cohen, 2008, p. 105).

It should be noted that during this same period (1955 – 1975), in both the UK and South Africa a "two-tier" system of pharmacy education existed. In the UK pharmacists could either qualify for registration with a Pharmaceutical Society accredited diploma or a university granted bachelor's degree in pharmacy (BPharm). Both streams required three years of fulltime academic study followed by one year of practical training under a pharmacist, a shortened version of the old apprenticeship, before becoming registered. The non-degree course although covering the same subjects over an identical period of time was considered to be less intense and more practical. This two-level system existed until, in preference for the degree programme, the diploma was phased out in 1967 (Sonnedecker, 1963). Similarly, in South Africa, with the introduction of degree programmes in 1956, a two-tier system of a

Pharmacy Board examined and accredited diploma and a university degree also existed. Although both required three years of academic study (becoming four years in the 1970's) and a practical year of "apprenticeship", the diploma course, was also considered to be less concentrated and more practical in nature, and was phased out in 1985.

Citing several authors, Williams (2005, p. 149) argues that pharmacy's struggle for "professional identity and legitimisation has inevitably influenced, and been influenced by, pharmacy education's location within the university, a situation common to professions as knowledge occupations". He argues that from 1940 to 1970, with the shift of focus to the pharmaceutical sciences, during what Hepler (1987, p. 370) describes as "the science era", pharmacy education found itself "conscripted in the battle for professional identity". During this era, Hepler (1987, p. 370) contends that in the struggle to gain academic status and scientific credibility "descriptive empirical teaching disciplines" were organised into "scientific paradigms" and that support in the curriculum for pharmacy practice and its concern for patient-centred care were essentially ignored to the point of almost completely disappearing. As Hepler (1987, p. 370) argued pharmaceutical education became one sided and appeared to lose focus, consequently losing professional status within society: "Faculty may have imagined that the methods that were legitimising pharmacy faculties in the university were somehow to legitimise practitioners in the drugstore. Unfortunately, society did not seem to need a scientist on every streetcorner".

2.4.4 Clinical pharmacy education

It was from amidst this generation of overeducated "streetcorner scientists" that the era of clinical pharmacy emerged (Section 2.3.3). Recognising their unique knowledge of drugs within the context of clinical practice, institutional pharmacists started to assert themselves as "drug information experts" who participated in medication related therapy decisions and advised doctors and other healthcare professionals about medicines (Higby, 1996, p. 41). Although the emphasis on the sciences had prepared these pharmacists with the capability of innovating and performing these expanded functions, the initiative to do so, came from within the practicing profession and not from pharmacy education (Higby, 1996). Initially in response, a few "progressive schools of pharmacy" in the US added modules in clinical therapeutics to their curricula; however the true transition toward clinical pharmacy education only started to happen in the late 1970s and into the 1980s. As Higby (1996, p. 42) maintains: "… pharmacy educators, who initially lagged behind practitioners as advocates of clinical practice, saw the prospects for the future". He further suggested that clinical pharmacy brought renewed meaning to teaching and "Rather than just supporting their own

scientific disciplines, professors turned their teaching toward contemporary practice issues and the challenges of the future" (p. 42).

Within pharmacy education in the US, the years succeeding the emergence of clinical pharmacy saw continuous, but "inconsistent, progress towards this 'clinical pharmacy' paradigm" (Cohen, 2008, p. 106). The curricula of many colleges were adjusted and greater focus was given to experiential education in the form of "clerkships" in institutional pharmacy environments. Most also employed clinical pharmacists to teach on clinical programmes, and to provide "practice role models" for students (Cohen, 2008, p. 106). Development and implementation of the long debated PharmD programme was also an apparent response to the clinical movement, with ten full PharmD and 22 post-graduate PharmD programmes offered by 1989. However although the trend obviously was toward a "clinical paradigm" and there had been substantial progress made toward the PharmD programme, there were still many unresolved contentious issues between pharmacy educators and other pharmacy organisations. In particular these included the relevance of a clinical practice model in community pharmacy and the concerns that the move to clinical pharmacy required a shift of the curriculum and resources away from the basic sciences. According to Cohen (2008, p. 108) many leaders within the profession "grew frustrated with the slow pace of change among the educators". This frustration gave rise to the APhA initiating and implementing the Task Force of Pharmacy Education in 1981. It was the work of this Task Force and the Commission to Implement Change in Pharmaceutical Education, appointed by the AACP that resulted in the ACPE finally adopting the PharmD programme as the entry level degree in 1992. By 2000 all colleges of pharmacy in the US offered the PharmD as an entry level programme.

In a similar manner to what happened in the US, clinical pharmacy during the 1960s and 1970s also developed in the UK, with brave pharmacists pioneering new and extended functions in hospital practice environments, such as reviewing the ward medication orders to ensure safe prescribing, formulary development and participation in the prescribing process. Education of pharmacists for clinical practice started at a postgraduate level with one of the first programmes in clinical pharmacy being offered at Manchester University in 1978. With clinical pharmacy being a new discipline, university pharmacy departments worked in close collaboration with medical colleagues to train clinical pharmacists. (Calvert, 1999)

In 1997 the length of the undergraduate pharmacy degree in the UK was increased from three years to four years when the programme was changed from bachelor's level to master's level, as part of European Union harmonisation. This also provided opportunity for

restructuring of curricula and the inclusion of more clinical pharmacy elements into the programmes at most schools of pharmacy. (Calvert, 1999)

In South Africa, the movement toward clinical pharmacy was slower and the thrust came mostly from within pharmacy education. Notwithstanding the thinking of leading South African pharmacy academics, Dowse and Kanfer (1987, p. 183), who suggested in 1987, that "the scope and depth of knowledge in the domain of clinical pharmacy is of such magnitude that many years of intensive learning are required to master the field", a number of postgraduate clinical pharmacy programmes were developed, including a postgraduate PharmD programme at Rhodes University (Gray, 2010). Undergraduate degree programmes were also restructured in order to include more clinical elements (Academy of Pharmaceutical Sciences, 2008; Summers *et al.*, 1987).

During the early 1990s consensus around pharmaceutical care - "a modified paradigm for clinical pharmacy" was starting to take place. Emerging at first from within the clinical pharmacy movement, the concept was grasped and a practice model was developed from within academic pharmacy by Charles Hepler and Linda Strand at the College of Pharmacy, University of Florida. The Hepler and Strand practice model is centred on the pharmacist taking direct responsibility for ensuring optimal use of medicines by patients – stated simply "extending clinical pharmacy directly to patient care" (Cohen, 2008, p. 106). Pharmaceutical care places the responsibility for drug therapy outcomes in all practice settings, on the pharmacist. It therefore clearly describes the direct patient care role of the pharmacist (Cohen, 2008, p. 106).

2.4.5 Pharmaceutical care education

The profession has sought unity under the ideology of pharmaceutical care which pharmaceutical professional organisations, both nationally and internationally, contend should be the defining philosophy of pharmacy practice (Williams, 2005). According to Cohen (2008, p. 107) all pharmacy programs in the US, "embraced the pharmaceutical care model and defined professional outcomes around competencies needed to deliver this type of care, ACPE also reinforced this paradigm with the revised PharmD Standards that went into effect in 2000." Subsequently, for the past 15 years pharmaceutical care has been the focus of pharmaceutical education both in the US and worldwide, and much has been discussed, researched and written about the purpose or necessity of teaching it (why it is taught); the curriculum for promoting it (what should be taught), and; the strategies or methods of instruction best employed in the process (how it should be taught).

Before giving consideration to each of these aspects of pharmaceutical education, in the context of preparing pharmacy students to become pharmaceutical care practitioners, it might be helpful to clarify what is meant by curriculum. Harden (2001, p. 125) describes a curriculum as "a sophisticated blend of educational strategies, course content, learning outcomes, educational experiences, assessment, the educational environment and the individual students' learning style, personal timetable and the program of work". There are three levels of curriculum, which may be described as: 1. the declared, intended or planned curriculum; 2. the delivered or taught curriculum, and 3. the experienced, received or learned curriculum (Harden, 2001; Prideaux, 2003). Embodied in these three levels are both the explicit or formal curriculum and the tacit, informal or "hidden" curriculum.

The formal curriculum refers to the explicit or stated aspects of the curriculum, that which can be "written on paper", whilst the "hidden" curriculum refers to the "cultural mores that are transmitted, but not openly acknowledged, through formal and informal educational endeavours" (Hafler, Ownby, Thompson *et al.*, 2011, p. 440). There is often a distinct difference between what students are taught and what they learn (Hafferty, 1998). What is taught often happens at the level of the formal curriculum, however what is learnt also includes learning through the "hidden" curriculum at the level of interpersonal relationships (Hafferty, 1998). Hafferty and Hafler (2011) argue that the balance between the formal and informal aspects of an educational programme has serious implications for the type of professional that is produced. The closer the hidden and informal curriculum is to the formal curriculum, the greater the "internalisation of a consistent professional identity" (Hafferty & Hafler, 2011, p. 22).

Although attention will be given to aspects of the formal curriculum in consideration of the purpose (why), topics (what) and the methods (how) used to teach in preparing pharmacists capable of delivering pharmaceutical care, the hidden curriculum will not be overlooked and aspects of it will be considered when attention is given to issues of professional socialisation and "who it is that teaches", that is pharmacy educators.

2.4.5.1 Purpose of pharmaceutical care education

The responsibility lies with pharmacy educators to prepare graduates who have the knowledge and education relevant to the time and place and in addition, have the competence to practice proficiently within evolving practice environments and future professional roles. In response to a severe shortage of appropriately trained pharmacists and pharmaceutical support staff, the International Pharmaceutical Federation (FIP), the World

Health Organisation (WHO) and United Nations Educational, Scientific and Cultural Organisation (UNESCO), formed the Pharmacy Education Taskforce which advocates a needs based approach to pharmaceutical education (Anderson, Bates, Futter *et al.*, 2010). Needs based education is a strategy which is based on assessing the needs of the community and then developing or adjusting the education system accordingly. As Anderson and colleagues (2010, pp. 6-7) on the Taskforce state: " … needs-based education asks the question: What does the community need pharmacists to do, and what do pharmacists need to learn to deliver those services to the community?" This would therefore suggest that pharmacy education needs to be focused on meeting the current pharmaceutical needs of the local population and society which it serves.

In the context of a society that has experienced a significant increase in mortality and morbidity associated with increased medicine use and related adverse reactions, pharmacists have the knowledge and expertise to help optimise patient outcomes through the identification, resolution and prevention of medicine-related problems (Section 2.3.2). On the other hand, the knowledge explosion of our age and the advancements and developments in technology, biogenetics and molecular medicine that are taught to students today may well be obsolete within five to ten years. This would suggest that pharmacy educators have the responsibility of educating students with the competencies not only sufficient for pharmaceutical care practice upon graduation, but for a career that might span 40 years (Hudgens & Chirico, 2010). Consequently it would require educators to make predictions regarding the nature of future practice and educate students accordingly. Although in this manner educators could arguably transform future practice, this would be what Hudgens and Chirico (2010, p. 1) aptly term "a daunting task". Furthermore Maddux and colleagues (2000, p. 14) contend that, "Academia can help to innovate, but any sustainable change in pharmacy practice ultimately must be driven and maintained by the practice community. Indeed, past efforts to educate and prepare graduates better for new professional activities have, ironically, distanced academia from the profession it serves". They caution that when new graduates are prepared for innovative practice roles, "in the absence of an empowering practice environment they become disenchanted by the mismatch between what they are 'taught' and what they actually 'do'; and more mature members of the profession grow increasingly convinced that the academy has lost touch with the real world" (Maddux *et al.*, 2000, p. 14).

Since the concept of pharmaceutical care and its underlying philosophy of patient-centred care has been widely acknowledged and extensively accepted within the profession worldwide, including South Africa (Section 2.3.4), it would seem, therefore, that the focus of

pharmaceutical education needs to be pharmaceutical care. Within the context of pharmaceutical care, an important outcome for pharmacy education is the development of professionally mature pharmacy practitioners with the knowledge, skills and attitudes necessary to deliver "medicine-centred, patient-focused" care (Kelley, DeBisschop, Donaldson *et al.*, 2009).

In a 2010 discussion paper prepared by the APhA and the American Society of Health-System Pharmacists attention is drawn to the fact that although pharmacy practice may be changing towards a more clinical and patient-centred approach, this would only be achieved over a number of years. During the process of transformation pharmacy graduates will need to be able to perform the traditional functions of the profession, in addition to clinical and direct patient-care activities. This will require of them a mind-set that will enable them to perform and not neglect traditional distributive and technical functions. As the paper suggests: "Pharmacy education must prepare graduates who are equipped intellectually, emotionally, and professionally to contribute to the transformation of practice and to cope with the transition process" (p.4). Such graduates should be able to cope with a changing practice environment throughout a potential 40 year career. (American Pharmacists Association and American Society of Health-System Pharmacists, 2010, p. 4)

I would argue that in terms of education, perhaps the patient-centred focus of pharmaceutical care needs to be extended to be relationship-centred. This would imply care in which the relationship between pharmacist and patient remains central, however, the relationship of pharmacists with themselves (their personhood), with each other, and with the broader community, are also recognised and emphasised (Section 2.3.7). At the heart of relationship-centred care is also practitioner self-awareness and mindfulness, attributes essential for the emotional and intellectual development of pharmacists capable of rendering professional pharmaceutical services, within the context of changing practice environments.

As Zlatic (2000, p. 365) proposed:

> Pharmaceutical care as the mission of pharmacy practice requires a new approach to education if pharmacy schools are to produce practitioners who are not only critical thinkers, problem solvers, communicators, and ethical decision makers but also caring providers who establish fiduciary relationships with the people they serve.

Consequently as educators have grappled to develop this new approach much attention has been given to what is taught. In the next section a summary of some of the topics that have been discussed and/or included in pharmacy curricula with a pharmaceutical care approach is provided.

2.4.5.2 Curriculum topics

A sound knowledge base is important for pharmacists to be able to make informed, quality medicine related decisions and choices which are in the best interests of the patient. Therefore, as many have suggested, foundational to all pharmaceutical curricula are basic and applied sciences, including administrative, biological, biomedical, clinical, pharmaceutical, physical and social sciences that are the basis for pharmaceutical care and underlying research (Brazeau, Meyer, Belsey *et al.*, 2009; Commission to Implement Change in Pharmaceutical Education, 1989; Figg & Cox, 2003).

Some authors do however caution that we must not lose sight of the fact that in order to prepare students for a pharmaceutical career and patient care in an environment that will include bio-scientific advances such as pharmacogenomics and personalised medicine, they must be taught the basic science on which these concepts are based (Brazeau *et al.*, 2009; Commission to Implement Change in Pharmaceutical Education, 1989; Figg & Cox, 2003). As Figg and Cox (2003, p. 1384) advise it is necessary to prepare future practitioners with "a broad but deep understanding and appreciation of contemporary clinical science. Science should be the foundation of our profession, and thus, we must devote more time to ensuring that our new graduates will receive the type of education that will cement this foundation". However as Hughes (2011) in trying to answer the question "How do we balance science and practice in the curriculum?" noted, it is neither possible or feasible to teach everything that graduates might require. He concluded by advising that pharmacy educators must recognise that pharmacy is a discipline in itself and they should be "integrating" the sciences for pharmacy, "moving away from "science silos" and "deliver the best for the pharmacy profession, as part of a life-long process" (Hughes, 2011). Although this does not answer the question of what the balance between science and clinical application should be – it raises two other important issues, namely: teaching an integrated programme and preparing students for life-long learning.

In a comparison of the typical baccalaureate curriculum predominant in the US in 1995 with the PharmD curriculum of 2011, Altiere (2011) demonstrated a decrease in the basic sciences component of the curriculum, from 48% to 22%, and an increase in the clinical

component, from 42% to 65%. In the PharmD programmes there are also fewer discipline specific courses and greater emphasis on integration, including: increased integration of coursework; integration of sciences within science courses; sciences with pharmacotherapeutics, as well as integration of skills within experiential components. It is the opinion of Altiere (2011) that a reciprocal relationship needs to exist between the sciences and clinical components in the curriculum, “Science should be taught within the context of human health and disease and for us within the context of pharmacy practice” and “clinical sciences and therapeutics should to be taught in the context of the scientific basis for understanding the disease state and its treatment”.

According to Jungnickel and colleagues (2009, p. 3) the skills necessary for “a lifetime of self-directed learning” need to be addressed in pharmacy education through a learner-centred curriculum. Students should, therefore, be taught reflection, including the use of portfolios and reflective journals (Jungnickel *et al.*, 2009). Allied to the notion of reflection, is what Williams (2005) described as reflexivity (Section 2.3.6), which he argued should be developed in students through an experiential approach to learning.

A variety of skills, and their underpinning knowledge base, important for the effective provision of pharmaceutical care have also been identified, and attempts to include them in the curriculum have been described by various authors. Some of these include:

1. Clinical skills necessary to provide the services and perform the tasks needed to support pharmaceutical care provision, including:
    a. Physical assessment – the investigation of the body of a patient for signs and symptoms of disease (Spray & Parnapy, 2007)
    b. Diagnosis – the identification of the nature and cause of illness (Draugalis, Beck, Raehl *et al.*, 2010; Seybert, Laughlin, Benedict, Barton, & Rea, 2006)
    c. Triage - the process of determining the priority of patients' treatments based on the severity of their condition (Draugalis *et al.*, 2010)
    d. Screening and monitoring – conducting of physiological tests to determine the health status of a person, in order to identify early signs of disease or monitor the progression of a disease or the response to treatment (Chase, 2006; Guirguis, Chewning, Kieser, & Kanous, 2006)
2. Skills directly related to the pharmaceutical care process, which include the clinical skills listed above, but in addition include:
    a. Patient history taking skills – the ability to elicit the appropriate information from a patient in order to make informed therapeutic decisions, interpret data and identify patient medication-related problems (Agness, Huynh, & Brandt,

2011; Dugan, 2006; Fjortoft & Zgarrick, 2001; Gallimore, Thorpe, & Trapskin, 2011; Perrier, Winslade, Pugsley, & Lavack, 1995; Seybert *et al.*, 2006)

b. Prioritise problems and determine desired clinical and pharmacotherapeutic outcomes (Agness *et al.*, 2011; Dugan, 2006; Fjortoft & Zgarrick, 2001; Gallimore *et al.*, 2011; Perrier *et al.*, 1995; Seybert *et al.*, 2006)
c. Develop a pharmacotherapeutic plan (Dugan, 2006; Perrier *et al.*, 1995)
d. Implement the plan and monitor and document outcomes (Dugan, 2006; Gallimore *et al.*, 2011; Perrier *et al.*, 1995)
e. Patient behaviour modification – assisting patients to be able to make the changes necessary to improve their health, for example improving adherence to medication regimens (Chase, 2006; Draugalis *et al.*, 2010; Maffeo, Chase, Brown, Tuohy, & Kalsekar, 2009)

3. Management skills and knowledge necessary for developing practices and providing pharmaceutical care services, including:
    a. Models of practice, such as Medication Therapy Management Service (Agness *et al.*, 2011; Maddux *et al.*, 2000)
    b. Population based management and care – the ability to assess the pharmaceutical care needs at a societal level and to develop and implement appropriate interventions that will address these (Jungnickel *et al.*, 2009; Maddux *et al.*, 2000)
    c. Disease state management – disease-specific care of patients with chronic illness, aimed at improving overall quality of life (Skledar, McKaveney, Ward *et al.*, 2006)
    d. Management and care of special patient groups – various groups of patients have unique and special care needs, these include gender related issues, terminally-ill patients, geriatrics and paediatrics (Woelfel, Boyce, & Patel, 2011; Yuksel, 2011)
    e. Systems management at an institutional or enterprise level, designed to support the effect provision of pharmaceutical services (Calomo, 2006; Jungnickel *et al.*, 2009)
    f. Information technology – for improved communications and for and health and pharmacy informatics – the use of technology in order to optimise the acquisition, storage and retrieval of health information (Brazeau *et al.*, 2009; Fox, 2011; Maddux *et al.*, 2000)
    g. Medicines information and literature evaluation – in an era of evidence based practice the ability to evaluate and use literature effectively to inform practice (Maddux *et al.*, 2000)

Many of these skills are dependent on a range of personal competencies within the affective domain which have been identified and many educators have attempted to include and address in both formal and hidden curricula. Amongst these are:

1. Communication skills – central to establishing and maintaining the necessary relationships including counselling (Agness *et al.*, 2011; Chisholm & Martin, 1997; Langley & Aheer, 2010; Maddux *et al.*, 2000; McDonough & Bennett, 2006; Mesquita, Lyra Jr, Brito *et al.*, 2010; Rao, 2011; Sánchez, 2011)
2. Critical thinking, decision making and problem solving (Brazeau *et al.*, 2009; Cisneros, 2009; Jungnickel *et al.*, 2009; Maddux *et al.*, 2000; Oderda, Zavod, Carter *et al.*, 2010)
3. Cultural and contextual competence – behaviour, attitudes and competencies that enable effective practice in cross-cultural contexts (Chen, LaLopa, & Dang, 2008; Futter, 2007; Haack, 2008; Jungnickel *et al.*, 2009; O'Connell, Korner, Rickles, & Sias, 2007)
4. Social interaction and citizenship – this involves social and contextual awareness and a sense of social interaction, which empowers socially responsible action (Drab, Lamsam, Connor *et al.*, 2004; Maddux *et al.*, 2000)
5. Advocacy – the process of influencing policy and resource allocation, and a pharmaceutical care approach on a societal level often calls for health advocacy (Beardsley, 2004; Boyle, Beardsley, & Hayes, 2004; Jungnickel *et al.*, 2009)
6. Inter-professional collaboration – the ability to work together with other healthcare practitioners is central to providing quality services and care to patients and to society at large (Brazeau *et al.*, 2009; Draugalis *et al.*, 2010; Dumez, 2011; Jungnickel *et al.*, 2009)
7. Self-directed or lifelong learning skills – the ability to maintain and develop professional competence in response to emerging professional issues and knowledge (Allison, 2006; Huynh, Haines, Plaza *et al.*, 2009; Jungnickel *et al.*, 2009; Maddux *et al.*, 2000)
8. Leadership, values and ethics – pharmacy is increasingly a values-based profession and "value judgments are inherent in every facet of pharmacy" (Deans, 2010, p. 9), (Berger, Butler, Duncan-Hewitt *et al.*, 2004; Deans, 2010; Maddux *et al.*, 2000; Sánchez, 2011)
9. Change advocacy and management - the success of new graduates will depend on their ability to influence change, thus students need to be taught how to initiate and implement change (Berg, 2007; Janke, Sorensen, & Traynor, 2009)

10. Professionalism and professional responsibility: as a consequence of the issues concerning the professional status of pharmacy and the efforts, through pharmaceutical care, to re-professionalise; there has been much focus on professionalism within the curriculum and the professional socialisation of students. This will therefore be discussed in greater detail in Section 2.4.6. (APhA-ASP/AACP-COD Task Force on Professionalism, 2000; Boyle, Beardsley, Morgan, & Rodriguez de Bittner, 2007; Brown *et al.*, 2001; Brown & Ferrill, 2009; Chase, 2006; Draugalis *et al.*, 2010; Hammer, 2006; Hammer, Berger, Beardsley, & Easton, 2003; Jungnickel *et al.*, 2009; Langley & Aheer, 2010; Sylvia, 2004)
11. Identity formation and professional identity – the development of self-understanding and a strong sense of who one is as a pharmacist are important components of pharmaceutical education and integral to the professional socialisation process (Commission to Implement Change in Pharmaceutical Education, 1993; Duncan-Hewitt & Austin, 2005; Noble, O'Brien, Coombes, Shaw, & Nissen, 2011)
12. Care and empathy – In the context of the significance of the concepts of caring and empathy as elements of pharmaceutical care (Section 2.3.7), educating students to be caring, empathetic pharmacists is important (Chen *et al.*, 2008; Fjortoft *et al.*, 2011; Galt, 2000). Galt (2000) cautions that although the teaching of caring behaviours relies heavily on the affective domain, and often on the hidden curriculum, all three learning domains: affective, cognitive and psychomotor, need to be fully integrated in order to incorporate caring values and actions into the teaching and consequent performance skills of pharmacy students.

The topics taught or addressed within the curriculum, although important are only one aspect of education. A consideration of the efforts made to revise and restructure the curriculum within the context of pharmaceutical care would not be complete without giving some attention to the educational strategies and methodologies that have been employed to provide for programmes, experiences and environments conducive to the preparation of capable and competent pharmacists.

2.4.5.3 Curriculum methods and strategies employed

In recognition of all the topics and issues, including cognitive and psychomotor, which need to be addressed by the curriculum within the context of pharmaceutical care, educators and educational institutions have adopted a variety of approaches and strategies in the delivery of programmes. Some institutions have sought to restructure their entire curriculum using a new approach whilst others have restructured existing modules and courses or introduced

new ones. A brief summary of some of the methods and approaches that have been employed is provided. It needs to be noted however, that again, this is neither a comprehensive nor a detailed account but rather an attempt to demonstrate the vast array of efforts which have been made to refocus the curriculum.

Many have argued that a curriculum grounded in a pharmaceutical care philosophy requires a student-centred approach to learning (Blouin, Joyner, & Pollack, 2008; Jungnickel *et al.*, 2009; Katajavuori, Hakkarainen, Kuosa *et al.*, 2009; Zlatic, 2000). A student-centred approach is one which emphasises learner activity, rather than passivity and requires that students are active, responsible participants in their own learning (Gibbs, 1995). In an effort to adopt a more student-centred approach many have introduced or restructured around constructivist inquiry-based or problem-based approaches (Novak, Shah, Wilson, Lawson, & Salzman, 2006; Oderda *et al.*, 2010; Romero, Eriksen, & Haworth, 2010; Ross, Crabtree, Theilman *et al.*, 2007; Summers, Haavik, Summers *et al.*, 2001).

In an attempt to develop the skills necessary for life-long learning some educators have adopted self-directed learning approaches (Brown *et al.*, 2001; Sauer, 2006; Toumas, Basheti, & Bosnic-Anticevich, 2009). Many curricula have also been restructured to include large experiential learning components. According to Stevenson and colleagues (2011, p. 116) experiential learning components account for approximately 30% of professional degree programmes in the US. These include both introductory and advanced pharmacy practice experiences (Accreditation Council for Pharmacy Education, 2006b). Service-learning – a form of experiential education in which students are engaged in activities that address either human or community needs coupled with structured opportunities that promote student learning and development has also been included in curricula (Allan, 2006; Drab *et al.*, 2004; Nemire, Margulis, & Frenzel-Shepherd, 2004; Sauer, 2006). By nature, service learning courses also include elements of community engagement (Brown, Heaton, & Wall, 2007).
There has also been a trend toward increased integration within the curriculum (Altiere, 2011), including the integration of: basic science and clinical courses (Marshall & Nykamp, 2010), didactic and experiential components (Karimi, Arendt, Cawley *et al.*, 2010), integration of skills within experiential components (Hastings, Flowers, & Spadaro, 2006; Mobley Smith, Koronkowski, & Petersen, 2004); integration of subject disciplines (Stewart, Buckner, & Wildfong, 2011), and; the integration of complementary and alternative medication approaches with conventional approaches (Tiralongo & Wallis, 2008). Allied to integrative approaches is also an increase in interdisciplinary courses where pharmacy students are integrated with other healthcare students, in order to encourage an increased team approach

to healthcare (Buring, Bhushan, Broeseker *et al.*, 2009; Odegard, Robins, Murphy *et al.*, 2009).

Other strategies have also included the use of: laboratory-based simulations (Darbishire, Plake, Nash, & Shepler, 2009; Gallimore *et al.*, 2011; Kiersma, Darbishire, Plake, Oswald, & Walters, 2009); role-play (Rao, 2011); computer-assisted and technology based learning (Blouin *et al.*, 2008; Fox, 2011; Fox & Varadarajan, 2011; Monaghan, Cain, Malone *et al.*, 2011), and mentoring (Haines, 2003; Oltmann, 2009).

Through all the curricula strategies and approaches there appears to be a common theme: finding the optimal balance between the cognitive and affective domains, within the formal and the hidden curricula that will produce knowledgeable, competent professionals capable of providing pharmaceutical care. There is also a constant struggle to find an effective equilibrium between "what" is taught and "how" it is taught. The essence of this academic dilemma is well described by Brown and co-authors (2001, p. 245) who suggest that: "… metaphorically in the words of William Butler Yeats, 'Education is not the filling of a pail, but the lighting of a fire'." They go on to argue that pharmacy educators have perhaps "devoted too much effort to filling the pail and not enough to lighting the fire", suggesting that professionalism is not something that can be taught; it is something that has to be "carefully nurtured." Furthermore, within the "framework of traditional methods of instruction" such nurturing is difficult to achieve and "the great challenge now facing the pharmacy academic community is to ignite the affective fires of professionalism in every student". (Brown *et al.*, 2001, p. 245)

2.4.5.4 Impact of curricula changes

According to Blouin and colleagues (2009, p. 1) "the *raison d'eˆtre* for higher education is simple and straightforward: to prepare students, predominantly young adults, for future success". Although they maintain that success can be defined in numerous ways, they suggest these include the capacity to follow and move forward in one's chosen career and the ability to make a meaningful contribution to one's community. Thus in order to determine the impact of and success of changes which have been made to the curriculum directed toward preparing pharmacy students for pharmaceutical care, one would need to consider the extent to which new graduates are moving forward in their careers and making a significant contribution to the communities which they serve.

In response to this, it would be pertinent to provide a reminder of the conclusions reached in Section 2.3.4, that despite proven evidence that pharmaceutical care services are of benefit to the community, and notwithstanding the fact that some pharmacists worldwide have embraced the concept of pharmaceutical care and incorporated aspects of it into their practice, comparatively few have restructured or developed their entire practice around a pharmaceutical care model or process. This would suggest therefore that revising the purpose, curriculum and methods of pharmacy education has not in itself sufficiently transformed practice. Austin and Duncan-Hewitt (2005, p. 381) argue that, "pharmacy education's tactical tinkering on the edges of the curriculum, while maintaining the same fundamental structure, may have resulted in some educational practices that do not fully meet the needs of students, practitioners, researchers, or (most importantly) the society they all must serve". In addition they propose that a "more strategic approach to organisational development is required if we are to create a culture within which pharmaceutical care practitioners may be educated and nurtured" (Austin & Duncan-Hewitt, 2005, p. 382).

Austin and colleagues (2006, p. 536), go so far as to suggest that

> … although professional and corporate mission statements, academic standards, and regulatory requirements have all rapidly changed to embrace 'the patient-centred model' of practice, the real-world experiences of pharmacists and of those who are served may be quite different and furthermore that this basic difference can give rise to 'misalignment of expectations, attitudes, and behaviours'.

This has implications for the socialisation of students into the profession.

2.4.6 Professional socialisation

Professional socialisation is a social learning process that encompasses the attainment of explicit knowledge and skills necessary for a professional role, together with the development of related values, attitudes and concept of self. Hammer and co-authors (2003, p. 9) suggest that it involves transformation ". . . the transformation of individuals from students to professionals who understand the values, attitudes, and behaviours of the profession deep in their soul". Brott and Kajs (2001) further propose that this happens on two levels: a structural or external level, involving formal education and on an attitudinal or internal level which involves the development of a "sense of calling" and "self-conceptualisation" associated with the profession.

It is an active process that needs to be nurtured throughout the student's development. According to Hammer and co-authors (2003, p. 9), the process of professional socialisation "… begins the moment a student interacts with pharmacists, evaluates what they do, or actively seeks information about the profession. Beliefs, attitudes and behaviours begin to develop with regard to pharmacists' roles". Keshishian (2010, p. 1) describes this early development of the understanding of the pharmacist's role and associated traits as "anticipatory socialisation", and suggests that it incorporates "the entire learning and knowledge intake that prepares the individual for becoming a professional". She describes two important facets in determining the outcome of "anticipatory socialisation", namely: ''realism", which is the extent to which a student has a complete and accurate concept of how life in the profession truly is and is an indication of how successfully the student has "completed the information shaping and information evaluation part of his recruitment'', and; ''congruence" - the extent to which the student feels a personal alignment with the beliefs, behaviours and attitudes that they see manifest by the profession - an indication of satisfaction with career choice (Keshishian, 2010, p. 1).

Based on personal experience, Hagemeier (2010) argues that the tendency is for pharmacy educators to prepare students with the basic skills necessary for ideal practice settings, and not prepare them for the real issues that they will confront in the practice environment, which will impact on their ability to provide patient care and ultimately on their job satisfaction and sense of fulfillment. He further advocates for "realism" - that the dissonance between what is taught at university and what is experienced in practice should be made apparent to students.

It is the socialisation process which promotes and fosters a distinct professional identity (Taylor & Harding, 2007). When a profession is however characterised by conflicting ideologies, or what Austin and colleagues (2006, p. 536) describe as "misaligned expectations", there is no solid base or uniform identity for consistent socialisation of students into the profession. As some authors have suggested, pharmacy students and new graduates often find themselves disenchanted and frustrated with pharmacy as a career and disappointed with their education (Berg, 2007; Brown *et al.*, 2001; Duncan-Hewitt & Austin, 2005). Although pharmacy students may have been taught the associated knowledge and required skills necessary for the delivery of pharmaceutical care, they are often not adequately prepared to initiate and implement the process or provide the direct patient care dimension (Fjortoft & Zgarrick, 2001). The pharmaceutical care model of practice and its patient-centred philosophy is often in severe contrast to the "technical, product-oriented, distributive practices" they encounter in practice (Brown *et al.*, 2001, p. 241). This contrast

often leads to internal feelings of conflict and confusion about one's professional role and identity and an inability to be an agent of change, within the newly forming boundaries of integrity of one's professional identity.

In response to what appears to be a general unsuccessful attempt by pharmacy education to foster a practice transforming professionalism within it's graduates, Brown and Ferrill (2009) describe a new approach, based on Bloom's taxonomy of educational objectives, to defining professionalism according to a patient care advocacy paradigm. They suggest that a straightforward definition of professionalism, centred on the concept of "patient care advocacy" as model of practice, could assist students in internalising a more "altruistic" notion of pharmacy practice (Brown & Ferrill, 2009, p. 4). Their behavioural model describes a hierarchical relationship between three domains of professionalism: competence or professional expertise is the basic foundation upon which professionalism is built; connection or interpersonal capability forms the second layer and the ability to connect effectively with other people elevates one's professional capability to this level, and; the highest level of professionalism, "commensurate with strong fiduciary relationships, results from progressing to the character domain, which adds the dimensions of trust and morality" (Brown & Ferrill, 2009, p. 4). In addition they maintain that true patient advocates are proficient in all three domains, suggesting that "their capability, compatibility, and reliability synergise in the workplace to produce optimal patient outcomes, while inspiring others to do the same" (Brown & Ferrill, 2009, pp. 6-7).

Citing several authors, Hammer and colleagues (2003) identified the factors that influence and form students' attitudes and behaviours, these include: the inherent values and behaviours that students bring with them into professional programs; the role models in the professional and academic environments to which they are exposed, and: the educational and professional practice environments themselves. Based on the literature, they further suggest that "the most significant predictor of students' socialisation is students' role models – both positive and negative" (Hammer *et al.*, 2003, p. 1).

In a study by Fjortoft and Zgarrick (2001) which assessed the factors which can be used to predict pharmacy students' caring ability across three colleges of pharmacy in the US, morale within the colleges was shown to be a significant factor. The items used to measure morale focused predominantly on the behaviour of pharmacy educators and included aspects such as mutual respect of educators for each other, pride of educators in the school and its students, and pride in being teachers. The researchers concluded that "faculty's impact on students' level of caring ability may be beyond what we teach and how we teach,

but who we are as teachers" (Fjortoft & Zgarrick, 2001, p. 338), in other words, it is dependent upon the identity of pharmacy educators.

2.4.7 Pharmacy educators

Central to the success of pharmacy education is the availability of sufficient numbers of appropriate and well-qualified pharmacy educators (Fjortoft & Zgarrick, 2001). These educators are not only required to shape and facilitate the educational process and teach the cognitive, technical and affective competencies, necessary for pharmacy practice, but they also need to take a lead in the professional socialisation process, serving as role models to demonstrate the kinds of attitudes, values, and behaviours expected of students (Beardsley, Matzke, Rospond *et al.*, 2008). Pharmacy educators are in a "unique position of influence" and have numerous opportunities through their interaction with pharmacists and pharmacy leaders of the future, to positively impact on the profession (Hagemeier, 2010, p. 134).

When attitudes and behaviours are modelled to and experienced by students, it is conceivable that they are more likely to learn and manifest them. This idea is supported by Mercer and Reynolds (2002, p. S11) who maintain that work with medical students has demonstrated that when there is a focus on empathy and students experience it from their educators, their empathy skills are significantly increased.

Analogous to the concept of pharmaceutical care, Popovich (1991, p. 350) described the concept of "educational care" which he proposed "mandates establishment of a commitment between the faculty and the student and cooperation with the student and other faculty in designing, implementing, and monitoring an educational plan that will produce specific performance-based outcomes for the student". In addition he suggested that pharmacy educators have to change their approach to education in order to nurture and develop caring students empowered "to create the future of pharmacy" (1991, p. 350). The role of pharmacy educators in a paradigm of educational care has also been described as "teaching, advising, mentoring, and serving as role models for the purpose of achieving outcomes that improve students' abilities to think critically, solve problems, and make ethical decisions that will ultimately improve patient care" (Becker & Schafermeyer, 1993, p. 6).

Hagemeier (2010) posits that there are two central characteristics of pharmacy educators which are necessary to achieve these outcomes, namely: integrity and awareness. He defines integrity as firmly adhering to moral principles which keep patient care as the central focus. Furthermore, he argues that it is integrity which helps the profession to hold firm to its

central focus of patient care when external forces might cause it to deviate. Awareness Hagemeier describes as knowledge of the environment in which patient care happens, and enables educators to portray the profession and practice in an accurate manner. Although he suggests that practicing in a pharmacy is one option for developing awareness, he further suggests for those educators for whom this is not possible, developing and maintaining honest, open relationships with professionals who do practice is a possibility.

It may be pertinent at this point to revisit Dobie's (2007) argument; introduced in Section 2.3.6, that central to the provision of relationship-centred care is practitioner self-awareness and mindfulness. She suggested that the practitioner brings his or her own culture and beliefs, assumptions, needs, feelings, passions, expectations, and skills to each patient encounter and that the better practitioners know themselves, the more they are able to give themselves attentively to the patient and to providing care. I would suggest that the same may be true of educators, the better they know themselves, the more they may be able to practice educational care.

Recognising the importance of pharmacy educators in the educational process Smith (2000, p. 100) argued that pharmaceutical educational reforms which have "focused on the what, how and why questions" concerning the curriculum and not on the "who" question – "who is it that teaches?", have produced only "limited successful results" and not the outcomes that were hoped for. Citing educationalist and author, Parker Palmer, Smith (2000, p. 100) suggested that the "who" question relates to the "selfhood" – the identity and integrity of teachers, suggesting that this informs and impacts on the way teachers relate to students, their subject and their colleagues. Arguing for greater attention to be given to the "inner landscape" of teachers generally, Palmer (1998) suggests that teaching arises from one's inwardness, and that good teaching cannot be reduced to knowledge and technique; good teaching comes from the identity and integrity of the teacher. He furthermore proposed that good teaching is located in the ability of the teacher to create connections between student, subject and self, and for teachers to do this successfully, it is not sufficient for them to be the knowledge experts in their academic discipline or to employ new techniques to impart that knowledge to students. Good teaching requires and is dependent on self-knowledge, without which teachers cannot know their subjects or understand their students. Good teachers therefore have a strong sense of personal and professional identity and integrity that infuses their work (Palmer, 1998). However, after decades of unsettling change within the pharmacy profession and its educational institutions, many pharmacy educational institutions and educators are struggling with issues of identity and meaning (Duncan-Hewitt & Austin, 2005).

It follows therefore that if any real progress is going to be made in terms of moving the pharmacy profession toward a greater pharmaceutical care focus, serious attention needs to be given to the professional identity of pharmacy educators. As Smith (2000, p. 10) suggested, if pharmacy educators were able to do the "heavy mental work" of looking deeply at their inner selves and personally reflect on who they are as teachers, "it might strike at the root of our [sic] ineffectiveness and enable us to produce positive educational reform and improved teaching".

2.5 Conclusions

In this chapter the changing role of the pharmacy profession relative to its relationship with society was reviewed. In particular, the emergence of the notion of pharmaceutical care as a means of conceptualising and identifying the patient-care responsibilities of the pharmacy profession was discussed. It was noted, however, that despite the profession widely embracing the philosophy of pharmaceutical care and there being much published evidence to demonstrate the potential of pharmaceutical care services to enhance quality and contain healthcare costs, it has not significantly penetrated or transformed practice. Although many barriers to the provision of pharmaceutical care worldwide and in South Africa were identified these were categorised into three themes: system related barriers including issues such as resources, government interventions and healthcare structures; professional identity related barriers; and educational barriers. The professional identity issues, in particular, appear to prevent the pharmacy profession from understanding its commitment and responsibility in the context of patient centred care.

The development of pharmaceutical education relative to the changing role of the profession and particularly with regard to pharmaceutical care was also reviewed. However, it was noted that despite revisions to the curricula and methods of education toward a more care-centred approach, these have been insufficient to significantly transform practice. Recognising the central role that pharmacy educators play in the socialisation of students into the pharmacy profession, and in the development of students' professional identities and noting that good teachers have a strong sense of their personal and professional identity, this chapter concluded by suggesting that encouraging educators to reflect on their professional identities might be key to moving the pharmacy profession toward a greater focus on pharmaceutical care.

CHAPTER 3

INDIVIDUAL, PROFESSIONAL AND ACADEMIC IDENTITIES

3.1 Introduction to identity

In the previous chapter I concluded with the notion that teaching emanates from an individual's inner self, and that good teaching cannot be attributed to knowledge and technique only; good teaching arises from the identity and integrity of the teacher (Palmer, 1998). As Palmer (1998) advocates, good teachers have a strong sense of personal and professional identity and integrity that infuses their work. Palmer is not alone in this opinion: based on their narrative and life history research with teachers, Carter and Doyle (1996, p. 120) proposed that "the act of teaching and teachers' experiences and choices are deeply personal matters inexorably linked to their identity and life history". It is this self-same concept that has also given rise, in the past twenty years, to a significant body of research on teacher identity (see literature reviews by Andrzejewski, 2008; Beijaard, Meijer, & Verloop, 2004; Menter, 2010). Similarly, recognition of the impact of identity on practice (Wenger, 1998) has seen the emergence of a comparable body of literature around the concept of teacher, professional and academic identities in higher education (Archer, 2008; Clegg, 2008; Hockings *et al.*, 2009; James, 2005; Trede *et al.*, 2012).

Identity is "one of the most ubiquitous and extensively investigated concepts in social science research" (Kim, 2010, p. 53). It "guides life paths and decisions", is the source of the meaning found in a sense of belonging to a group, and is also at the basis of both constructive and destructive behaviour toward others (Vignoles, Schwartz, & Luyckx, 2011, p. 2). Henkel (2005) cites Taylor (1989, p.28) as suggesting that "to know who you are is to be oriented in moral space, a space in which questions arise about what is good and bad … and about what has meaning and importance for you". Furthermore, Henkel proposes that there are three dimensions to the moral framework which identity supports, specifically: an "obligation to others, fulfilment or meaningfulness and range of notions concerned with dignity, respect and self-esteem" (Henkel, 2005, p. 157)

Identity is very difficult to define and can be understood in a variety of ways, using different terms or metaphors to communicate its meaning (Billot, 2010; Canrinus, Helms-Lorenz, Beijaard, Buitink, & Hofman, 2011). Identity or a "sense of self" describes how people characterise themselves through their perception of self, their relationships with others, and within broader groups to which they belong. In essence, "identity" seeks to answer the question "who am I?", and is an on-going "process of development", embodying a continual "organised endeavour" to make sense of the question in the context of past, present and future lived experiences (Billot, 2010, p. 713). Identity can be broadly thought of as a "label attributed to the attempt to differentiate and integrate a sense of self along different social and personal dimensions" (Bamberg, 2011, p. 6). Vignoles *et al.* (2011) extend the concept further by suggesting that identity is not only about who you think you are, individually or collectively, but also about "who you act as being" (p. 2) in dealings with others and in groups, and the recognition you receive from them in the process. McFadden (2008, p. 1) proposes that identity has both an individual and social function, in that it can offer the individual a "sense of uniqueness by establishing a definition of who one is as an individual" whilst also being able to provide a "sense of connectedness and belonging to social groups".

In an attempt to define and classify identity and describe its formation and development, a vast body of research literature has accumulated over the last fifty years, both within and across various disciplines, including: psychology, sociology and anthropology (Vignoles *et al.*, 2011). Based on this extensive research and literature on identity, this chapter commences with a consideration of the classification of identity, and then explores certain theories of identity through a discussion of a number of the common themes underpinning them. The concepts of professional and academic identities are then discussed, and finally the literature pertaining to the identity of academics, teaching on professional or vocational programmes within higher education is reviewed.

3.1.1 Classification of identity

Building on the work of Triandis (1989), Jameson (2007) proposes a classification of individual identity (Figure 3.1). The classification suggests that at a general level identity can be described as either objective or subjective. Objective identity is identity in terms of official records, for example birth certificates, identity documents, passports, tax registration numbers and returns. On the other hand, subjective identity is a "person's sense of who he or she is as a human being", and encompasses both collective and personal identity (Jameson, 2007, p. 207).

Personal identity refers to the “unique elements that we associate with our individuated self” (Ting-Toomey, 2005, p. 212) and as Jameson (2007, p. 207) maintains, is a “sense of self derived from personality, character, spirit, and style”, that makes us who we are and creates a sense of uniqueness.

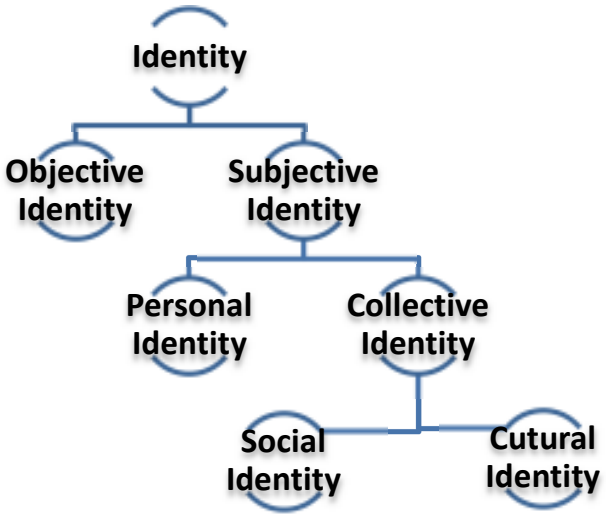

Figure 3.1: Classification of individual identity (adapted from Jameson, 2007, p. 208)

Based on self-categorisation theory, Onorato and Turner (2004) make a distinction between personal identity and social identity, or what Jameson (2007) would more broadly call collective identity. Personal identity (the personal self) “refers to ‘me’ versus ‘not me’ categorisations - all the attributes that come to the fore when the perceiver makes interpersonal comparisons with other in-group members” (Onorato & Turner, 2004, p. 259). Personal identity addresses questions of individuality, uniqueness, and distinctiveness, relative to other people. Conversely, social identity (the collective self), “refers to ‘us’ versus ‘them’ categorisations - all the attributes that come to the fore when the perceiver compares his or her group (as a collective) to a psychologically relevant out-group” (Onorato & Turner, 2004, p. 259). Social or collective identity can therefore be thought of as the individual’s self-concept consequential to their perceived membership of social groups. Simply stated, it is an individual-based perception of what defines the “us” associated with group membership and is distinguishable from the idea of personal identity which refers to self-knowledge originating from the individual’s unique attributes.

In contrast, collective identity (of individuals and not groups), describes the sense of self that arises from both formal and informal group membership and has both social and cultural aspects (Jameson, 2007). According to Jameson (2007, pp. 208-209), "social identity is often anchored in a particular moment in time", and refers to the "roles people play in the present". Whereas "cultural identity involves historical perspective, focusing on the transmission of knowledge and values between generations", and consequently includes "what people have learned in the past and how they plan to influence the future" (Jameson, 2007, p. 209).

Varner and Beamer (2005), cited by Jameson (2007) defined culture as "the coherent, learned, shared view of a group of people about life's concerns that ranks what is important, furnishes attitudes about what things are appropriate, and dictates behaviour". Based on their work Jameson (2007) identified six different categories of group commonalities that underpin cultural identity, namely: vocation, class, geography, philosophy, language, and biology (Figure 3.2).

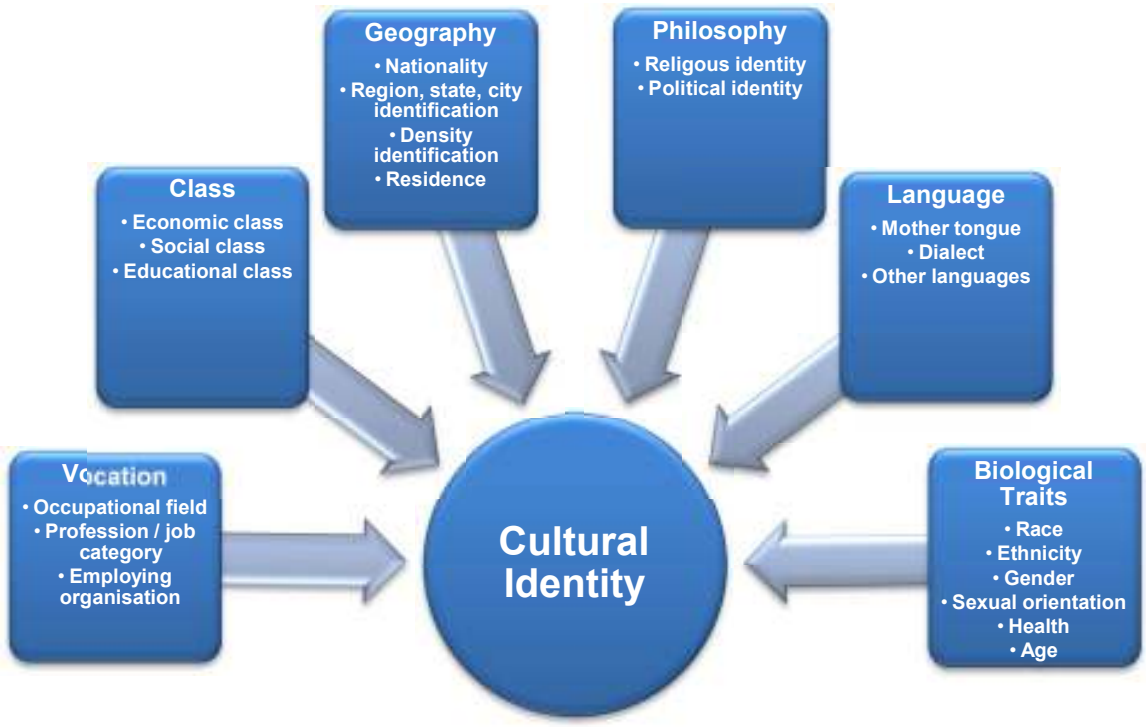

Figure 3.2: The components of cultural identity (adpated from Jameson, 2007)

Vignoles and co-authors (2011) identify a third level of identity, besides the personal and collective levels, which they describe as relational identity. Relational identity is comprised of

the roles one assumes and plays, relative to others - for example: parent, child, co-worker, manager, or client - and describes not only the roles but the understanding and values attributed to them, by the one who assumes them.

In categorising identity this way, it would appear that identity is disjointed, and that people could have multiple identities, depending on their context or situation. According to Jameson (2007, p. 211) many who have theorised about identity have suggested it is "fragmented" and comprised of "layers of separate identities, one of which rises to the top at any given time". As Gee (2000, p. 1) proposes "all people have multiple identities connected not to their 'internal states', but to their performances in society", and - "the 'kind of person' one is recognised as 'being', at a given time and place, can change from moment to moment in the interaction, can change from context to context, and, of course, can be ambiguous or unstable".

This layered approach to understanding identity has "a practical appeal for researchers" who can separate and study discrete layers or aspects of identity in isolation (Jameson, 2007, p. 209). However, as Jameson (2007, p. 211) argues, this approach does not take cognisance of the fact that people have a conception of themselves as "whole persons with integrated identities" and that a more "unified" or cohesive approach to understanding and describing identity may be "more appropriate". It is because of this sentiment expressed so well by Jameson that many theories attempting to describe a more cohesive understanding of identity have emerged from within the various social science disciplines. Rather than trying to understand identity by providing a comprehensive overview of these theories of identity and their implications, it may be pertinent at this point to consider some of the common themes underpinning them, particularly with regard to contemporary theories.

3.1.2 Common themes underpinning contemporary theories of identity

Rodgers and Scott (2008) identify four common themes that underpin contemporary conceptions of identity, namely: 1. identity as contextual and the formation thereof as dependent upon the prevailing social, political, cultural and historical elements comprising the multiple contexts within which individuals absorb themselves; 2. identity as relational - being formed through engagement with others and having an emotional element; 3. identity as dynamic – that is "shifting, unstable and multiple"; and 4. identity as understood and constructed through narration.

In developing an understanding of identity and more specifically professional identity as a basis for this study, each of these themes will be considered in greater detail. It needs to be noted however, that although many theories of identity encompass all four of these themes some may depend to a greater or lesser extent on one or other of these themes in its definition and description of identity (Rodgers & Scott, 2008).

3.1.2.1 Identity as contextual

Identity involves a personal understanding of "individuality" and is a social construct emerging from a "personal, ethnic and national context" (Billot, 2010, p. 711). The context in which one finds oneself, the expectations placed upon one by others, and the extent to which we allow others to influence us, all impact on identity (Reynolds, 1996). The extent of the contextual nature of identity is described by Palmer (1997) who defines identity as:

> … an evolving nexus where all the forces that constitute my life converge in the mystery of self: my genetic makeup, the nature of the man and woman that gave me life, the culture in which I was raised, people who have sustained me and people who have done me harm, the good and ill I have done to others, and to myself, the experience of love and suffering – and much, much more. In the midst of that complex field, identity is a moving intersection of the inner and outer forces that make me who I am, converging in the irreducible mystery of being human. (p. 18).

It is then no surprise when authors such as Beijaard and colleagues (2004, p. 115) suggest that the contextual influence on identity is often undervalued and identity formation is often a struggle because one has to "make sense of varying and sometimes competing perspectives, expectations and roles that [one has] to confront and adapt to".

The complexities of the cultural, social and political contextual dimensions of identity formation are well described by the five aspects of identity elucidated by Wenger (1998). These aspects characterise identity as negotiated experiences through which we come to know who we are, by the manner in which we experience ourselves, through participation in the many communities to which we belong, as well as the way we and others make sense of who we are, and include:

1. identity as membership of communities, where we define who we are by the "familiar" and the "unfamiliar";
2. identity as a journey of learning, where we define who we are by the path we have travelled and the paths we are still travelling;

3. identity as nexus of multi-membership, where we define ourselves by the manner in which we bring together our various forms of identity, and
4. identity as a relationship between the local and the global, where we define who we are by negotiating local ways of belonging in relation to wide-ranging contexts and broader approaches and discourses.

Buch (1999) observes that as our lives evolve, "new situations and contexts are interpreted, understood and subjectively incorporated as experiences. Eventually the production and transformation of identities can be seen as a result of this lived process" (cited in James, 2005, p. 7). By recognising four interdependent and interrelated perspectives to identity, Gee (2000) also describes a way in which the contextual nature of identity can be understood. These perspectives include:

1. The nature perspective or identity, which is a state of being that is developed from forces in nature. It includes those parts of who we are that are grounded in our nature rather than formed though participation in society - for example biologically or genetically determined aspects of ourselves, such as being a twin, or being tall. Gee (2000) describes the nature perspective as "being a state I am in" rather than "what I have done or accomplished". In addition he notes that "natural identities can only become identities because they are recognised, by myself or others, as meaningful in the sense that they constitute (at least, in part) the 'kind of person' I am" (Gee, 2000).
2. The institutional perspective or identity – a position that is endorsed by authorities within an institution. It is those parts of who we are that are located in an institutional authority. Gee (2000) argues that the degree to which an occupant of a position actively or passively accepts and fulfils the roles or duties of the position, determines the extent to which the position is either viewed as "a vocation or a calling" or as an "imposition".
3. The discourse perspective or identity comprises individual traits which are recognised in dialogue with others. These are the parts of ourselves which are attributed to us through interaction with others, and can be actively achieved or passively ascribed. For example, we can purposefully interact with others in a manner which actively achieves or facilitates being identified as "charismatic", or the trait "charismatic" can be ascribed to us by those we interact with as a passive consequence of our behaviour in the interaction.
4. The affinity perspective or identity is composed of experiences which are shared in the practices of affinity groups. It is those aspects of one's self which are located in

> distinctive practices within a group. Gee (2000) proposes that affinity identities "focus on distinctive social practices that create and sustain group affiliations".

Gee (2000) cautions that it:

> …is crucial to realise that these four perspectives are not separate from each other. Both in theory and practice they inter-relate in complex and important ways. Rather than discrete categories, they are ways to focus our attention on different aspects of how identities are formed and sustained.

He further argues that "they are four ways to formulate questions about how identity is functioning for a specific person … in a given context or across a set of different contexts".

The contextual nature of identity also underpins the concept of social identity. Social identity theory was first described by Henri Tajfel, and subsequently has been tested in frequent quantitative and qualitative studies in the field of social psychology (Holmes & Meyerhoff, 1999). Tajfel (1978, p. 44) proposed that an individual's social behaviour is a shared consequence of affiliation to a particular group identity that is dominant at the time, and their understanding of the relationship of what they consider to be their in-group to relevant out-groups. From a social identity theory perspective, identity is not something that belongs to the individual, as a set of stable or fixed traits or layers, but is something that surfaces out of the interaction between the person and their situation or their context. The interchange between a person's perception of his or her self and the situation, encompassing the social forces coming from other people and the groups that direct or motivate their thinking, feeling and behaving, is central to the process of identification (Liu & László, 2007).

Current thinking within the social identity framework views identity more as a "cumulative project, involving a relationship between individuals and the social structures in which they are located", rather than a set of "essential, given elements" (Whitchurch & Gordon, 2010, p. 129). Modern social identity theory therefore brings the relational aspect of identity to the fore at the macro systemic level.

3.1.2.2 Identity as relational and emotional

Central to Tajfel, Wenger and Gee's understandings, is the relational aspect of identity. Wenger (1998, p. 149) argues that, "we define who we are by the ways we experience ourselves through participation as well as by the ways we and others reify ourselves". In

other words, identity is not merely, or only, defined by the individual but also by the manner in which, and the extent to which, the individual is in relationship with others and is perceived as being a fully engaged member of a community. In this context, identity can then be considered to refer to "the perception of oneness with or belonging to a particular human group, such as a specific organisation or profession" (Stout, 2001).

Gee (2000) goes further, to suggest that relationship is central to identity, and underpins all four perspectives of identity (nature, discourse, institutional and affinity), because fundamental to one's identity is being recognised by others as a particular "kind of person". He argues that what then becomes the key issue in identity is "how and by whom a particular identity is to be recognised". Furthermore, "human beings must see each other in certain ways and not others if there are to be identities of any sort" (Gee, 2000, p. 109). Expanding on this relational nature of identity, Rodgers and Scott (2008, p. 735) note that within the varied contexts which people inhabit, they form numerous relationships which "brings forth multiple aspects of oneself". Thus when shaped by relationships, "identity necessarily becomes a multiple and shifting affair, in process and changeable" (Rodgers & Scott, 2008, p. 736).

The relational and emotional aspect of identity is central to Erikson's theory of psychosocial development. Erik Erikson, described as the architect of identity (Friedman, 2000), in his theory of psychosocial development, described the development of what he termed "ego identity", through eight stages of ego growth. Each stage is "marked by a chronological phase-specific psychosocial crisis" (Kroger & Marcia, 2011, p. 32) and ego identity can be described as the conscious sense of self that is formed and developed through the process of social interactions whilst negotiating one's way through the crises. Along with the development of a consciousness of self, Erikson proposed that a sense of competence develops, which serves as the motivation underlying behaviours and actions. The extent to which the competency develops at each stage determines the individual's perceived sense of mastery, sometimes referred to as ego strength or ego quality. Lack of mastery of any stage may result in the development of feelings of inadequacy. The eight stages can be summarised as follows (Erikson, 1950):

1. Stage 1: Trust vs mistrust – this stage occurs between birth and one year of age, at a stage in life when one is totally dependent upon one's caregivers. The successful development of trust in relationship to caregivers, results in feelings of security, whilst failure to develop trust, results in the perception that the world is unpredictable and unreliable.

2. Stage 2: Autonomy vs shame and doubt – occurs during early childhood. In this stage the extent to which a child develops a sense of control and independence from the caregivers, determines the degree to which the child emerges with a sense of confidence and adequacy or inadequacy and self-doubt.
3. Stage 3: Initiative vs guilt – this stage occurs during pre-school years when a child is learning to discover and proclaim their sense of power and control over the world, through learning to self-direct their play and their social interactions with others. If successfully negotiated, a sense of capability and ability to lead or direct the behaviour of others develops. Failure to develop this sense of initiative can leave the child with feelings of guilt and an inability to take initiative.
4. Stage 4: Industry vs inferiority – occurs between the ages of 5 to 11, and covers the early school years. Through affirming relationships during this stage, children develop a sense of pride in their achievements, a belief in their abilities and feelings of competence. A lack of affirming adult relationships, can leave the child doubting its abilities and competencies and with feelings of inferiority.
5. Stage 5: Identity vs confusion – this is the phase of adolescence during which children develop their independence and their sense of self is formed. Relationships which positively support and encourage personal exploration assist in a well-developed sense of self and feelings of independence. Where the exploration is not supported insecurities and fears for the future, can emerge.
6. Stage 6: Intimacy vs isolation – the stage of early adulthood where the individual is exploring personal relationships. The ability to develop intimate, committed relationships during this phase is, in part, dependent on a strong sense of personal identity. Conversely, a poorly developed sense of self can result in an inability to develop committed relationships and can therefore be accompanied by feelings of loneliness and isolation.
7. Stage 7: Generativity vs stagnation – the stage of adulthood which is concerned with building lives, careers and families. Feelings of positive self-worth and a sense of ability to contribute positively to the world emerge from successful negotiation of this stage; whist feelings of unproductivity, stagnation, and lack of engagement with society may accompany failure to successfully negotiate this phase.
8. Stage 8: Integrity vs despair – the phase of reflection which accompanies old age. During this phase, a person who has developed a strong sense of identity, self-worth, and value in society during the previous stages is likely to reflect back on their life with a proud sense of achievement and feelings of honour and integrity. A person who has not successfully negotiated the previous stages, may be left with feelings of regret, bitterness, and a sense of despair.

Although Erikson (1968, p. 128) defined identity as a "subjective sense of sameness felt by individuals, within themselves", in his model he described identity as a developing concept, and acknowledged its dynamic nature by suggesting that the "sameness" is in a constant state of tension, where identity is being constantly constructed by the blending of many perspectives through the processes of self-observation, self-reflection and self-judgment.

3.1.2.3 Identity as dynamic and multifaceted

Henkel (2000) describes identity as being on a continuum that connects the past and the future with the present, and suggests that it is ever changing. As Billot (2010, p. 712) proposes, identity has "strong connections with the known and the valued, is influenced and modified by the unforeseen and the disruptive and is transformed by external social pressures at both the micro and macro levels", thus "each component of the individual's identity, while being connected to the past and contributing to that of the future, may well emerge from the imagined and the projected as well as the real".

A similar view holds that identity is neither "static nor time-specific" – but it is dynamic (Billot, 2010, p. 712). This dynamic nature of identity is understood and conveyed by Palmer (1998, p. 13) when he states that "identity is a moving intersection of the inner and outer forces that make me who I am", and as Sugrue (2005, p. 8) suggests, it "is both robust and fragile … fashioned continuously between chaos and order, between attachments to certainties and the creative risk orientated leap of imagination beyond slavish adherence to routines as previously enacted".

Rooted in the work of Erikson, Marcia (1966) identified four different identity statuses: identity achievement, moratorium, foreclosure and diffusion. Here, identity status refers to identifiable ways of dealing with pertinent identity issues and is characterised by the balance between "exploration" and "commitment" (Kroger & Marcia, 2011, p. 34). Exploration is the active process of self-reflection, self-observation and choosing between alternatives, whilst commitment refers to the degree of personal investment in an identity (Kroger & Marcia, 2011). Identity achievement is the status where an individual has engaged on an exploration process of different identities and then made a commitment to one. Kroger and Marcia (2011, p. 35) describe these people as being "solid", with "important focuses in their lives" whilst able to remain "flexible" and "have room for understanding the experiences of others". Those in the moratorium identity status, are actively involved in exploration, but have not made a commitment, - they are "struggling to define themselves" (Kroger & Marcia, 2011, p. 35). If persons in this status are able to make firm commitments, they can move on to identity achievement, if not, they can become paralysed by their indecisiveness (Kroger &

Marcia, 2011). Those that have committed to an identity without thorough exploration are in what Marcia (1966) describes as foreclosure status. Because foreclosures have committed to an identity without considering alternatives, there is often an "underlying fragility, to their position" which they fiercely defend (Kroger & Marcia, 2011, p. 35). Identity diffusion results when a person neither explores identity alternatives, nor makes any definite commitment. People in this identity status can either be relatively happy, and "infinitely adaptable" or they can be "lost and isolated, beset by feelings of emptiness and meaninglessness" (Kroger & Marcia, 2011, p. 35).

Through self-evaluation, exploration and commitment, identity is continually informed, formed and reformed as individuals develop over time and interact with others and as situations are experienced and anticipated. Citing Giddens, Sugrue (2005, p. 9) proposes that identity is "routinely created and sustained in the reflexive activities of the individual". In an attempt to illustrate the fluidity of identity Sfard and Prusak (2005, p. 16) suggest that trying to describe an identity is akin to attempting to "collapse a video clip into a snapshot".

Akkerman and Meijer (2011, p. 309) contend that a postmodern approach to identity views it as "fragmented along with the multiple social worlds that people engage in" rather than "an overarching and unified framework". They propose that central to a postmodern approach to identity is the notion that "participation in different communities causes a self that is decentralised into a multiplicity of social and situated contexts" and consequentially "self is no longer seen as having a centre or one core, but as varied and dynamic" (Akkerman & Meijer, 2011, p. 309). Citing Gee's notion of the relational nature of identity, Akkerman and Meijer (2011, p. 309) further argue that identity "can change from moment to moment in the interaction, can change from context to context, and, of course, can be ambiguous or unstable .. all people have multiple identities connected not only to their 'internal state' but to their performances in society."

This is consistent with Bakhtin's concept of the "unfinalizable self", which suggests that an individual's identity can never be finalised or completely comprehended, known, or labelled. The concept of the "unfinalizable self" respects the likelihood that an individual can and will change and that they are never fully revealed or known by others, and even themselves. In addition, the individual is interconnected with others and is therefore inevitably influenced by others. Furthermore, Bakhtin suggests that it is in "dialogue" and through the "multiple voices of others" that the individual's sense of sense or identity is heard. (New World Encyclopedia, 2008)

It is in the context of this dynamic and multifaceted nature of identity that Rodger and Scott (2008, p. 736) suggest that: “identities appear to be like a deck of cards spread out on a tabletop; anyone might be turned up at any time, depending upon the who, what and where of circumstance”. In addition, they argue that in this confusing milieu, the most accepted manner of making sense of identities such that they are useful is through the telling of stories or narrative.

3.1.2.4 Identity as constructed through narrative

Narratives arise out of experience and are an effort to describe experience in words or using language (Dyer & Keller-Cohen, 2000). Basically, a narrative is a story: a way in which “we construct disparate facts in our own worlds and weave them together cognitively in order to make sense of our reality” (Patterson & Monroe, 1998, p. 315). Thus, by telling a life-story, not only can a person come to describe or define themselves, but they are also able to understand the self in context (McAdams, 1996). It is through the ability of narrative to transform “knowing into telling” that human experience is made meaningful (Dyer & Keller-Cohen, 2000, p. 284). Consequently, it is through narrative that individuals are able to know, understand, and to make meaning of the social world, and “constitute our social identities (Somers, 1992, p. 606). As Patterson and Munroe (1998, p. 316) propose, narrative is of particular value in “revealing the speaker’s concept of self, for it is the self that is located at the centre of the narrative, whether as active agent, passive experiencer, or tool of destiny”.

In a review on research pertaining to the identity of teachers, Beijaard and colleagues (2004, p. 121) propose that through the telling of their stories “teachers engage in narrative 'theorising',” and as a consequence may further discern and form their professional identity, a process which may in itself give rise to new or different stories. As Dyer and Keller-Cohen (2000) posit, narrative permits the narrator to construct the self in a variety of ways: he or she is enabled to reflect on and describe past experiences and actions, and yet the narrator can revise, amend and interpret them in the telling. In addition they suggest that narrative “provides us with an opportunity to unite the selves of our past with those of the present, and even with the projected selves of the future”, thus bringing aspects of selves together into a more coherent whole, with a “deeper sense of understanding” (Dyer & Keller-Cohen, 2000, p. 285).

In suggesting that identity is “created and recreated in interactions between people”, Sfard and Prusak (2005, p. 16) describe identity-making as a “communicational practice” and suggest that it is more specifically those narratives that are “reifying, endorsable and

significant" which portray identity. *Reifying* narratives are those about being and having, rather than about doing, and describe who an individual "is". An *endorsable* narrative, "faithfully reflects the state of affairs in the world" and *significant* refers to a narrative that if modified, would evoke a change in emotional response in respect of the narrator's identity (Sfard & Prusak, 2005, p. 16).

The context within which the narrative is told can also influence the identity that is both formed and owned in the process. As Spector-Mersel (2011) proposes, there are three levels of context which impact on the telling of narrative and therefore identity. These include: the macro context, comprised of the prevailing social, political, and economic climates; the micro context, which includes recent events, relationships, thoughts and feelings and the immediate context, which is the time, location, setting and audience within which the narration occurs, together with the trigger factors which give rise to the narrative process. It is through the use of narrative that cultures, societies or communities craft and give expression to the world views that provide a basis for, and models of, identity and belonging to their members (Bruner, 1996). According to Somers (1994, p. 614):

> … people construct identities (however multiple and changing) by locating themselves or being located within a repertoire of emplotted stories; that 'experience' is constituted through narratives; that people make sense of what has happened and is happening to them by attempting to assemble or in some way to integrate these happenings within one of more narratives; and that people are guided to act in certain ways, and not others, on the basis of projections, expectations, and memories derived from a multiplicity but limited repertoire of available social, public and cultural narratives.

In this context, Somers (1994, p. 608) proposed a definition of narratives which states that: "narratives are constellations of relationships (connected parts) embedded in time and space, constituted by causal emplotment". Embodied in this definition are four features. The first of these: relationality of parts, suggests that sense is only made of elements of a story (experience or events) when they are placed in relation to other elements; in isolation they do not carry meaning. "Causal emplotment", the second feature, describes the relationship between elements: it is an "accounting of why a narrative has the story line it does". "Emplotment" basically refers to locating the elements of the narrative in a plot such that there is a causal relationship between them (Somers, 1994, p. 616). As Somers suggests "emplotment" provides "significance to independent instances, not their chronological or categorical order", furthermore it is "emplotment" that translates "events into episodes". The

third feature, “selective appropriation”, suggests that the narrator evaluates what is appropriate and elects to incorporate some elements into the narrative whilst omitting other potential elements. The fourth element, “time and space”, collectively termed “temporality”, describes how the narrative elements are located with respect to each other. Temporality suggests that the elements of a narrative are placed in a sequence and that the order in which they are placed, which is seldom chronological, carries meaning.
In an elucidation of the definition, Somers (1994, p. 616) suggests that:

> Unlike the attempt to produce meaning by placing an event in a specified category, narrativity precludes sense-making of a singular isolated phenomenon. Narrativity demands that we discern the meaning of any single event only in temporal and spatial relationship to other events. Indeed, the chief characteristic of narrative is that it renders understanding only by connecting (however unstably) parts to a constructed configuration or a social network of relationships (however incoherent or unrealisable) composed of symbolic, institutional, and material practice.

In addition to these four features of narrative, Somers (1994) identifies four different types of narrative. These include:

1. Ontological narratives – which are personal stories which individuals tell themselves about their place in the world and about their own personal history. They serve the purpose of making sense of, or defining who one is, an understanding and knowledge of which becomes a precondition for knowing how to act, which sequentially produces new narratives and hence new actions. The “relationship between narrative and ontology is processual and mutually constitutive” and “ontological narratives make identity and the self, something that one *becomes*” (p. 618). Somers proposes that ontological narratives are foundational to any theory of agency (the capacity of an agent – person or other entity – to act in the world). This would suggest and support a relationship between identity – an understanding of self, and agency. Put more simply, “a theory of how people act to change their world requires an understanding of how people understand themselves” (Patterson & Monroe, 1998, p. 325). Ontological narratives are social and interpersonal and are embedded in public narratives.
2. Public narratives or cultural narratives are “narratives attached to cultural and institutional frameworks larger than the single individual” (Somers, 1994, p. 619). They range from narratives at a family level, to those at a national level. According to

Phibbs (2008, p. 46) public narratives "transcend the individual; they are the cultural stereotypes that exist in the wider communities of interpretation through which stories circulate". They serve as a basis for ontological narratives: "Who I understand myself to be will depend in part on how I understand the institutions in which I am embedded" (Patterson & Monroe, 1998, p. 325).

3. Conceptual narratives are narratives and explanations of social forces, including "market patterns, institutional practices and organisational constraints" that are constructed by social researchers. Somers (1994, p. 620) maintains that the "conceptual challenge that narrativity poses is to develop a social analytic vocabulary that can accommodate the contention that social life, social organisations, social action, and social identities are narratively, that is, temporally and relationally constructed through both ontological and public narratives". Baker (2005, p. 6) argues for an extension of this definition to include disciplinary narratives in any field of study, suggesting that: "conceptual narratives may be more broadly defined as the stories and explanations that scholars in any field elaborate for themselves and others about their object of inquiry". In addition, Baker (2005) suggests that whilst some conceptual narratives may have a significant impact on the wider world, others will remain more narrow and be applicable only to the scholars in a specific discipline.
4. Meta- or master- narratives are abstract ideas that are thought to be a comprehensive explanation of historical experience or knowledge. They provide an all-encompassing account or world-view and "sociological theories and concepts are encoded with aspects of these master narratives" (Somers, 1994, p. 620). Meta-narratives go beyond the confines of specific professions or disciplines – for example the concepts of informed consent, equality, empowerment and autonomy have significance and meaning across health disciplines and belong to the realm of meta-narrativity. Meta-narratives may also include the master narratives of contemporary social life, such as democracy, freedom, or the doctrine of progress (Phibbs, 2008). According to Patterson and Monroe (1998, p. 326) "meta-narratives are so ingrained in our common understanding that they are difficult to recognise and are often uncritically adopted as the central organising concepts of our theories".

Drawing upon Somers' features of and types of narrative Phibbs (2008, p. 47) suggests that:

> Identities are crafted, modified and abandoned, and particular courses of action followed, according to how people are located by and locate themselves, however temporarily, in a range of given narratives. Narrative identities are never complete; they are always in the process of being

formed. In this sense they embed identities in an ever unfolding flow of temporally and spatially specific social relationships.

Having noted the multiple, shifting and often contradictory aspects of identity contained within these four themes underpinning theories of identity, Rodgers and Scott (2008) indicated that there is a need for an internal arrangement and control that holds identity together. They argued that the self needs to be viewed as an evolving historical unity that can be seen as the narrator and meaning-maker and that identities are the stories that are being told or the meaning that is being made. Instead of viewing self as an entity they describe self as a process: "an evolving yet coherent being, that consciously and unconsciously constructs and is constructed, reconstructs and is reconstructed, in interaction with the cultural contexts, institutions, and people with which the self lives, learns, and functions" (Rodgers & Scott, 2008, p. 739).

In an effort to describe an approach to teacher identity, based on the emerging theory of dialogical self in psychology, Akkerman and Meijer (2011) endorse this description by Rodgers and Scott. They contend that by combining a postmodern and a modern approach: "dialogical views provide a theoretical viewpoint that assumes a multiple, discontinuous and social nature of identity, while simultaneously explaining identity as being unitary, continuous and individual" (Akkerman & Meijer, 2011, p. 310). On the basis of this dialogical approach, they define identity as "an ongoing process of negotiating and interrelating multiple I-positions in such a way that a more or less coherent and consistent sense of self is maintained throughout various participations and self-investments in one's life" (Akkerman & Meijer, 2011, p. 315).

3.1.3 Summary

Although multiple definitions and theories of identity exist, for the purposes of this study, based on the assumptions identified by Rodgers and Scott (2008) and the work of Jameson (2007), identity will be defined as: An experienced sense of self, formed and re-formed as a consequence of context and relationships. It is multifaceted and dynamic and is constructed and becomes manifest to oneself and others through dialogue and the telling of one's story.

It is in light of the understanding that "the study of professional identity is embedded in the study of personal identity" (Slay & Smith, 2010, p. 3), and it is in the context of the definition of identity provided above, that in the sections that ensue, literature pertaining to professional identity and academic identity will be reviewed.

3.2 Professional identity

Professional identity, sometimes termed occupational, work, vocational, or career identity (Skorikov & Vonracek, 2011), has been described as "self-meaning connected with work" (Olesen, 2001, p. 296), or the "conscious awareness of oneself as a worker" (Skorikov & Vonracek, 2011, p. 693). It is therefore analogous with the "sense of self" central to the concept of identity described in Section 3.1.2, although it can be considered to be more contextually specific. As Stets and Burt (2000, p. 225) suggest, it may be regarded as "the categorisation of self as an occupant of a role, and the incorporation into the self, of the meanings and expectations associated with that role and its performance". It has also been described as the sustaining interests, values, beliefs, motives, goals and experiences that are characteristic of individuals who enact the same professional role (Ibarra, 1999; Skorikov & Vonracek, 2011).

Trede and co-authors (2012, p. 10), citing Paterson and co-authors (2002), suggest that feelings of "personal adequacy and satisfaction" in the workplace are related to professional identity and emerge as the "individual develops the values and behaviour patterns consistent with society's expectations of members of the profession". In addition they report the view of Higgs (1993), that professional identity forms when a person cultivates the "attitudes, beliefs and standards which support the practitioner role" and couple it with "a clear understanding of the responsibilities" of being a professional (Trede *et al.*, 2012, p. 10).

This concept of professional identity – as being a consequence of a professional occupation or work, as provided in these descriptions, is what Oliver (2007), citing Halford and Leonard, (1999), describe as a "structural" approach – "…'who we are' is constructed out of 'what we do'..". (p. 37). However, Oliver suggests that professional identity can also be viewed as agency, suggesting that it is the individual's identity that will determine what they do and also how they do it: "…'what we do' is constructed out of 'who we are'…" (p. 37).

The agency notion of professional identity is expressed in the idea that professional or career success are associated with the positive construction of professional identity (Slay & Smith, 2010). This notion also underlies the sentiment expressed by Palmer (1998) when he suggests that good teaching emanates from the identity and integrity of the teacher. The concept of professional identity as agency is supported by Healey and Hays (2011, p. 2) who suggest that professional identity and the process involved in its development, not only deepens the individual's self-concept, but also their understanding of their profession:

"enabling them to articulate their role, philosophy, and approach to others within and outside of their chosen field".

Skorikov and Vonracek (2011, p. 698) advocate that professional identity "represents the central mechanism of agentic control over one's career development", arguing that it is the central means by which individuals interpret and embrace professional and self- knowledge in order to make rational and sound career choices and decisions. They furthermore report that professional identity has been demonstrated, in several studies, to positively correlate with the ability to make career choices and decisions, and conversely, a poor sense of professional identity relates to career indecisiveness. Citing a further body of studies, Skorikov and Vonracek (2011) propose that professional identity is an important indicator of the individuals work-role continuity, work-place commitment, performance and career stability. Within the broader context: "empirical studies have provided strong and consistent evidence for positive relationships between occupational identity and psychosocial functioning" with a well-developed professional identity being viewed as a major contributory factor to one's "psychosocial adjustment, well-being and life satisfaction" (Skorikov & Vonracek, 2011, p. 699).

Although the importance of professional identity in career success and the development of professional values, beliefs, and practices are well recognised, similar to the concept of identity, it remains difficult to define. In a review of the literature relating to the development of professional identity in higher education, Trede and colleagues (2012) reported that of 20 articles reviewed, only one defined professional identity, and this was a brief definition of identity as being a "sense of being professional". The other 19 articles reviewed suggested the idea that "professional identity is a way of being and a lens to evaluate, learn and make sense of practice" (p. 374). Similarly, in a study reviewing the body of research on the professional identity of teachers, Beijaard and colleagues (2004) found that in 22 papers, the concept of professional identity was defined in various ways, or in many instances, not defined at all. They did suggest however, that from the studies reviewed, four characteristics emerged which could be considered to be essential features of professional identity. These included professional identity as: 1. a continuous process of "interpretation and re-interpretation of experiences" that is neither "stable or fixed"; 2. dependent upon both "person and context"; 3. consisting of sub-identities, that relate to different contexts and relationships; and 4. requiring active engagement or agency, in order to develop (Beijaard *et al.*, 2004, p. 122). Modern theories of professional identity have elsewhere also been described as having the following features: possessing elements of continuity and change; fashioned by the dynamics of interpersonal relationships; largely self-constructed by the

individual involved; controlled by social and economic factors; and, varying in significance in the context of the individual's overall sense of identity (Brown, Kirpal and Rauner (2007) cited by Skorikov & Vonracek, 2011, p. 696)

All of these features can be broadly aligned with the common themes identified by Rogers and Scott (2008), namely: identity as contextual; relational; dynamic and multifaceted and constructed through narrative.

3.2.1 Professional identity as contextual and relational

Since professional identity is by its very nature "the categorisation of self as an occupant of a role" (Stets & Burke, 2000) or simply stated, "connected with work" (Olesen, 2001, p. 296), it is context-dependent. Skorikov and Vonracek (2011) advocate that, in addition to an individual's practices and experiences, the development of professional identity is influenced by a range of individual and contextual factors, and the interactions between them (Skorikov & Vonracek, 2011). Contextual factors, such as family and peer relationships, and the prevailing socio-economic climate, can have either a direct or indirect influence on identity. Directly they can dictate "social stereotypes, modelling, perceived opportunity structure, and environmental constraints", and indirectly by "regulating the direction and repertoire of individual actions" (Skorikov & Vonracek, 2011, p. 701). According to Jameson (2007) professional identity can be considered to be an aspect or a component of cultural identity, and from the perspective of social identity theory as described by Whitchurch and Gordon (2010, p. 129), professional identity may be regarded as "the interplay of the agency of the individual with the structures and boundaries that they encounter".

In identifying three aspects involved in the formation of a professional identity, Trede and colleagues (2012) describe the contextual nature of professional identity. The first aspect is the development of the knowledge, skills, attitudes and values consistent with those of the members of the profession of which one is becoming a part. Secondly, this then creates a distinguishable difference between the individual and those outside of the profession, and thirdly the individual identifies themselves with the profession. As Trede and colleagues (2012, p. 380) suggest, "a person identifies him or herself as a member of that category of people that make up the profession. This professional membership thus becomes part of one's identity". Allied to this contextual notion of professional identity - a sense of self, relative to and in the context of one's occupation, is the perception that professional identity can then be described as relational or as a "form of membership" (Reybold, 2008, p. 140).

This sense of professional self in relation to others, is the consequence of membership of and engagement with a community of practice, and is sustained or maintained by a community of practice (Reybold, 2008). The contextual and relational nature of professional identity can be more fully understood through further consideration of the nature of communities of practice.

3.2.1.1 Communities of practice

The term "community of practice" was coined by anthropologists Lave and Wenger (1991, p. 98), to describe a group of people "who share a concern or a passion for something they do and learn how to do better, as they interact regularly". Viskovic and Robson (2001) suggest that communities form by the continued engagement in mutual activities or practices and it is shared practice which provides the basis for the community's existence.

The fundamental characteristics of a community of practice include: 1. a *domain* or field of knowledge that provides a unifying common focus and shared area of interest which provides a basis for member participation and learning; 2. a *community*, in which there is mutual interaction and engagement amongst members; and 3. a shared *practice* which is the particular focus around which the community is created and gives rise to "shared repertoires" consisting of routines, language, mannerisms and activities. Communities of practice are formed around issues that people regard as having value, and practices that reflect these central values. (Wenger, McDermott, & Snyder, 2002)

Communities of practice are primarily about learning and membership of a practice community provides opportunities for learning and for personal and professional growth (Wenger, 1998). It is the milieu within which individuals acquire and develop the practices (including ideals, standards and relationships) appropriate to that community (Wenger, 1998). It is also through participation in communities of practice that identity is negotiated. Wenger (1998) argues that that it is in the tension between identification with – a sense of belonging, and negotiability – an individual's capacity to contribute to, and form meanings that matter, within a community, that identity formation occurs. It needs to be noted however, that just as participation in a community of practice is a source of identity, so is non-participation. As Viskovic and Robson (2001, p. 225) advocate: "We know who we are by what is familiar and we know who we are *not* by what is unfamiliar".

This notion of participation or non-participation in communities of practice and their impact on identity is described by Wenger (1998) as "trajectories", or paths of motion both within and between communities of practice. Various types of trajectories exist, including: peripheral

trajectories, which make access to a community available, without leading to full membership; inbound trajectories offer the future possibility and opportunity of full membership and participation; insider trajectories refer to the opportunities afforded members of a community of practice for on-going re-negotiation of identity through the evolution of their practice; boundary trajectories, cross boundaries and bridge multiple communities of practice; and outbound trajectories, which lead out of a community of practice. (Wenger, 1998)

Thus a person may be a core member within some communities of practice, whilst in others they participate on the margins or the periphery. On entering a community of practice, early membership often involves learning at the periphery, as an apprentice or an intern. With time, and a socialisation process involving increased engagement with the practice of the community, peripheral participation can lead through occasional to active or full participation at the core (Figure 3.3). It is the concept of trajectories that supports the idea of identity as being essentially temporal in nature, dynamic, and consequential upon the interaction of multiple convergent and divergent trajectories both within and across communities of practice. (Wenger, 1998)

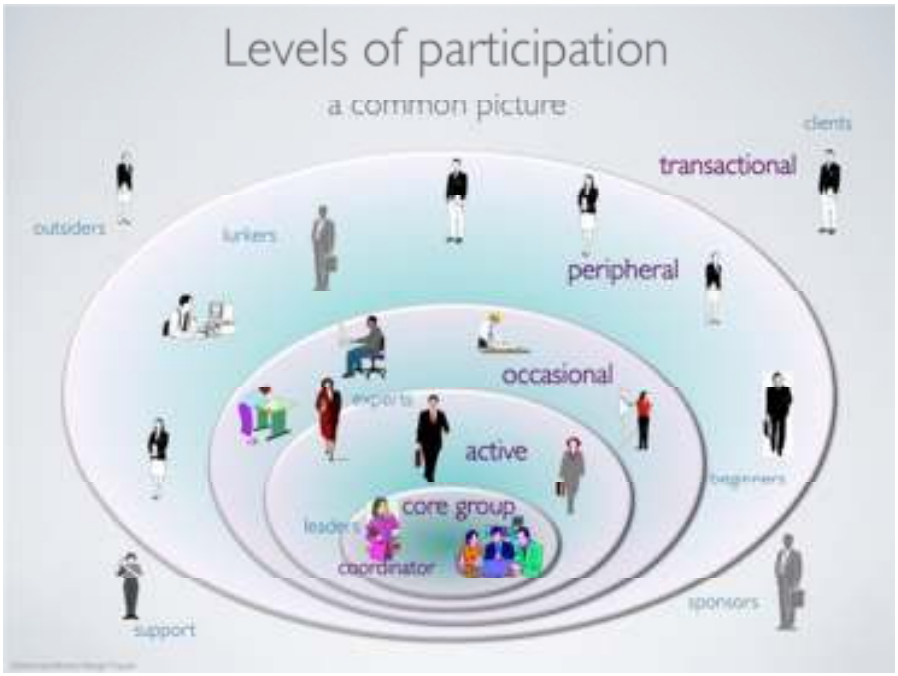

Figure 3.3: Levels of participation in communities of practice (Wenger & Trayner, 2012)

The notion of boundaries of communities of practice is considered by Wenger (2000) to be an important one. Although usually of a fluid nature, the very notion of a shared practice

within a community of practice, based on competence and experience, implies or creates boundaries. It is at the boundaries of a community of practice that "competence and experience tend to diverge" (p. 233) and where exposure to new and "foreign competencies" occurs. Boundaries can therefore be considered to be sources of opportunities for new learning. Similarly it is the recognition of boundaries which helps us to "define who we are", by identifying "what is familiar and what is foreign" (Wenger, 2000, p. 239).

Wenger (1998, p. 158) further advocates that professional identity is a "nexus of multi membership" whereby: "An identity combines multiple forms of membership through a process of reconciliation across boundaries of practice." It is the experience of multi-membership, and its accompanying juncture of relationships across boundaries, that provides the basis for an experiential understanding of the concept of "being a person, at once one and multiple" (Wenger, 2000, p. 242). Furthermore the work required to "combine, confront, or reconcile various aspects of our identities" is a stimulus for personal growth, and a "source of social cohesion", helping to build connections across communities of practice. Identity is therefore both a consequence of and a determining force for social structure.

Wenger (2000, p. 241) proposed that since "identity extends in time", it can be considered an evolving trajectory that encompasses both the past (where you have been) and the future (where you are going). Furthermore it "brings the past and the future into the experience of the present". Early membership on the periphery of a community does not only include learning the practices and skills of the community, but also provides exposure of the newcomer to "possible futures" within the community, and a "sense of trajectory that expands their identity in time". Wenger (2000, p. 241) furthermore purports that the members of a community represent a set of "paradigmatic trajectories" that offer newcomers a basis for constructing their own trajectories into and through the community. In addition, the encounters between newcomers and established community members can be considered to be mutually beneficial, in which "the identities of both are expanded".

Meaningful core membership is only possible across a fairly limited number of communities; however a peripheral or a transitory form of participation in several additional communities is possible. Wenger (2000, p. 242) suggests that communities that are able to accommodate aspects of the multi-membership of their members in other communities, as an essential element of their participation in this community, are more likely to engage the "whole identity" of members. He suggests, by way of an example that if a community member's role as a parent is accepted, rather than denied, within the work community, they are more likely to put their heart into their work.

Within the milieu of communities of practices, beyond the relational and contextual nature of professional identities, is the inherent notion of professional identities as multifaceted – "a nexus of multi-membership" and dynamic – "an evolving trajectory" (Wenger, 2000, p. 241).

3.2.2 Professional identity as dynamic and multifaceted

There are many aspects to professional identity, of which Briggs (2007, p. 471) identifies three as being foundational to professional identity: professional values, professional location and professional role. These may be typified as: "what I profess"; "the profession to which I belong", and; "my role within the institution", respectively. Healey and Hays (2011) contend that "one's agreement with the guiding philosophy" of a profession is central to professional identity and determines one's "fundamental beliefs and values" and the "resulting approach to their role within the profession".

Considering the contextual and relational aspects of professional identity already discussed, professional identity can be considered to be a multifaceted relationship between individual beliefs and value systems, membership within communities of practice, institutional structure, and culture, within which the individual practices. The interplay of these factors in turn significantly affects one's "sense of purpose, self-efficacy, motivation, commitment, job satisfaction and effectiveness" (Briggs, 2007, p. 473).

Slay and Smith (2010) suggest the context of contemporary professions is constantly changing, and that they are "characterised by shifting boundaries in occupational, organisational, national, and global work arrangements". In addition, they suggest that "both professional identity and contemporary careers are subject to relational and social influences within, and even beyond, the individual's present occupation or organisation" (p. 2). Grounded in an understanding of the changing nature of the world of professions, Trede and co-authors (2012), in discussing a concept of professional identity proposed by Bauman, as something that has to be actively constructed by an individual within their context, suggest that: "Goals have become fragile and finishing lines are constantly shifting." (p. 381), and thus: "Building or capturing an identity has become slippery, flexible and always on the move" (p. 381).

The contextual and relational nature of professional identity suggests that professional identity will also change when professionals alter their work location, their role within the workplace or organisation, or their career. Since practice and participation in a community of practice fosters the development of professional identity, changes to these can modify an

individual's sense of self, relative to their work or occupation (Reybold, 2008). As Reybold (2008, p. 140) states, with change "professional identity is transformed vis-à-vis membership and engagement in the new community of practice". The extent to which change transforms professional identity varies, and in some instances requires concurrent participation in more than one community of practice, for example: a professional practitioner who moves to teach on a professional programme in higher education is often required to maintain their expertise and standing within their profession, whilst simultaneously negotiating membership in a new community of practice within higher education (Reybold, 2008).

Skorikov and Vonracek (2011, p. 699) advocate that, from a developmental perspective, professional identity "represents a lifelong process of constructing, shaping and reshaping the self as a worker", and at any given moment, emerging from a person's amassed experiences of life, professional identity represents their conceptual understanding of who they are as a person and who it is they wish to become. Although the development of professional identity is acknowledged as beginning in adolescence, it is built on a foundation of childhood experiences. At an early age, contact with various professions and occupations, and factors such as experience of family members attitudes toward work and work behaviour, and exposure to cultural stereotypes such as gender and social class roles, can all contribute to future professional identity formation. Building on the identity status work of Marcia (Section 3.1.2.2), Skorikov and Vonracek (2011) propose an expanded model of occupational identity status (Table 3.1), in which they identity six different levels of occupational identity status.

Table 3.1: Occupational identity status classification (adapted from Skorikov & Vonracek, 2011, p. 696)

OCCUPATIONAL COMMITMENT	OCCUPATIONAL SELF-EXPLORATION		
	Limited	***Active***	***Completed***
Not made	Occupational identity diffusion	Occupational identity moratorium	Occupational identity confusion
Made	Occupational identity foreclosure	Dynamic occupational identity achievement	Static occupational identity achievement

Despite an attempt in this model to encapsulate the multifaceted and dynamic nature of identity development, through the introduction of three levels of identity exploration, namely: limited, active and completed, as Skorikov and Vonracek (2011, p. 695) suggest, "it still does

not fully capture the occupational identity as the complex, evolving structure of meanings in which the individual links his or her motivation and competencies with acceptable career roles".

From the perspective of a study exploring professional identities in teacher education, Vloet and van Swet (2010) suggest that the contemporary view of professional identity is of a complex, lifelong, ever-changing process of interpreting and reinterpreting significant practice experiences. In addition, they suggest that this complex concept can be defined as "a story told by a person about himself or herself at a given moment, within a certain context" (p. 152), highlighting the manner in which professional identity can be constructed through narrative.

3.2.3 Professional identity as constructed through narrative

Professionals can build and rebuild their professional identity by a process of self-reflection on, and internal dialogue with, their significant practice experiences, and by talking about those experiences with others (Vloet & van Swet, 2010, p. 151). Palmer (1997, p. 18) reasons that no-one can wholly know or name identity, including their own and suggests that "elusive realities" of identity "can be caught only occasionally out of the corner of the eye" and that "stories are the best way to portray realities of this sort".

According to McCormack (2009) the practice experiences of professionals work are often complex and diverse, such that it is often not easy to make personal meaning of and learn from them. Stories can then offer professionals the opportunity to "reveal both the individual and collective nature of experience" and to "see into themselves" (McCormack, 2009, p. 143). The place of narrative in the formation and validation of professional identity is also highlighted by Lave and Wenger (1991) who suggest that through "talk" or speech, professionals develop identification with their practice and their profession. The putting into words of one's story of personal experiences through talk or narrative enables the individual to both position and make meaning of it, in the context of their understanding of self or identity (Dyer & Keller-Cohen, 2000).

In the context of teacher identity, Gill and Pryor (2006) argue that since professional identity cannot be separated from personal identity and sense of self, telling life histories and stories about teaching and learning, provides opportunity for teachers to construct and re-construct their sense of self, on both a personal and a professional level. In addition, they suggest that narratives can enable individuals to make sense of their own understanding of life and work,

to re-examine their assumptions, values and beliefs and potentially transform personal knowledge of their professional identity and practices.

3.2.4 Summarising professional identity

The concept of professional identity can be considered to be both: structural in nature – constructed as a consequence of one's profession, occupation or vocation; and to serve as agency – be a determining factor in what work a person does and how they do it. Professional identity is also multifaceted, dynamic and contextual. The contextual nature is, to a large extent, a consequence of the communities within which one practices and the levels of one's participation within these communities. As Wenger (2000) proposes, professional identity is often a "nexus of multi-membership" of several communities of practice.

In this study, the professional identity I am seeking to explore and describe is that of people who are qualified and registered as pharmacists and who are working in higher education as educators. Within the domain of identity research literature, there is body of studies that pertain particularly to the identity of academics in higher education. In the section that follows, aspects of this literature will be reviewed within the same common themes described by Rodgers and Scott (2008) as underpinning contemporary identity literature: identity as relational, contextual, multifaceted, dynamic and constructed through narrative.

3.3 Academic identity

The term "academic" is often used to describe or identify an educator within the higher education environment. Billot (2010, p. 709) proposes that the use of the term is in the context of both describing a relationship with the institution itself, as well as with the academic profession, and inherent to the concept are the "values, beliefs and practices held in common with others of that affiliation". She furthermore explains this as a three dimensional identification of professional values, role, and location. In addition to being influenced by one's context (location), academic identity is therefore influenced by one's beliefs and values, and in turn impacts on one's sense of meaning and purpose, self-belief, enthusiasm, drive, dedication and efficacy (Billot, 2010). According to Shreeve (2011, p. 79), "being an academic is a question of identity". Furthermore as with any other facet of identity, "there are multiple possible configurations that require 'identity work'" (Shreeve, 2011, p. 79). As Winter (2009, p. 123) proposes, at the heart of academic identity is the concept of academic professionalism with the inherent values of self-regulation and professional autonomy, the values of discipline-based scholarship, intellectual curiosity, communities of

practice and accountability to peers. The construction and formation of academic identities involves multiple layers of disciplinary, departmental and institutional cultures and traditions, locations and contexts, goals and missions, co-workers and students (Becher & Trowler, 2001).

3.3.1 Multifaceted and dynamic nature of academic identity

Similar to other identities, academic identity is complex, multi-faceted and influenced by many factors (Quigley, 2011; Whitchurch, 2008). McAlpine and Akerlind (2010) provide a comprehensive explanation of the complex nature of academic identity by describing it in terms of academic practice, where:

> The term 'practice' represents more than a job, appointment or title that academics hold; it is also more than the tasks, duties and responsibilities that academics engage in; and more than the skills or knowledge academics develop. 'Practice' incorporates the totality of individual (and collective) experiences – the ways in which we think, interact, enact and engage as academics in the work we do. The term 'practice' brings into play the underlying, sometimes implicit, purpose(s) that motivate us to be academics and through which it is possible to integrate an array of multi-faceted duties, responsibilities, skills and knowledge into a coherent sense of academic identity (Kindle Locations 328-333).

Historically, the academic profession was teaching-focussed, but by the early twentieth century it came to include both teaching and research (Kreber, 2010). The blend of these two activities, teaching – which may be considered the transference of knowledge, and research – the generation of new knowledge, and the extent to which academics identified with either one or both of them, allowed for the categorisation of academic identities on a continuum between researcher on the one end, to teacher on the other end (Henkel, 2007). Over the last thirty years, with the internationally held perception that greater institutional recognition and reward are associated with research, the balance in focus between teaching and learning is viewed as having tipped toward research (Kreber, 2010). However, a balanced interface between research and teaching is recognised as being necessary for maintaining quality and scholarship in higher education, and therefore most academics are, to varying degrees, expected to be actively engaged in both (The University of the Free State, 2006).
Increasingly in the higher education environment there is a greater focus on outputs, with issues of accountability, efficiency, and control having become central driving factors,

resulting in academics having to assume far greater administrative and managerial roles. Consequently, the nature of academic work has changed as institutional pressures to produce specific research outputs, at the same time as teaching and undertaking managerial/administrative responsibilities have increased. The progressively complex interplay between teaching, research and administration/management, has also created tension between what academics perceive as their professional identity and that prescribed by their employing institution (Billot, 2010; Kreber, 2010; Winter, 2009). In the South African context, some universities have historically been classified as either teaching or research-oriented (Chetty & Lubben, 2010) and, depending on the nature of the institution, the perceived "prescribed" identity can also vary.

For many within the university environment, research is central to academic identity (Henkel, 2005), with some authors such as Lea and Stierer (2011, p. 608) even going so far as to suggest that, from a review of the academic identity literature, it appears that research is the "trademark activity of the university academic, and the primary source of their "role definition, identity formation and intellectual fulfilment". In a study that explored the relationship between research capacity development and identity formation, Dison (2004 p.83) argued that the ability to do research is more than simply about knowledge and competencies: it "arises from the capacity of the whole person", and is inextricably interrelated to the individual's identity as a researcher and academic. From this perspective, either the inability to obtain research funding, or having administrative or teaching functions impede on research time, poses a serious threat to the identity of research focussed academics (Henkel, 2005). This is not unexpected when, in the current climate, higher education worldwide, appears to, in comparison with teaching, place greater importance on research (Chetty & Lubben, 2010).

3.3.1.1 Role of doctoral studies in the formation of academic identity

Within the South African context, it is the "research doctorate", or PhD, which is a "specialised qualification" grounded on the "mastery" of research within a specific academic discipline, that is considered the highest qualification offered in higher education, and is "typically the desired qualification for an academic or research career" (du Toit, 2012, p. 1). In a study by Backhouse (2009), in which she investigated doctoral education in four academic units, at three South African universities, across different disciplines, she suggested that the research policies and strategies of South African universities support the notion of the doctorate as research. In the academic environment, the doctorate is considered to be preparation for an academic or research career, and has been equated to

an “academic apprenticeship” (Backhouse, 2009, p. 4), similar to that described by Lave and Wenger (1991) (see Sections 2.4.1 and 3.2.1.1). Backhouse (2009) advocates that within the apprenticeship model, whilst being “legitimate peripheral participants in a community of practice” (p. 4), through research, doctoral students provide academic disciplines with a means of sustained continuation and regeneration by “expanding the knowledge base and developing the debates and discourses” (p. 4).

Although internationally there has been a shift in doctoral studies toward course work programmes, with both taught and research components, this has not been the trend in South Africa, with the research degree remaining the primary means of attaining a doctorate. However, as du Toit (2012, p. 2) suggests, a research doctorate results in highly “specialised knowledge” limited to very specific topics, and is “not well-suited to serve as an entry-level qualification for an academic career”; furthermore he suggests that students with serious intentions of pursuing an academic career would be “better advised to proceed ‘overseas’”.

Despite the emphasis that is placed on the doctorate, in higher education in South Africa in 2010, only 5191 - one third of all South African academics - had a doctoral degree (Cherry, 2010). It is further estimated that of the roughly 7000 part-time doctoral students in South Africa, a large proportion of these are comprised of the two-thirds of academics, who do not hold doctoral degrees (Cherry, 2010). This would suggest that, since the research doctorate is recognised as the highest academic qualification, and research is ordinarily given priority in terms of recognition and even promotion within universities, not having a doctorate has implications for academic identity. Harrison (2009, p. 26), citing Walker, Golde, Jones, Bueschel and Hutchings (2008) suggests that, “doctoral education is a complex process of formation”, and that “what is formed, in short, is the scholar’s professional identity in all its dimensions”.

A doctorate is viewed as “leading to an academic career”, and develops “a certain kind of person”: more specifically, a person “who displays the characteristics of a scholar – one who displays independence, thinks in an academic way and shapes the intellectual landscape” (Backhouse, 2009, p. 102). In the context in which a doctorate is viewed as preparation for an academic career, providing “the necessary certification for an academic appointment”, it is similarly considered to provide opportunity for both exposure to, and development in aspects of academic work other than research (Backhouse, 2009, p. 105). It is certainly viewed as the primary process of enculturation into an academic discipline, providing an opportunity to learn the ways of, and develop both an identity with and commitment to, the discipline (Backhouse, 2009). Green (2005, p. 162) proposes that doctoral studies are as much about

"the production of identity" as they are about "the production of knowledge". A doctorate is thus often also considered to be the final stage of socialisation into a discipline and integral to the development of a disciplinary identity (Becher & Trowler, 2001). Doctoral study within a discipline provides a student with a framework for viewing the world, and for making "certain interpretations of real-life occurrences and of meaning in texts" (Dison, 2004, p. 89). With reference to Wenger's (1998) suggestion that identity formation occurs in the tension between identification and negotiability (see Section 3.2.1.1), Dison (2004, p. 90) advocates that it is within the discipline, and the framework that it provides for making meaning, that the doctoral student finds both a degree of identification and negotiability – "ownership of meaning".

Notwithstanding the fact that a doctorate is viewed as a means of developing the "tacit skills of being an academic" (Backhouse, 2009, p. 106), and as preparation for an academic career, as Backhouse (2009) argues, "learning to teach is not always part of the PhD" (p. 107). The manner in which teachers in higher education learn to teach, and perceive their teaching and teaching practice, can be viewed as being impacted upon by the communities of practice within which they are located, rather than through any formal preparation or qualification (Kreber, 2010; Lave & Wenger, 1991). The lack of formal teaching qualifications held by academics in South African universities was highlighted in a study by Wadesango and Machingambi (2011), who interviewed 36 academics across three universities, and reported that 95% of those interviewed did not have any formal teaching qualification. Thus the formation of teacher identity within higher education may be viewed as a "process of socialisation" (Kreber, 2010).

3.3.1.2 Identity of academics as teachers

Based on a study which explored the manner in which lecturers at two universities in the UK perceived themselves as teachers, Hockings and co-researchers (2009) concluded that, within higher education, the identity of academics as teachers is influenced by their own experiences of education, the way in which they perceive knowledge to be constructed within discipline communities, and by their personal beliefs about themselves and their students. In addition their pedagogic practices – the manner in which they teach, was influenced by their identities. As Cranton and Carusetta (2004, p. 6) propose, the development of teachers within higher education is largely an "adult education enterprise", and rather than being viewed as simply the acquisition of technical skills, it needs to take into account how teachers learn, develop, and transform their "sense of self" or "authenticity". They describe authenticity as a complex concept including: "being genuine, showing consistency between

values and actions, relating to others in such a way as to encourage their authenticity, and living a critical life" (Cranton & Carusetta, 2004, p. 7).

Integrity, or authenticity, has the potential to provide an environment in which "vital connections", between teacher and subject, teacher and student, and student and subject, are made (Palmer, 1998). Being authentic has also been described as opening one's self to the possibility of being caring (Kreber, Klampfleitner, McCune, Bayne, & Knottenbelt, 2007). Building on the work of Nodding, Heidegger and Zimmerman, Kreber and colleagues (2007, p. 33), purport that "care is the very essence of being human", and that the more authentic we become, the greater our capacity to care for ourselves and others; and furthermore, the more we care, the more open we are to ourselves and others. It might be pertinent to note that within academia, caring qualities have been associated more with those inclined to teaching than to research. In a study of the relationship between teaching and research, within a research-focussed university, the heads of departments typically identified qualities such as motivated, self-driven, perseverant and driven, as those associated with successful researchers, whilst good teachers were characterised by qualities such as caring, concerned and open (Rowland, 1996). As Cranton (2001, p. 81) argues, "the authentic teacher cares about teaching, believes in its value, wants to work well with students, and has a professional respect for students in general". She further suggests that "if we don't know who we are as human beings it is very difficult to know who we are as teachers", and that finding one's identity as a teacher can lead to greater authenticity (p. 6).

Although a wealth of literature on teacher identity within the school context has emerged (Akkerman & Meijer, 2011; Beauchamp & Thomas, 2009; Beijaard *et al.*, 2004; Beijaard, Verloop, & Vermunt, 2000; Canrinus, Helms-Lorenz, Beijaard, Buitink, & Hofman, 2012; Canrinus *et al.*, 2011; Stout, 2001), the body of literature concerning teacher identity within higher education is relatively limited (Haigh, Xiaomin, & Lindsay, 2010; Hockings *et al.*, 2009; Krabbi, 2005; Kreber, 2010). Drawing on the literature pertaining to the formation of teacher identity within the school environment, Kreber (2010, p. 172), proposed that teacher identities can be construed as being formed by a dynamic interplay between "personal theories of teaching" and "perceptions of self", both subject to influences within the "social and occupational context". For the majority of academics, their immediate social context is comprised of the discipline, department or faculty within which they are located, and includes the variety of relationships within that context, including relationships with students and academic and non-academic colleagues (Becher & Trowler, 2001; Kogan, 2000; Kreber, 2010). The individual's personal, social and cultural background can also be considered part of their social context (Kreber, 2010). The occupational context is shaped by a variety of

factors, including macro factors impacting on the higher education environment, such as political, social and economic, and institutional factors, such as the way the institution positions itself in terms of the "research-teaching nexus" (Kreber, 2010, p. 173). Contextual factors are important, since the context within which academics work can impact on how they perceive themselves, their colleagues, their students, their relationships and ultimately their practice (Cranton & Carusetta, 2004; Kreber, 2010).

According to Galbraith and Jones (2008), context is not all-important though, suggesting that it is a myth that being a specialist in a discipline implies that you will be able to teach it effectively, and that teaching in each discipline is unique. In addition, quoting Weimer (2008), they suggest that "there is no guarantee that colleagues in the discipline are pedagogically savvy – that their views of teaching are anything but eclectic, idiosyncratic and uninformed" (p. 1). They propose that it is self-awareness and understanding which is central to being a good teacher and for developing an effective teaching practice, suggesting that "self-awareness lays the ground work for developing a vision for teaching, becoming authentic and credible, and understanding your teaching perspective" (Galbraith & Jones, 2008, p. 2). In an intensive longitudinal study which explored the influential factors on the formation of the identities of eight teachers in higher education, in the UK, Hockings and colleagues (2009) concluded that teachers' identities are influenced by their educational experiences, the manner in which they conceive discipline specific knowledge generation, and by the their perceptions and beliefs about themselves and their students. Furthermore, the teachers' pedagogic practices were influenced by their identities. One of the recommendations emerging from this study was that academic development programmes which seek to develop teaching skills need to provide opportunities for academics to reflect on their individual identities and explore ways of tailoring their teaching to suit their identity.

3.3.1.3 Service as a facet of academic identity

The higher education context within which academics find themselves is complex: "academic practices are changing as multiple roles emerge from the reshaping of academic work" (Billot, 2010, p. 709). Beyond the two traditional tasks, of teaching and research, and the added responsibility of administration and management, other functions are progressively being required of academics. Based on their research which explored issues of changing academic identities through an examination of academics' everyday professional writing practices, Lea and Stierer (2011) argue that, within a milieu of a "multiplicity of roles, activities and functions" demanded of academics, and impacting on their academic identity,

the “conventional three-part formulation of ‘research, teaching and administration’”, is relatively insignificant.

This increased demand by modern society for universities to be more relevant (Kogan & Teichler, 2007), and more actively engaged in the pursuit of answers to “our most pressing social, economic and moral problems” (The University of the Free State, 2006, p. 21), has implications for the roles, and consequently, identities of academics. As Nzimande advocates in the preface to the Green Paper for Post-School Education and Training (Department of Higher Education and Training, 2012), South African universities “need to be at the forefront of knowledge creation to enhance the economic, social and cultural life of all our citizens”. As growing numbers of universities accept the challenge of “pursuing an agenda of public and civic engagement” (The University of the Free State, 2006, p. 21), there is also a growing requirement for academics to become actively involved in service. Within the higher education environment, service normally refers to service to the institution, the external community and the wider academic university. Service to the wider community, termed community service, may either be rooted in and integral to the research and teaching work of academics, or it may be apart from it (The University of the Free State, 2006). It often includes activities such as leadership in civic and non-governmental organisations, professional societies, and advisory councils. The extent to which academics actively engage in service is dependent upon several factors, including the institutional and departmental culture, and the psychological characteristics and preferences of the individual. It has even been suggested that “many people become academics precisely because they want to avoid the messy affairs of the wider world” (Martin, 1984, p. 20), and therefore prefer to avoid community service.

The multifaceted nature of academic identities is not only a consequence of the different roles and tasks required of academics, but may also be related to membership of various communities of practice (Section 3.2.1.1), in the fulfilment of these roles and tasks. As Kreber (2010, p. 173) submits “It is a widely shared view that academics construct multiple identities due to their membership in several communities at different levels (eg, local, national and international), with each of these contributing to an ‘overall’, though possibly fragmented academic identity”.

How the individual academic responds to the multiple role demands and the array of communities with which they are required to interact, also impacts on their academic identity. As Whitchurch and Gordon (2009, p. 3) argue:

> The traditionally discrete roles of teaching, research, technology transfer and/or administration are increasingly overlaid by, for instance, community and business partnership, widening participation, outreach, and the student experience. Learning design and support has added another dimension. However, while for some this may imply an identity crisis, for others it enables new identities to be forged.

The traditional academic culture can be viewed as being one that often fosters a strong sense of "individuality and isolation" (Deem & Brehony, 2000, p. 149). Consequently, although a widening participation in multiple communities of practice may be a threat to some, for others it may be the opportunity to develop a "collaborative attitude" and also allows for the emergence of a "collective identity" (McAlpine & Amundsen, 2009, p. 122).

3.3.1.4 Academic identity as a trajectory through time

Academic identity has also been described as dynamic - "a constantly shifting target" (Quigley, 2011, p. 21). Based on their work with doctoral students, early career academics, and their own experiences, McAlpine, Amundsen, and Jazvak-Martek (2010) describe the concept of academic identity as "a trajectory through time" (Kindle Location 2964). The idea of an academic identity as a trajectory supports the notion that although academic identity is dynamic, individuals find a way of linking past, present and future experiences, in a meaningful and coherent manner (McAlpine *et al.*, 2010). Furthermore, for these researchers, it was the emergence of four common themes underpinning the experiences of doctoral students and early-career academics that gave rise to the concept of identity-trajectory.

1. a lack of clear communication of what was expected of the person creates confusion,
2. although it involves emotional vulnerability, exposing personal intentions, ideas and work to senior colleagues has the potential for a more powerfully negotiated standpoint,
3. the personal life of an academic, including their principles, beliefs, needs and responsibilities, are all integral to their academic identity, and
4. the process of reflecting on and learning from everyday activities and interactions, helps construct and make sense of the present in terms of the past and future. (McAlpine *et al.*, 2010)

In the words of McAlpine and colleagues (2010), it is these four common themes which support the notion of academic experience and identity as "a dynamic biographical process grounded in history and memory" (Kindle Location 3142). These authors furthermore

describe the trajectory notion of identity as highlighting "the desire to enact personal intentions and hopes over time; to maintain a momentum in constructing identity despite challenges and detours; and to imagine possible futures" (McAlpine *et al.*, 2010, Kindle Location 3183-3184).

Expanding the identity-trajectory concept, McAlpine and co-authors (2010) further emphasise the multifaceted nature of academic identity by suggesting that identity trajectories are essentially comprised of three identifiable and discrete elements of experience, namely: "intellectual", "networking" and "institutional". They propose that: "each strand develops asynchronously through time and space, yet is integrated into and influences the other strands of the trajectory" (McAlpine *et al.*, 2010, Kindle Location 3186).

The intellectual component can be considered to be the contribution the individual is making to the body of knowledge and scholarship in their chosen academic field, through both teaching and research. This strand, particularly the research component, is often considered to be measureable by the number of research outputs such as papers, publications, chapters and books, and conference presentations, the individual produces. This component is, however, also open to review, scrutiny and criticism by peers and the wider academic community, and consequently may be the source of either rejection or affirmation, both of which can impact on academic identity. The networking and institutional strands bring to the fore the relational and contextual nature of academic identity, described in the section that follows. (McAlpine *et al.*, 2010)

3.3.2 Academic identity as contextual

The formation of academic identity is, amongst other things, highly influenced by the nested subsystems within which the individual works, including institutional, departmental and disciplinary contexts (Becher & Trowler, 2001). Furthermore, globally, the context and nature of higher education is changing (Qualter & Willis, 2012; Whitchurch, 2006, 2008; Whitchurch & Gordon, 2009; Whitchurch & Gordon, 2010; Winberg, 2008; Winter, 2009). These changes are occurring at many levels, all of which have the potential to impact on the professional identity of academics. McAlpine and Akerlind (2010) suggest that: "While individuals create their own personal meaning and identity around academic practice, this practice is also situated within particular socio-geographical-historical contexts, that is, individual experience of academic work is situated within a series of nested contexts" (Kindle Locations 373-375).

As a member of various communities, each defined by their own semantics, structures, histories and culture, the academic can be viewed as an "embedded individual" (Kogan, 2000, p. 210). Kogan (2000) identifies and classifies the communities which have direct influence on the formation of academic identities into two types, namely: internal and external academic communities. The internal community includes the discipline, faculty or department within which the academic is located, and the external academic community he describes as encompassing widening circles, starting with the institution, and extending outwards to the societal and world level.

3.3.2.1 External communities and academic identity

At an institutional level, there are many changes within higher education, with universities being under pressure "to adapt to new demands and initiatives" (Qualter & Willis, 2012, p. 121), particularly notable in the milieu of an economic recession, "when governments turn to universities to contribute more directly to economic recovery whilst at the same time imposing financial cuts" (p. 121). At the same time, what Qualter and Willis (2012, p. 123) describe as a "neoliberal reform agenda" has led to "market forces, business discipline and managerial control" being imposed on many sectors of the public sector, including higher education.

Citing several authors, Winter (2009, p. 121) noted that at that time, "managerialism", with an emphasis on accountability and control, has remodelled "all aspects of academic work and identity around an idealised image of corporate efficiency, a strong managerial culture, entrepreneurialism, and profit-making ideals". He proposed that this resulted in an "identity schism" in the academic environment between those who held values consistent with the managerial milieu (academic managers) and those whose values were inconsistent with it (managed academics). Furthermore, he argued that central to this "schism" was the idea of professional identity, and the "extent to which the academic seeks to separate her/his inner professional self from an outer organisational self that privileges commercial principles and practices and enhances the role and importance of the academic manager" (Winter, 2009, p. 122).

In addition to the changing nature and function of universities and an increase in the variety of roles played by academics, summarising the work of various authors, Winberg (2008, p. 353) listed other changes within university environments, that were also viewed as influencing the identity formation of academic staff. These included increased numbers of

students enrolled in higher education institution - often termed massification - and greater diversity among student populations worldwide.

Within the South African context, both massification and increased diversity could become an even greater factor, with the Minister of Higher Education, Blade Nzimande (Department of Higher Education and Training, 2012) suggesting that the number of enrolled students has to increase by approximately 70% in the next 15 years. Furthermore, Winberg suggested that in South African higher education there have been significant changes to the demographic composition of student populations, with an increase in the numbers of black students who, as a consequence of apartheid educational policies, are generally under-prepared for higher education. She also contended that "mergers and incorporations, changes to governance structures, new funding formulae, new policies and new legislation for higher education … have impacted on the nature of academic work and identity in South African higher education" (Winberg, 2008, p. 353). Additional changes are proposed, as the government seeks to address issues such as: low success and throughput rates; low numbers of postgraduates, especially PhD graduates; poor student support structures, an aging academic population; and a shortage of academic staff, particularly in scarce skill areas (Department of Higher Education and Training, 2012). With respect to academic staff, the Department of Higher Education and Training (2012) highlights the need to address issues such as: heavy teaching loads as a result of increased student numbers; staff shortages; low funding for research; poor through-flow of postgraduate students into academic careers; age, racial and gender imbalances; greater staff support and development; upgrading of academic postgraduate qualifications; upgrading of teaching qualifications of academics; and the overall quality of academics. These potential changes each have the ability to further alter the context within which academics in South Africa work, and will certainly impact on their academic identities.

3.3.2.2 Identity and the discipline

Several authors have suggested that, in addition to institutional factors, the discipline within which the individual is located also plays a key role in the formation of academic identity (Becher & Trowler, 2001; Henkel, 2000, 2005; Jawitz, 2009; Malcolm & Zukas, 2009; Neumann, 2001). From semi-structured interviews conducted over eight years with 20 academics in the UK and Australia, Malcolm and Zukas (2007) suggested that there was an inextricable link between discipline, research, pedagogy and academic identity, and that the discipline was of great significance in the daily working life of many academics. Universities are commonly created "physically, organisationally, culturally, managerially and in many

other ways by discipline" (Malcolm & Zukas, 2009, p. 498) Within higher education, discipline, supported by a distinctive knowledge base, is considered to be a central organisational mechanism, and provides the contextual framework within which academics construct their values, beliefs, teaching practices, identities and sense of self-worth (Henkel, 2000, 2005; Jawitz, 2009; Malcolm & Zukas, 2009; Neumann, 2001). As Becher and Trowler (2001, p. 47) suggest, belonging to a "disciplinary community involves a sense of identity and personal commitment".

In a paper drawing on the results of two research projects exploring the implications of policy change in the UK for academic identities, Henkel (2005, p. 166) concludes that, despite the dominance of discipline as an organising structure within universities being severely challenged by policy changes, the discipline remains a primary source of both meaning, values and self-esteem. She suggested that making a distinguishable personal contribution, within a discipline, was of key importance to academics. It is often a passion for a subject within a particular discipline that leads to an individual choosing academia as a career (Kreber, 2010). It is also this connection with a subject or discipline that Palmer (1998) describes as an integral component of teacher integrity, or authenticity. From the evidence gathered in their study, Malcolm and Zukas (2009, p. 499) suggested that academics often refer to their work "primarily as disciplinary endeavour, rather than as 'research' or 'teaching'", and that research and teaching are viewed as a means for both teachers and students to "produce disciplinary knowledge". The notion, for academics, that their work both "proceeds from and constructs the discipline and occurs within it, wherever they may be situated in time and space" (Malcolm & Zukas, 2009, p. 499) is a "unifying and positive factor" (p. 499), which supports a sense of the contribution one is able to make, and the manner in which one's sense of self as an academic is partially constructed.

3.3.3 Relational aspects of academic identity and its construction through narrative

In introducing their concept of the academic identity-trajectory, McAlpine and co-authors (2010, Kindle Location 2966) suggest that academic identity is "interwoven into the fabric of personal experiences and relationships". In the same vein, Henkel (2005) contended that it was "within the context of social institutions and relationships" that academic identity is constructed. She further suggested that academic identity may be viewed as a function of membership of a community, and was formed in the interactions between the individual and the discipline and institution. Qualter and Willis (2012, p. 127) further extended these

concepts by suggesting that academic identity is formed through engagement with other academics: “through mutual recognition of the status of members of the discipline”.

Returning to Wenger’s notion of communities of practice (see Section 3.2.2.1), Wenger (1998, p. 149) argued that it was through participation with others that one experienced one’s self, and negotiated this experience through the manner in which others “reify us”, thus suggesting that we find legitimation for our own identity in relationship with others. Within the academic environment, the communities of practice can be numerous, including both the external and internal communities discussed in the previous section, and all the networks included in the networking strand proposed by McAlpine and co-authors (2010) (Section 3.3.1.4). In describing the networking strand of their academic identity-trajectory model, McAlpine and co-authors suggest that it includes “the range of local, national and international networks an individual has been and is connected with”. These networks include: 1. academic colleagues – fellow staff and post-graduate students; 2. practicing professionals – particularly relevant to academics in professional schools and departments; 3. fellow members of academic bodies in the external community – such as those serving on review boards; 4. other academics who the individual acknowledges as contributing to their intellectual thinking; 5. the journals particular to the individual’s discipline; and 6. other academics, students and professionals with whom the individual collaborates in research and publications. The networks described by McAlpine and co-authors appear to be largely research based; I would therefore want to expand the list to all those networks that develop around: 1. issues of teaching and learning, very specifically including also the undergraduate students; 2. administrative and managerial issues, and 3. networks that develop in the service activities of academics.

Since academics often perceive themselves as being at home within a discipline, it is both within the discipline, and around the shared subject of a discipline, that the majority of their relationships at work are located. Although a shared discipline does provide the basis for “collectivity and communal bonding” (Kogan, 2000, p. 213), academic relationships are not always collegial in nature. As Kogan (2000, p. 213) states, they may not always be characterised by “sweet heart behaviour” and often relationships with those in the same discipline and “closest to each other in subject interests” can be the source of the fiercest criticism and competition. Archer (2008, p. 386) goes so far as to describe academia as a “contested territory”, suggesting that central to the formation of social relations within the academic environment are issues of authenticity and legitimacy – “with individuals and groups competing to ensure that their particular interests, characteristics and identities are accorded recognition and value”. Following Colley and James (2005), Archer (2008) views

identity as “disrupted processes” (p. 387), which are not only about “becoming”, but also “unbecoming” (p. 387). She states that “becoming an academic is not smooth, straightforward, linear or automatic, but can also involve conflict and instances of inauthenticity, marginalisation and exclusion” (p. 387).

Within this “contested territory”, it may be helpful to return to the concept of authenticity (or integrity) as it was discussed in Section 3.3.1.2. As was suggested, authenticity has the potential to create a milieu in which “vital connections”, between teacher and subject, teacher and student, and student and subject, are fostered. Authenticity also has the capacity to open the individual to caring, which reciprocally can lead to greater openness to oneself and others, and a more developed sense of identity. Grounded in their research involving 23 academics at three universities in Canada, Cranton and Carusetta (2004) theorise that an individual who has a well-developed awareness of the humanness of others is more inclined to authenticity in teaching, and such authenticity has the potential to develop, as awareness of others develops. However according to Akerlind and McAlpine (2010) “central to an identity perspective is individual variation in intentions” (Kindle Location 3688). That is to suggest that identity and the meaning an individual attributes to it, emerge from and are formed

> … in the kinds of actions and interactions individuals engage in and respond to as they endeavour to contribute to the dynamics of academic life in ways that they hope are distinct, yet also collectively valued by their academic community – that help develop a feeling of belonging. Their personal values, motivations, perceptions of rewards and challenges are all present (implicitly or explicitly) in how they evaluate their past and present and create hopes and desires for the future. Equally important and varied are underlying values and emotions, both positive and negative, which influence how academic work is experienced. (Akerlind & McAlpine, 2010, Kindle Locations 3695-3700).

Shreeve (2011) argues that the ability to successfully manage the various aspects of the academic role is essentially an issue of identity, suggesting that when the various facets of an individual’s “identity are not reconciled” (p. 87), it can result in a lack of true engagement with the academy. She further purports that there are contextual factors of both a personal and social nature which need to be taken into account in the negotiation of identity and that the academy needs to create spaces within which academics can express and position themselves.

Reflection on experiences and informal learning through interactions with others provides one manner in which academics can make personal sense and meaning of their experiences, and "create a personal perspective on what being an academic means to them" (Akerlind & McAlpine, 2010, Kindle Location 3704) - in other words develop their academic identity. In the context of academic identity construction, McCormack (2009, p. 146) offers that reflection can be defined as "an interactive dialogue with self, and between self and others, involving looking to the past from the present with an eye to the future". In the relational context, reflection would then include dialogue with others; academic identity can therefore be negotiated and constructed through dialogue with others. Returning to the discussion on construction of identity through narrative in Section 3.1.2.4, it would follow that through the telling of an academic life-story, not only can an individual describe or define themselves, but they can also be enabled to understand themselves more fully, in context, and even be enabled to form or re-form their identity. From her work with doctoral supervisors McCormack (2009, p. 144) offered that stories can serve as mirrors through which we can "see multiple selves not just the back to front image we see on first looking". Suggesting that there are multiple layers to who we are beyond the obvious, and the telling of stories enables these levels to be revealed and become evident. She further proposed that stories that were capable of facilitating this process are characterised by authenticity, plausibility, a rich context in which "nothing is hidden" and "emotions are exposed" (p. 145), and they are detailed. Furthermore, they use a traditional story framework and they need to be elicited within a supportive environment.

Although narrative has the potential for enhancing self-understanding and for the construction of identity, "telling stories about troubles" is also a way of coming to terms with an altered identity (Mewburn, 2011, p. 322). As Mewburn (2011) suggests, negative talk can often dominate academic dialogue, but when represented humorously, or used in generative ways, it can be used to understand work and to "fashion, manage, rework and resist" multiple identities.

As with professional identity (Section 3.2), academic identity also brings forth a sense of agency, having the "capacity to perceive personal goals towards which one is directing action" and narrative or identity talk is a way to both express personal goals and to negotiate them with others (McAlpine & Amundsen, 2009, p. 112). In other words, "agency represents the fact that … individuals generally, construct their histories, 're-story' themselves, in terms of personal intentions and the ability to influence in various ways the experiences they have" (McAlpine & Amundsen, 2009, p. 112).

Within the dynamic academic context, telling one's story moves beyond a simple recounting of events and experiences, but rather creates "spaces for understanding our selves as multiple and diverse, as a work-in-progress, constantly evolving, growing, shifting and changing" (Whelan, Huber, Rose, Davies, & Clandinin, 2001, p. 148). Story-telling, or narrative, expresses the experiences and values of the narrator, and provides opportunity for identity construction, allowing for expression of the complex, multifaceted, contextual, dynamic and relational nature of academic identity.

3.3.4 Academic identity issues for those teaching on professional programmes

The complex and multifaceted nature of academic identity is further compounded for academics teaching on professional or vocational programmes, such as, amongst others, pharmacy, medicine, law or psychology. Holroyd (2000) argued that such academics often had a sense of confusion about the basis of their professional identity. Despite the notion that their identity should be founded on their "sense of unity with their peers in the academy", they recognise that, in practice, it is located within the professions for which they are preparing their students (Holroyd, 2000, p. 41). Furthermore, many of them may have begun their own studies with a perceived "calling" to a profession, and now find themselves in a university, where their primary activities are those of teaching and research. In general, they may have been successful in their careers as professionals, and it is because of their industrial or commercial experience and expertise that they may have been appointed to a teaching position (Boyd & Smith, 2011; Shreeve, 2011). Although they have the relevant vocational qualifications, and may be acknowledged experts in particular disciplines, for the most part, their teaching skills have been acquired and developed experientially, and are not grounded in a solid scientific, research-led knowledge base; they have learnt to teach "on the job" (McShane, 2005; Viskovic & Robson, 2001). The unvoiced assumption is often made that since they have previously demonstrated proficiency in learning and in the skills necessary for their vocational roles, they will become effective teachers (Reybold, 2008; Trowler & Knight, 2000). Shreeve (2011, p. 80) even goes so far as to suggest that the relationship between practice and teaching ability is often oversimplified, and it is often assumed that because they have been effective practitioners there will be "a kind of osmosis of knowledge from the presence of professional practitioner to students".

In her "Professional Identity Transition Theory", Kember (2011) proposes that a change in career, which necessitates a change in practice community, impacts on the knowledge and expertise, confidence, expectations, beliefs and motivations of professionals. Furthermore,

she posits that the change is often accompanied by “transitional shock”, which impacts - to varying degrees - on professional identity. The acknowledgement and recognition of previously developed knowledge and expertise within the new work environment appears to be central to the success of the transition process (Mayotte, 2003).

Citing several studies Williams (2010) described the struggles that people have in making career-changes into teaching. These include: maintaining a strong identity with their previous career, which often impacts on their identity within their new role as teacher, and their willingness to learn the skills required within it; a reluctance to be relegated to the role of novice within the teaching environment; and a belief that their content knowledge is sufficient to be a teacher, and that knowledge of pedagogy is not required. Furthermore, they tended to default to the pedagogical understandings that were predominant during their own learning, which tended to be more traditional and teacher-dominated in nature, rather than being willing to learn and adopt more current learner-focused perspectives.

By way of an example from another healthcare profession, the challenges and culture shock faced by nurses who make the transition from clinician to educator within the academic environment are well described by Andrew, Ferguson, Wilkie, Corcoran, and Simpson (2009). They propose that “becoming an academic involves a socialisation process that leads the individual on a journey, either moving from one organisation to another, or often requiring them to span two organisational cultures, one, clinical and known territory, the other educational and unknown” (p. 609).

In a UK based study to explore the experiences of new physiotherapy lecturers making the shift from clinical practice into academia, Hurst (2010) revealed that the experiences of change were multifaceted, and unique to the individual. The experiences and the formation of academic identity were heavily influenced by both professional practice and life experiences, and by the support mechanisms within the academic institution. Some of the key tensions identified included initial periods of uncertainty, and a lack of confidence, related to perceived credibility as a lecturer. In contrast to the findings of Williams (2010), the participants in Hurst’s study described the need to develop pedagogical knowledge and skills as a key challenge.

Smith and Boyd (2012) investigating the experiences of new university lecturers in nursing, midwifery and allied health professions in the UK, found that the lecturers saw teaching as a priority, to which they gave the bulk of their time and energy. Many of the lecturers in their study had made mid-career changes to teaching, after first establishing themselves as expert

clinicians with associated clinical practices and identities. In general, they found the transition to higher education an enjoyable challenge in which they were well supported and motivated by the opportunity to nurture the development of new practitioners. However, many of the new lecturers expressed difficulty with negotiating a perceived lack of clarity concerning the expectations of their academic role, role boundaries and ways of working. They also experienced greater difficulty with maintaining a balance between their work and their personal life. One of the biggest difficulties expressed was the tension experienced from the underlying pressure to complete a doctorate and engage in research, and they viewed this as a contradiction to their priority for teaching. Furthermore, the researchers demonstrated that it was these academic workplace experiences of newly appointed lecturers that made them reluctant to let go of their clinician-related identity and credibility, and slow to adopt new identities as scholars and researchers within their professional fields. A general feeling was expressed that sustained support in the development of scholarship and research skills could be a critical factor in the building of an academic identity. The researchers suggested that Wenger's (1998) focus on the relationship between practice and identity was of significance in that observation. Faced with negotiating a path through multiple and often interwoven trajectories of identity, new lecturers appeared to cling to their existing identity trajectory as clinicians or practitioners and as mentors of new practitioners, and avoided focussing on developing new identity trajectories as educators or as researchers within their professional field. As Smith and Boyd (2012, p. 65) suggest, "it is the clinical practice and procedural knowledge elements of the professional field that appear to have a priority status in the minds and practices of these new lecturers".

This highlights the perception that teaching on vocational programmes often requires of academic staff, membership of, and varying levels of participation in, at least two communities of practice - a vocational or occupational community, as well as the academic community. Simultaneously, whilst negotiating membership of the academic community, faculty staff experience the responsibility and the demand to sustain competence within their discipline, and a level of standing within their occupational communities of practice. Credibility and perceived success of vocational educators is also often bound to their vocational practice experience, and it is also often within occupational communities that identity is not only gained and defined, but is socially legitimated. In this respect, higher education can be thought of as a "community of communities" and vocational educators can be viewed as members of multiple communities of practice (Winberg, 2008). As Winberg (2008, p. 354) proposed "within this community of communities, special interest groups, project groups, and various other work groups can form, sub-cultures can develop, and academic identities can develop and change".

Viskovic and Robson (2001) advocated that it was difficult to establish or retain links with a vocational or professional group or community, whilst becoming or being a member of another community, such as an academic community. They further suggested that it can create tension for both individuals and communities, since as Smith and Boyd (2012) also suggested, the occupational or vocational role is often given priority over the teaching role, by both the educators and the policy makers, with the result that teaching as an activity often becomes "devalued" (Viskovic & Robson, 2001, p. 223). Consequently, many vocational educators do not become fully participating members of a wider teaching community.

It is in this context that James (2005) suggested that being an educator or an academic was "no longer straightforward", especially when considering the membership of multiple communities of practice, both within and beyond the academic environment. Participation in the community of higher education no longer holds centrality of focus for the educator, and their professional identity is both developed and achieved through multiple settings and collective groupings. However, as Wenger (1998) argued, the experience of multi-membership is central to the concept of identity and that the work of "reconciliation" is necessary to nurture and sustain an identity across community boundaries. It is both within these communities and at the interface between them, that culture is constructed and lived out, and where professional identities are formed and re-formed.

3.4 Conclusions

Identity in all its manifestations is complex, yet being able to understand more fully and address the question, "who am I?" is important in structuring, knowing, and understanding one's beliefs, values and practices; in having the capacity or agency to control them; and in being able to situate oneself within society. Through a review, in the preceding sections, of some body of literature on personal identity theories, the multifaceted, contextual, relational, dynamic, and constructional nature of identity, proposed by Rodgers and Scott (2008) was brought to the fore. This was then used as a framework to review specific literature pertaining to both professional and academic identities.

At all levels, identity is contextual. In the complexity of modern society, our lives are often lived as a "nexus of multi-membership" we inhabit. We find our sense of belonging in multiple communities, each with its own contextual forces, shaping and forming the manner in which we see ourselves. It is our contexts which provide us with the array of social interactions and relationships through which we define ourselves, in relation to others. We heighten our sense of "who we are" and also "who we are not", through our sense of belonging, and through the

"kind of person" others recognise us as being. In our struggle to confront, adapt to and make meaning of competing points of view, role demands and expectations, and multiple forms of belonging, our identity is negotiated and formed.

Identity is however not fixed or unitary, it is multifaceted and dynamic. Comprised of many aspects, identity formation is a continual and constantly changing process. Trying to describe identity has delightfully been equated with attempting to "collapse a video clip into a snapshot" (Sfard & Prusak, 2005, p. 16). It is in this respect therefore, that the use of narrative, the telling life-stories, provides a valuable means for reflecting on, constructing, and reconstructing, identities.

The many dimensions and conceptualisations of professional identity discussed provide a framework from which academic identity, a distinct form of professional identity, can be more clearly understood. For example, the formation and negotiation of academic identity across multiple exterior and interior communities, including the university, the discipline, the teaching and research communities, and practice communities outside of the university, can be more fully comprehended through an understanding of Wenger's communities of practice model; or Lave and Wenger's apprenticeship model where doctoral studies can be viewed as entry into an academic career.

Of particular relevance to this study, which seeks to identify, describe and analyse the self-perceived professional identity of pharmacy educators within the South African context, the full complexity of, and the nature of issues around the negotiation of academic identity for those teaching on professional programmes, were highlighted.

As was argued in Chapter 2, in order to move the pharmacy profession closer to embodying it's defining philosophy of pharmaceutical care, pharmacy education needs to widen it's focus from: what is taught – the curriculum; why it is taught – the philosophy; and, strategies - how it is taught, to include a focus on who it is that teaches – the pharmacy academics or educators. In the light of this chapter, it becomes clear, therefore, that we need to give attention to the identity of pharmacy educators. Identifying and describing "who it is" that teaches pharmacy students - may provide a platform for facilitating what Smith (2000, p. 10) describes as the "heavy mental work" of self-reflection by pharmacy educators and the negotiation of their professional and academic identities, which in turn may lead to enhanced authenticity and greater effectiveness.

CHAPTER 4

METHODOLOGY

4.1 Introduction

The current study made use of a qualitative, constructivist-interpretive approach and methodological triangulation to explore, analyse and describe pharmacy educators' self-perceived professional identities. The factors which contributed to the formation of their professional identities, their beliefs about pharmaceutical care and pharmacy practice and their perceived role in the education and the formation of future pharmacists were also described and analysed.

In this chapter the rationale for adopting a constructivist-interpretive framework with a qualitative approach will be described. In addition, the specific qualitative methods utilised for data collection and analysis will be discussed. A detailed description of the recruitment of participants, data collection and analysis will also be provided. Lastly discussion of the role of the researcher, issues of ethics and the trustworthiness of data will also be provided.

4.2 Research approach and paradigm

In determining and understanding the design of a research project, it is not only important to have clarity with respect to the study objectives but also to have a clear understanding of the implicit and explicit assumptions upon which the study is based and to select the paradigm, research approach, methodology and methods accordingly. In order to do this however an understanding of the various research paradigms and approaches is necessary. In this section I will provide a brief overview of some of the major research paradigms, particularly in the context of qualitative research and also explain the reasoning for adopting a constructivist-interpretive paradigm.

4.2.1 Quantitative and qualitative research traditions

There are essentially two fundamental research traditions, the quantitative tradition and the qualitative tradition. The difference between the two traditions is frequently described in

terms of the data collected and the methods used in analysis of the data. The quantitative tradition is viewed as being concerned with measurement and is quantitative research approaches that focus on accurately capturing aspects of the social world in terms of numbers which they express as percentages, probabilities, variances, ratios and such like. By contrast although the qualitative tradition is also focused on capturing and describing aspects of the social world, in various ways, numbers are not ordinarily the unit of analysis. (Henning, van Rensburg, & Smit, 2004; King & Horrocks, 2010; Willis, 2007)

However as Willis (2007) argues the fundamental difference between the two traditions does not lie in the type of data collected and the manner in which this data is presented, but rather in the foundational assumptions about the nature of reality and the manner in which knowledge about reality is constructed, that underpins each tradition. He furthermore argues that when approached from the perspective of underlying assumptions, qualitative researchers sometimes use number-based research methods and similarly quantitative researchers use what are generally considered to be qualitative research data and methods.

Furthermore, within each these two research traditions there are various paradigms which differ in their assumptions and implications. A paradigm can be defined as a "set of interrelated assumptions about the social world which provides a philosophical and conceptual framework for the organised study of that world" (Filstead, 1979, p. 34). Guba and Lincoln (1994, p. 107) propose that a paradigm is a "set of basic beliefs" that underlie a "worldview that defines for its holder, the nature of the 'world', the individual's place in it and the range of possible relationships in it".

Research paradigms are normally described in terms of their ontological and epistemological stances. *Ontology* concerns the nature or philosophy of reality and being and *epistemology* refers to the nature or philosophy of knowledge and knowing, or how we come to know (Guba & Lincoln, 1994; Krauss, 2005; Ponterotto, 2005). By understanding the epistemology and the ontology of a research paradigm, and positioning a research study in terms of them, the philosophical assumptions underlying the study can be understood. Furthermore, the epistemology and ontology guide the researcher's choice of research methodology and methods (Denzin & Lincoln, 2000). *Methodology* describes the processes involved in making evident and justifying the design of a research project and the selection of the research methods which are the practices and techniques used to collect and analyse data (Guba & Lincoln, 1994; King & Horrocks, 2010; Krauss, 2005).

4.2.1.1 The quantitative tradition

From an ontological perspective the quantitative tradition is essentially *realist.* Simply stated a realist ontology views the real world as being "out there" and existing "independently from us" (King & Horrocks, 2010, p. 9). The world is viewed as being comprised of objects and structures that are governed by undeniable natural laws and mechanisms that have detectable cause and effect relationships (King & Horrocks, 2010; Willis, 2007). Moreover underpinning the quantitative research tradition is the assumption that these real world objects, structures, laws and mechanisms can be uncovered and described using appropriate methods of data collection and analysis (King & Horrocks, 2010; Willis, 2007). Furthermore they can be summarised in generalisations which are independent of time and context (King & Horrocks, 2010; Willis, 2007). Therefore research in the quantitative tradition is usually *nomothetic* and is concerned with "uncovering general patterns of behaviour that have a normative base" (Ponterotto, 2005, p. 128).

The epistemological stance within a quantitative tradition is normally that of *objectivism.* Since the world and objects are viewed as existing "independently from any subjective consciousness of them" (King & Horrocks, 2010, p. 12), knowledge of reality can be uncovered or revealed through research that is "value-neutral, unbiased by the research/researcher process" (King & Horrocks, 2010, p. 12). It is the objectivist and nomothetic nature of research in the quantitative tradition, which is foundational to the employment of methods which are quantitative and involve careful control of variables. Since as King and Horrocks (2010, p. 12) argue: "Aggregate data across large populations, statistical analysis, replication, generalisation and the reduction of intervening social variables are scientific strategies that claim to make known the 'real' aspects of existence".

The two major research paradigms within the quantitative tradition are positivism and postpositivism. Both are based on a realist ontology that assumes that reality is objective and therefore is focussed on discovering the truth and "proving it through empirical means" (Henning *et al.*, 2004, p. 2). In broad terms they reject metaphysics and suggest that the "goal of knowledge is to describe the phenomena that we experience" (Krauss, 2005, p. 760) and furthermore to "understand the world well enough so that we might predict and control it" (Trochim, 2000). The major difference between the two paradigms is that while positivists "accept an objective apprehendable reality, postpositivists acknowledge an objective reality that is only imperfectly apprehendable" (Ponterotto, 2005, p. 129). Furthermore, postpositivists have reservations about the ability "to know reality with certainty" and believe that "observation is fallible" and subject to error (Trochim, 2000). As a consequence, while the focus in positivism is on verifying theories by conducting scientific research, in

postpositivism the focus is on “theory falsification” (Ponterotto, 2005, p. 129). Postpositivists are of the belief that theories are always subject to revision, and argue that you can never be certain that a theory cannot be proven wrong. Another primary difference between the two paradigms is that a positivist approach uses data to develop generalisable theories, while in postpositivism data are used to test theory (Willis, 2007).

4.2.1.2 Critical theory

Located somewhere between the postpositivist paradigm and the interpretive paradigm of the qualitative tradition is the critical theory paradigm. Some authors suggest that critical theorists share the ontological stance of positivism and postpositivism, in that they adopt a realist approach to reality, which views it as material and external to the human mind (Trochim, 2000; Willis, 2007). While other authors suggest that critical theorists “advocate a reality that is constructed within a social-historical context” (Ponterotto, 2005). However, they seem to be in agreement that central to critical theory is the notion that reality has to be understood in the context of power relationships. The goal of critical theory research is therefore to uncover these power relationships and to consequently help to free and empower oppressed groups (Ponterotto, 2005; Willis, 2007). Thus within a critical paradigm research and practice are integrated activities (Willis, 2007).

Because of the ideological nature of critical theory research, it is value-driven and not limited to any specific type of research methods. The research process is subjective and highly dependent on the values and beliefs of the researcher. Furthermore, although it often employs qualitative approaches, the interpretation of data, from a critical perspective, “entails thoughtful analysis and reflection” (Willis, 2007, p. 86).

4.2.1.3 The qualitative tradition

In contrast to the quantitative tradition and a critical theory paradigm, the qualitative tradition is founded on a *relativist* understanding of the nature of reality. Relativism is the notion that the world or reality is not a “pre-existent ‘real’ entity with objects and structures” (King & Horrocks, 2010, p. 9) but rather it is constructed through people interacting with one another and is “always conditioned by our experiences and our culture” (Willis, 2007, p. 48). Since peoples’ understandings and experiences are related to their particular social and cultural contexts, they are always open to an array of interpretations. Consequently, “relativism is more consistent with the social practices and interactive explanation of how people exist and live in the world” (King & Horrocks, 2010, p. 9). Although influenced by culture and context, relativists recognise that each individual constructs their own version of reality, and

consequently the focus of relativist research is *idiographic*. Idiographic means "applying to the individual" and idiographic research focuses on "understanding the individual as a unique, complex entity" (Ponterotto, 2005, p. 128).

The viewpoint of qualitative researchers is that individuals order their perceptions of reality in order to create meaning and that cognition or the meaning-making process is integral to meaning and not external to it (Krauss, 2005; Ponterotto, 2005). Furthermore, in qualitative research the interaction between the researcher and the participant or participants is integral to the construction of knowledge. This suggests that the epistemology underpinning qualitative research is subjectivist in that "the knower and subject construct understandings" (Denzin & Lincoln, 1998, p. 27).

In short then, qualitative research therefore involves the social construction of reality where the emphasis is on meaning and experience, and the relationship between the researcher and the researched is central (Denzin & Lincoln, 1994). However, the manner in which people interact and subsequently construct their world is highly variable and dependent on context. Therefore, underpinning qualitative research, is the "belief that there is no one truth, and thus consensus is neither necessarily achievable nor a necessary goal." (Johnson & Waterfield, 2004, p. 122).

Qualitative research is, however, an all-encompassing term, used to describe a wide range of research paradigms and methodologies that have been influenced by various philosophical traditions and adopt holistic approaches to study social phenomena (King & Horrocks, 2010; Patton, 2002). However qualitative approaches are generally, although not always, based upon theoretical perspectives which are grounded in an *interpretivist* or a *constructivist-interpretive* paradigm (King & Horrocks, 2010; Ponterotto, 2005).

Table 4.1 provides a summary of the major differences between the positivist, postpositivist, critical theory and interpretivist paradigms. The table is based on the five issues which Willis (2007) views as distinguishing one paradigm from another, namely: the nature of the reality; the purpose of research; acceptable methods and data; the types of meaning and the manner in which meaning is derived from the data gathered, and the relationship between research and practice.

Table 4.1: Differences between the positivist, postpositivist, critical theory and interpretivist research paradigms. (adapted from Willis, 2007, pp. 72, 83, 95)

	POSITIVISM	POSTPOSITIVISM	CRITICAL THEORY	INTERPRETIVISM
Nature of reality	Material and external to the human mind	Material and external to the human mind	Material and external to the human mind	Socially constructed
Purpose of research	Find universals	Find universals	Uncover local instances of universal power relationships and empower the oppressed	Reflect understanding
Acceptable methods and data	• Scientific method • Objective data	• Scientific method • Objective data	Subjective inquiry based on ideology and values; both quantitative and qualitative are acceptable	Subjective and objective research methods are acceptable
Meaning of data	• Mirror to reality • Used to develop theory	• Falsification • Used to test theory	Interpreted through ideology; used to enlighten and emancipate	• Understanding is contextual • Universals are deemphasised
Relationship of research to practice	• Separate activities • Research guides practice	• Separate activities • Research guides practice	• Integrated activities • Research guides practice	• Integrated activities • Both guide and become the other

4.2.1.3.1 Constructivist-interpretive research paradigm

A constructivist-interpretive research paradigm is based on the qualitative tradition's relativist worldview that there is no objective reality (Krauss, 2005), rather there are multiple realities that are constructed by individuals who experience the phenomenon under study. As Ponterotto (2005) suggests constructivist-interpretivism can be traced back to the German philosopher – Immanuel Kant's (1881-1966) *Critique of Pure Reason.* In this work Kant suggested that the cognitive processes involved in processing sensory inputs were integral to human perception and claims about reality. Furthermore, it is a paradigm that emerged out of Edmund Husserl's phenomenology philosophy and Wilhelm Dilthey and other German philosophers' study of interpretive understanding – hermeneutics (Mackenzie & Knipe, 2006; Miles & Huberman, 1994), which recognises that "being and doing are intimately connected"

(Given, 2008, p. 464). Consequently, the "divide between interpretive research and practice is not great" (Willis, 2007, p. 117) and both have the potential to impact on the other.

Furthermore, as Krauss (2005, p. 761) suggests, within a constructivist-interpretive paradigm "the knower and the known are co-created during the inquiry". Therefore, as Miles and Huberman (1994, p. 8) argue, researchers with their own historical and cultural backgrounds have personal understandings, opinions, beliefs and "conceptual orientations". Consequently the researcher in a constructivist-interpretive paradigm recognises and acknowledges the impact of their own background, experiences and beliefs on the research process (Mackenzie & Knipe, 2006). And as Ponterotto (Ponterotto, 2005, p. 131) suggests, rather than attempting to eliminate their own influence on the research, the researcher should "acknowledge, describe and 'bracket' his or her values"

Acknowledging the integral role of the researcher, an interpretivist approach to research seeks contextual understanding of a particular phenomenon and is concerned with the *situatedness* of knowledge (Willis, 2007). Thus the goal of research in this paradigm is "an understanding of a particular situation or context" rather the discovery of universals and the development of theories or laws to support them (Willis, 2007, p. 99). It can also provide the basis for deep insight into "the complex world of lived experience from the point of view of those who live it" (Schwandt, 1994, p. 118). The constructivist-interpretive approach is summed up well by Ponterotto (2005, p. 131): "Constructivists–interpretivists advocate a transactional and subjectivist stance that maintains that reality is socially constructed and, therefore, the dynamic interaction between researcher and participant is central to capturing and describing the "lived experience" (*Erlebnis*) of the participant".

Interpretivists are of the belief that "there is no particular right or correct path to knowledge, no special method that automatically leads to intellectual progress" (Smith, 1993, p. 120 cited by Willis, 2007, p. 109). Consequently, a variety of methods, including those normally associated with quantitative research, are permissible within this paradigm. However, since contextual understanding is so central to this research paradigm, which is based on a subjectivist epistemology, "data sources that are close to the point of application" are favoured (Willis, 2007, p. 111) and "professional practice knowledge is elevated to a position that is often considered superior to knowledge based on out-of-context empirical research" (Willis, 2007, p. 111).

Significant features of interpretive qualitative research are an emphasis on descriptive data and emergent research design. Qualitative inquiry predominantly deals with data that are in the form of words, rather than numbers and statistics and focuses on developing an

interpretation of that data that explores the meaning of the data under study. Qualitative designs cannot usually be prescriptively described in advance but require adequate flexibility to allow for exploration of emergent themes and concepts.

Denzin and Lincoln (1994, p. 2) broadly define qualitative research in the constructivist-interpretive paradigm as:

> … multi-method in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them. Qualitative research involves the studied use and collection of a variety of empirical materials – case study, personal experience, introspective, life story, interview, observational, historical, interactional, and visual texts - that describe routine and problematic moments and meanings in individuals' lives. Accordingly, qualitative research deploys a wide range of interconnected methods, hoping always to get a better fix on the subject matter at hand.

4.2.2 Locating this study within a constructivist-interpretive paradigm

The primary aim of this study, described in Section 1.2 was to identify, analyse and describe the self-perceived professional identities of pharmacy educators within the South African context. Furthermore, its objectives were to describe the many factors which might have contributed to the formation of their professional identities, including participation in multiple communities of practice and to determine the attitudes, beliefs and behaviours of the participants with respect to the philosophy and practice of pharmacy, pharmaceutical care and pharmaceutical education. In essence the study was seeking to provide or reflect an in-depth understanding of a complex concept – the professional identities of pharmacy educators. Although professional identity is a form of social or collective identity, it remains an *individual-based* perception of what defines the "us" associated with group membership (Onorato & Turner, 2004, p. 259) (see Section 3.1.1). The focus of the study was therefore on the individual participants and idiographic in nature and there was no intention to create universal or generalisable theories.

Within the context of the identity literature reviewed in Chapter 3, it became apparent that by its very nature identity is contextual, relational, dynamic and constructed through narrative (Rodgers & Scott, 2008) (see Section 3.1.2). Identity is a social construct that is dependent

on the “personal, ethnic and national context” within which it is constructed (Billot, 2010, p. 711). Moreover, identity is formed through and in relationship and therefore “necessarily becomes a multiple and shifting affair, in process and changeable” (Rodgers & Scott, 2008, p. 736). And it is through the ability of narrative to transform “knowing into telling” that identities can be constructed (Dyer & Keller-Cohen, 2000, p. 284)

Furthermore, as described in Chapter 1, the study emerged from my own personal story, experiences, and beliefs, and as the researcher I recognised the subjective nature of the study. I also acknowledged that through the study I was not only looking to deepen collective understanding of the professional identities of pharmacy educators, but to provide opportunity for the study participants, and myself, to do what Smith (2000, p. 10) describes as the “heavy mental work” of deep reflection on “who” we are as educators.

For all of these reasons, it seemed appropriate that this study should not only be located within the qualitative research tradition but more specifically be situated in a constructivist-interpretive paradigm. Within this paradigm, the focus is primarily on understanding and producing descriptive analyses that highlight deep, interpretive understandings of multiple perceptions and experiences. This is consistent with the aims and objectives of the study which sought to understand and describe the perceptions and beliefs of pharmacy educators. Moreover the underlying intentions of this study and the assumptions regarding the nature of identity which became evident in the literature review are congruent with the philosophical foundations underpinning the constructivist-interpretive research paradigm.

4.3 Research design and process

Research design is concerned with translating the epistemological and ontological assumptions of the research paradigm into “distinct methodological strategies” which support the research objectives (Krauss, 2005, p. 764). When the research objectives are concerned with describing deep understanding of complex human experience and perceptions, such as identity, it is as Denzin and Lincoln (1994, p. 2) propose, useful to employ a “wide range of interconnected methods” in an effort to get “a better fix on the subject matter at hand”. Furthermore, the use of diverse methods of gathering data from various sources “can provide richer data, encourage reflexivity and help to increase the comprehensive understanding of phenomena” (Johnson & Waterfield, 2004, p. 126).

Therefore in order to both enhance understanding and provide for a level of “completeness”, and in keeping with the notion underlying qualitative research that there is no single truth and consensus is not the goal, methodological triangulation was employed in this study (Johnson

& Waterfield, 2004, p. 126). Triangulation involves the researcher gathering data from different sources or from using different research methods. Denzin (1978) identifies four basic types of triangulation: 1. data triangulation where a variety of data sources are used; 2. investigator triangulation which makes use of several different researchers; 3. theory triangulation which makes use of multiple theories in the interpretation of a single set of data, and; 4. methodological triangulation in which multiple methods are used to study a single problem.

This study was conducted in three phases (Figure 4.1), and each phase made use of a different method. The first phase employed narrative interviews and narrative analysis (Clandinin & Connelly, 2000) to gain an in-depth understanding of pharmacy educators' perceived professional identity and to explore how their lived experiences, across various communities of practice, formed their self-concept. A focus group approach was used in the second phase, to explore, within a broader interactive context, some of the factors and communities of practice identified by participants in the first phase, as contributing to development of professional identity. The third phase of the study made use a purpose-designed qualitative questionnaire, developed from the insights gained in the first and second phases, to further explore the self-perceived professional identity, attitudes, beliefs and practices related to pharmaceutical care and the socialisation of students into the pharmacy profession, with a wider base of pharmacy educators in South Africa. The emphasis on widening the participation base throughout the three phases was on deepening understanding rather than trying to explore universals in order to develop generalisable theories.

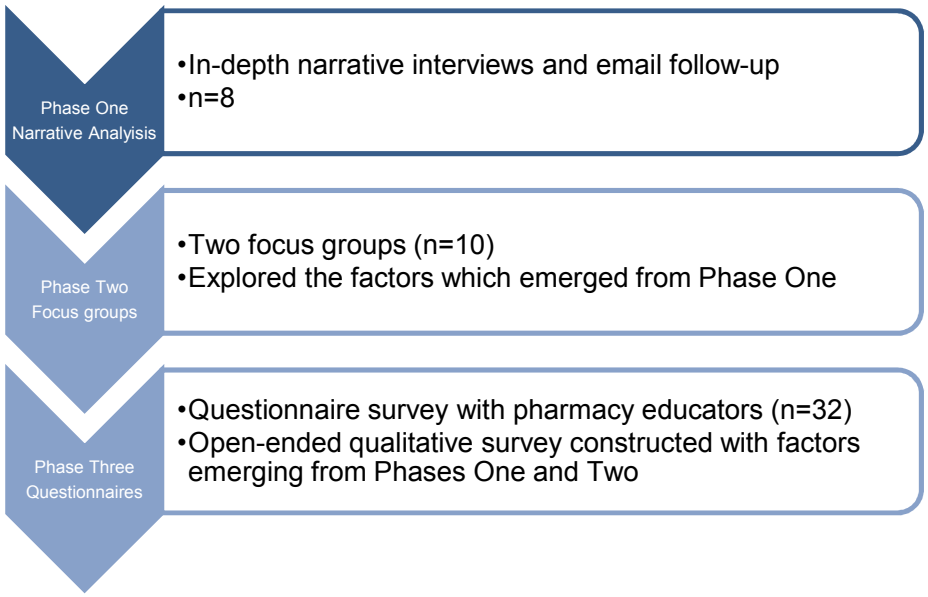

Figure 4.1: Three phases of the research process

Throughout these three phases, as the researcher, I adopted an emergent or flexible approach to the research. In adopting this approach, I reserved the right to explore unexpected findings that may have contributed to the understanding of the participants' experiences, if and when they materialised. This feature of qualitative research that allows unexpected discoveries to be explored by the researcher if they emerge is called "emergent design flexibility" (Patton, 2002, p. 244).

4.3.1 Phase 1: Narrative analysis

This first phase of the study employed a thematic narrative method of analysis of in-depth narrative interviews in order to explore the self-perceived professional identity of eight pharmacy educators and to determine how their experiences, as lived and told through stories, formed the basis for their professional identity. Narrative analysis is a cluster of analytical methods used for analysing texts that have a storied format in common (Riessman, 2008). Riessman (2008) classifies these narrative analysis approaches into two broad types, thematic and structural. The thematic approach seeks to explore and uncover meaning within a story or stories, while the structural approach focuses on the composition of a story or stories to identify "particular communicative aims" (Riessman, 2008, p. 539).

Narrative analysis is a form of qualititative research which Clandinin and Connelly (2000, p. 20) define as

> … a way of understanding experience. It is collaboration between researcher and participants, over time, in a place or series of places, and in social interaction with milieus. An inquirer enters this matrix in the midst and progresses in this same spirit, concluding the inquiry still in the midst of living and telling, reliving and retelling, the stories of the experience that make up people's lives, both individual and social. Simply stated … narrative inquiry is stories lived and told.

They further suggest that it is a research method that uses a variety of field texts, including: stories, autobiography, journals, field notes, letters, conversations, interviews, family stories, photos, other artefacts, and life experience, as data sources (Clandinin & Connelly, 2000). Narrative analysis recognises the extent to which the stories which people tell provide insights into their lived experiences, perceptions and beliefs (Thorne, 2000). Furthermore, the narrative approach, as a qualitative research method has been recognised for its acknowledgment of the subjective experiences of individuals (Parker, 2005).

Since identity can be considered to be constructed through narrative (see Section 3.1.2.4), as Robertson (1998, p. 1) proposes, narrative analysis provides a tool "for getting at the relationship between ideas, experience and action; for understanding how identities are constructed and reconstructed in specific contexts and over time; for explicating 'how things are connected'". Furthermore McCormack (2009, p. 142) suggests that it is through stories that individuals "construct and reconstruct their sense of self as they learn to 'be' in the world". Therefore, narrative analysis is not only a tool for understanding identity, but it is also a means by which the storytellers or participants can also fashion their identity and learn about themselves (Larsson & Sjöblom, 2010). Singer (2004, p. 438) goes so far as to suggest that: "To understand the identity formation process is to understand how individuals craft narratives from experiences, tell these stories internally and to others, and ultimately apply these stories to knowledge of self, other and the world in general".

Stories are characterised by ordering and sequence and therefore they not only have the potential to impart knowledge but to provide insights into how they evolved (Larsson & Sjöblom, 2010). Thus, in addition to revealing and even creating identity, stories have the potential to provide insights into the factors and processes which contributed to the development of identity:

> The individuals and how they position themselves according to agency and their imagination determine what gets included and excluded in the story, how events are put together and what they mean. Individuals piece together past events and actions in their personal narratives to claim identities and construct their lives. (Larsson & Sjöblom, 2010, p. 276).

The words "story" and "narrative" are often used interchangeably, but they are essentially different. As Riley and Hawe (2005, p. 227) suggest, the difference relates to "where the primary data ends and where the analysis of that data begins". The told stories are the primary data, but it is the analysis of the stories through interpretation by the researcher that transform them into narratives. Narrative analysis involves the eliciting and collection of stories and also the analysis or interpretation of these into narratives to make known the meaning." Therefore in narrative analysis, not only is the process of eliciting stories, and the methods used to analyse them important but the relationship between the researcher and the researched is an integral part of the study and can have a significant impact on the narrative interpretation and outcomes (Johnson & Waterfield, 2004; Larsson & Sjöblom, 2010).

In the current study stories were elicited through narrative interviews and analysed using thematic analysis. The emphasis was on what the narratives communicated, rather than on the structure of the narratives. A more detailed account of thematic analysis will be provided in the sections that follow. However, prior to providing a more detailed account of the research process and the specific research methods employed in this study, the role of the researcher needs to be explained.

4.3.1.1 Role of the researcher

Maykut and Morehouse (1994, p. 123) suggest that:

> The qualitative researcher's perspective is perhaps a paradoxical one: it is to be acutely tuned-in to the experiences and meaning systems of others - to indwell - and at the same time to be aware of how one's own biases and preconceptions may be influencing what one is trying to understand.

This is especially true when the researcher is an "insider" and shares the distinctive characteristics, roles, involvements or practices under study with the participants (Corbin Dwyer & Buckle, 2009, p. 55). Being an "insider" can be beneficial since it may provide the researcher "access, entry and common ground" from which to begin the research (Corbin Dwyer & Buckle, 2009, p. 58). However, in order to prevent undue bias and influence on participants' responses and on interpretation of findings the "insider" researcher needs to develop and maintain an acute awareness of his or her personal standpoint and possible predisposition and preconceptions. Furthermore, Connolly (2007, p. 453) proposes that in reporting on narratives, an explicit elucidation of the researcher's stance, social location, personal experiences, and subjectivity, assists in understanding "where the voice of the researcher exists in the narrative". Similarly, Patton (2002) contends that a qualitative researcher needs to maintain a reflexive stance throughout the research process, in order to balance their understanding of the perceptions of participants with that of their own. Citing several authors Nollet (2009, p. 55) argues that a qualitative researcher has to make explicit and "bracket" her preconceptions and biases in order to fully comprehend the research participants' points of view or stories.

Researcher reflexivity which can be defined as "an attitude of attending systematically to the context of knowledge construction, especially to the effect of the researcher, at every step of the research process" is an important aspect of the qualitative research process (Cohen &

Crabtree, 2008). Angen (2000) explains that reflexivity attempts to identify, understand, and value the researcher's seminal participatory role in shaping the data rather than attempting to objectively maintain distance from the research. Citing Sim and Wright (2000), Johnson and Waterfield (2004, p. 128) propose that researcher subjectivity can serve as a research resource, rather than be viewed as a source of bias or error, and that reflexivity can "lend plausibility to the findings". This argument supports the proposal of Mays and Pope (2000) who contend that the explicit disclosure of personal and intellectual biases by the researcher can enhance the credibility of research findings.

Citing Hawes (1998), Russell and Kelly (2002, p. 3) suggest that the goal of reflexivity is to "turn the researcher's gaze back upon oneself for the purpose of separation and differentiation". They further suggest this can be achieved through self-examination of one's personal assumptions and goals, and the elucidation of one's belief systems and biases through the keeping of self-reflective records and journals. In addition, Connolly (2007, p. 453) suggests, that reporting on participants' narratives in a narrative analysis should include an auto-ethnographic report in which the "researcher provides an account of his or her own voice, stance, assumptions, and analytic lens so that the reader is abundantly clear on whose story is whose."

Since this research arises, in part, out of my own (the researcher's) personal interest and questions about my professional identity as a pharmacy educator, it was important in the context of this study to tell and explore my own narrative. Therefore, in Chapter One I provide an auto-ethnographic report. In this manner, my experiences, position and subjectivities have been "bracketed" or made explicit. This not only served to enhance my own awareness of my preconceptions and biases but will hopefully assist the reader in being able to better identify my voice in the reporting and analysis of participant narratives.

Furthermore, in the interests of researcher reflexivity, throughout the research process I maintained a reflective research journal (Ortlipp, 2008). This created a means of critical self-reflection throughout the research process and allowed for examination of my own personal assumptions and beliefs. It also assisted in making the "messiness of the research process" visible to myself and supported understanding and implementation of the research design, methods and approaches.

4.3.1.2 Narrative analysis participants

Eight pharmacy educators, one from each school, department or faculty of pharmacy in South Africa were included as participants in this phase. A maximum variation, purposeful

sampling approach was adopted (Patton, 2002). As Johnson and Waterfield (2004, p. 124) advocate, the aim of the sampling approach in qualitative research is not to achieve "statistical representativeness", but rather to reflect the diversity within the study population. The participants were therefore, as far as possible, diverse in age, gender, race and teaching experience, and representative of the various disciplines within pharmacy.

A summary of the participants' demographic details is provided in Table 5.1, however in the interests of maintaining participant confidentiality, some details, for example race have not been included in the table. There were five female and three male participants and the ages ranged from 29 to 55+. Each of the four traditional subject disciplines within pharmacy: pharmacology, pharmaceutics, pharmaceutical chemistry and pharmacology were represented, as were all of the major racial groups. As indicated in Table 5.1, each participant was allocated a pseudonym. These pseudonyms were allocated by myself after analysing each interview and were chosen to reflect some aspect of the participants' professional identity. In the interpretation of each of the stories in Chapter 5 an explanation of the origin and meaning of each pseudonym is provided. The choice of pseudonym was also checked with each of the participants. All participants indicated that they were satisfied with the selected pseudonym.

The study was aimed specifically at pharmacy educators, who were themselves registered pharmacists and who were not only working within a university environment, but were also teaching on an undergraduate pharmacy programme. The inclusion criteria therefore required participants to be registered with the South African Pharmacy Council as a pharmacist and to be teaching on an undergraduate pharmacy programme.

A general letter requesting permission to invite participation in the study was sent to all the heads or deans of each of the pharmacy departments, schools or faculties at the universities which offer an undergraduate pharmacy programme (Appendix B). These included: Rhodes University, North-West University, University of Limpopo, University of the Western Cape, Nelson Mandela Metropolitan University, University of Kwazulu-Natal, University of Witwatersrand, North-West University, University of Limpopo – Medunsa Campus, and Tshwane University of Technology. A further letter outlining the study and inviting participation was sent, via email, through the heads or deans to all pharmacy educators. (Appendix C). This general invitation only elicited one spontaneous offer of participation. Further potential participants at each university were then identified and personally invited by the researcher via email, to participate. Prior to the interview the participant was asked to complete and sign the consent form (Appendix D).

4.3.1.3 Narrative analysis process

The approach to this phase of the study was based on that outlined by Clandinin and Connelly (2000) and essentially employed a movement between three sets of questions: the transition from field experience to field texts (the interviews and email communication), from field texts to research texts (preparing interview data and email communication for analysis, including transcription from oral speech to written text), and finally from research texts to the research account (including analysing, verifying and reporting).

4.3.1.3.1 The interview process

The field experience consisted of eight in-depth interviews, conducted by the researcher with the participants. Following the interviews, the participants were invited to keep the interview process on-going, through email communication. It was felt that this would provide the participants the opportunity to add any thoughts which might emerge on reflection, after the interview. However, none of the participants did so, and beyond their email responses to the "member checking" process employed to verify the trustworthiness of the data (see Section 5.10) no further email correspondence was included as field text.

The in-depth interviews were essentially conducted as narrative interviews and for the most part focused on eliciting a story from the participants. The interview was the "field experience", which provided the raw material or research data which served as a basis for the ensuing process of interpretation or analysis of meaning. The quality of the interview was therefore fundamental to the quality of the research process (Kvale, 1996). The quality criteria for an interview, described by Kvale (1996, p. 145) include: eliciting "spontaneous, rich, specific and relevant" answers; keeping questions short relative to interviewee's responses; following up, clarifying, interpreting and verifying responses during the interview process. These principles were recognised and adhered to; however, in addition, a narrative interview approach was adopted. This was in-part because of the inexperience of the researcher as an interviewer. Narrative interviews attempt, through the use of storytelling and listening, to go beyond the traditional "questions-response-type" interview (Bauer, 1996, p. 2). By selecting the themes and topics, ordering the questions and wording questions in their own style, researchers in the "questions-response-type" interview impose their own structure on the interview (Bauer, 1996). In narrative interviewing the aim is to "elicit a less imposed and therefore more valid account of the informant's perspective" and to maintain the influence of the researcher on the participant to a minimum (Bauer, 1996, p. 3). Bauer (1996) proposes a four phase interview process, which begins with an introductory phase, moves through the narration and questioning phases and ends with "small talk". In the introductory

phase the context of the research project is explained to the participant in broad terms, following which the participant is invited to tell their story. The narration phase involves the participant telling their story in an uninterrupted manner with the researcher providing non-verbal support only. Once the narration has come to a natural end, the researcher moves the interview into the questioning phase. In a true narrative interview, the questioning phase only involves questions that relate directly to the story, that the researcher feels might benefit from greater elaboration, it does not involve, opinion attitude or cause and effect questions. The interview is then concluded and moves into the "small talk" phase. Bauer suggests that the "small talk" phase can be a very valuable source of contextual information useful for the interpretation of the participant's story.

A narrative interview approach informed the eight in-depth interviews in this study. After an initial introductory phase I invited each participant to tell me their story; "Tell me the story of your career thus far, from what first attracted you into pharmacy to where you find yourself now". The narration phase was allowed to run uninterrupted and my responses were kept to a bare minimum and non-verbal signals of attentive listening were provided when appropriate. Although I was disciplined in keeping questions during this phase to a minimum and in not adding my own comments, the non-verbal responses and the participants knowing that as a pharmacy educator I had a level of "insider" knowledge, created a particular context for the interview. For example, in some of the interviews there was shared laughter which was based on a mutual understanding, between the participant and myself of mutual experiences and issues.

The initial part of the questioning phase regarding the participants' stories involved clarifying various aspects of the stories and was consistent with the classic narrative interview style. However, the interview then moved into the more traditional "questions-response-type" style in which I explored attitudes and beliefs about communities of practice, pharmaceutical care and pharmacy education. During this phase use was also made of the exploration of metaphor as a way to further investigate the participants' professional identity and more particularly their image of themselves as "teacher" and "role model" for students. Participants were invited and asked to explain their perception of themselves as professionals in terms of a metaphor. A metaphor can be defined as "an implied analogy which imaginatively identifies one object with another" (Holman & Hugh, 1980, p. 264). In terms of exploring educator identity McShane (2005) describes the use of metaphor as a "creative linguistic device that enables us to describe a way of being, feeling or doing in terms of another image" – thereby offering "a safe, playful and meaningful way of accessing the professional and psychological orientations of teachers."

By nature of the designated roles of interviewer and participant, the interviewer is normally in control of the path an interview takes. In an attempt to counter this potential power dynamic, the interviews were conducted in the participant's preferred environment. Furthermore questions were non-directive and open-ended in nature, in an effort to evoke a predominantly narrative response from participants, even during the questioning phase. I adopted an open and attentive listening approach, giving careful attention to unexpected and unusual participant response. This was aimed at ensuring that "the participant's own voice is heard and the text is not primarily an interviewer's own creation". (Polkinghorne, 2007, p. 482). Kvale (1996, p. 4) uses the metaphor of the interviewer as "traveller" to depict a conversational, postmodern, constructivist approach to interviewing and social research. I viewed my role as the interviewer, as that of a fellow "traveller" who was "on a journey that leads to a tale to be told on returning home" (Kvale, 1996, p. 4). Although there was an interview protocol (Appendix E) which acted as a guide, each interview was individualised according to both the participant's story and their responses to questions.

The intention was not to restrict the interview to the face-to-face encounter between the participant and myself but to hold it open, via email communication; however, this did not transpire. After transcribing, analysing and constructing the narratives and interpreting them, participants were invited, in what is termed a "member-checking" process, to comment on the narrative, elaborate on their original statements, if considered necessary, and to clarify and correct my interpretations (see Section 5.11). This collaborative approach "dehierarchicalises [*sic*] the relationship between researcher and subject", allowing the interviewee to be a "co-creator of the resulting narrative" (Hadley, 2003, p. 36), and the interpretation thereof.

Prior to conducting the interviews, assisted by a colleague, I subjected myself to the same interview process. This provided invaluable personal insights into the interview process, for example the importance of non-verbal signals of encouragement in the narrative process and the use of the participants' own words in the questioning phase. It also served as the basis for telling my own story (Chapter 1).

The audio aspect of the interviews was recorded using a digital recorder. Suggestions put forward by Poland (1995) for ensuring quality recorded interview material, such as minimising background noise and careful placement of the recording device to make certain of clear voice capturing were given careful consideration. My own interview also served as

pilot for the recording process and thereafter as a pilot for the transcription, analysis and reporting phases of the study.

4.3.1.3.2 Preparing transcripts for analysis

This step of the research process involved the transcription of the recorded interviews to written texts suitable for analysis. Transcribing encompasses the translation from “an oral language”, with its own predefined rules, to a written language governed by a further set of rules (Kvale, 1996, p. 165). As Kvale (1996, p. 165) proposes, transcripts are “abstractions”, they are “decontextualised conversations” which are not replicas of an original reality but rather “interpretive constructions” which may be useful for research.

Since transcription involves a degree of interpretation or analysis, the interviews were transcribed verbatim, by the researcher. However, because the transcriptions did not serve as the material for a sociolinguistic or psychological analysis, but rather as a basis for gaining a general understanding of the participants’ perceptions and beliefs through the informational content of the interview, a “denaturalised” approach to transcription was adopted (Oliver, Serovich, & Mason, 2005, p. 1276). Whilst a denaturalised approach still attempts to transcribe the interview verbatim, greater attention is given to the substance of the interview, which is the meanings and perceptions created during the interview, than to the accents, “involuntary vocalisations”, pauses and repetitions (Kvale, 1996; Oliver *et al.*, 2005).

Voice recognition and transcription software, namely Dragon Naturally Speaking® (Version 11), was used for the initial transcription of the interviews. The quality of the transcription was manually verified by the researcher.

The initial transcription of the interviews was verbatim and included some speech utterances by both the participant and myself. The first transcripts also included all details such as names and places mentioned by the participants. However, prior to analysis, the transcripts were revised, many of the speech utterances were removed as were any possible identifying features, including names of people, the university of affiliation, specific areas of research interest and cultural background details. All insertions used to replace identifying features were indicated by the use of square brackets, for example when a head of department was mentioned by name, the name was removed and replaced with [the head of department].

4.3.1.3.3 Analysing, verifying and reporting the interview transcripts

The interview transcripts were analysed using thematic analysis. Thematic analysis is a foundational method of qualitative analysis that is used for "identifying, analysing and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 6). Thematic analysis can be used within and across other analytical traditions such as narrative analysis or grounded theory, or it can be considered as a distinct approach in its own right (Braun & Clarke, 2006). It is used to organise and describe data in "rich" detail; however, thematic analysis can also be used in the interpretation of the research topic.

According to Braun and Clarke (2006, p. 87) "a theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set". However, in the context of qualitative data analysis, particularly from a constructivist-interpretive paradigm, more instances of a theme either within each data item (for example within each interview transcript) or across the data set (for example across all interview transcripts), do not necessarily imply greater importance or significance. In other words, "the 'keyness' of a theme is not necessarily dependent on quantifiable measure – but in terms of whether it captures something important in relation to the overall research question" (Braun & Clarke, 2006, p. 88).

Thematic analysis can involve either a deductive approach – in which a theoretical framework and associated themes are imposed on the data – or an inductive approach – in which the themes identified emerge from the data itself (Braun & Clarke, 2006; Patton, 2002). Whilst a deductive or theoretical thematic analysis is driven by the researcher's understanding and interpretation of the theory, an inductive approach is more data-driven. However, as Braun and Clark (2006, p. 90) caution, data cannot be coded within an "epistemological vacuum" and will always be influenced by the researcher's "theoretical and epistemological commitments".

Following Braun and Clarke (2006), thematic analysis essentially involves six stages which are summarised in Table 4.2. Since the qualitative data analysis software – Atlas.ti® (version 7.0.77) was used to manage the process of analysis; each stage will also be described in terms of the corresponding software procedure.

Table 4.2: The six stages of the thematic analysis process and the corresponding Atlas. ti® procedures (Braun & Clarke, 2006)

STAGES	DESCRIPTION OF THE PROCESS	USE OF ATLAS.TI®
1. Familiarisation with the data	Transcribing data, revising transcripts, reading and rereading the data, noting initial ideas	Transcripts were uploaded as primary documents in a hermeneutic unit (HU), paragraphing of transcripts was revisited
2. Initial coding	Coding interesting features of the data in a systematic fashion and collating data relevant to each code	Paragraphs or sentences of interest were marked as quotations and these were coded
3. Searching for themes	Collating codes into potential themes, gathering all data, relevant to each potential theme	Individual codes were collated together in code families
4. Reviewing themes	Checking themes in relation to the coded extracts and the entire data set, generating a thematic map of the analysis	Network maps were created from the code families or themes as nodes
5. Defining and naming themes	On-going analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme	Network maps were revised, relationships between nodes and codes was revisited and code-networks were used to retrieve quotations
6. Reporting	Final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.	Retrieved quotations and network maps were used as the basis for the reporting process.

In the first stage of thematic analysis, the researcher acquaints him or herself with the data until he or she is familiar with all aspects of the content. In this phase of the study, the data set included transcripts of the eight interviews. These had been transcribed by me in a process that involved listening to the digital recordings several times, as well reading and comparing the transcriptions against the recordings, thus ensuring deep familiarity with the data set. The interview transcripts were also uploaded as primary documents into a new hermeneutic unit (HU) in Atlas.ti®. Following this process they were all further edited within the software environment, in order to control the length of paragraphs to ensure ease of

reporting in the last stage of the analysis. Figure 4.2 provides a screenshot showing the eight interview transcripts as primary documents within the hermeneutic unit.

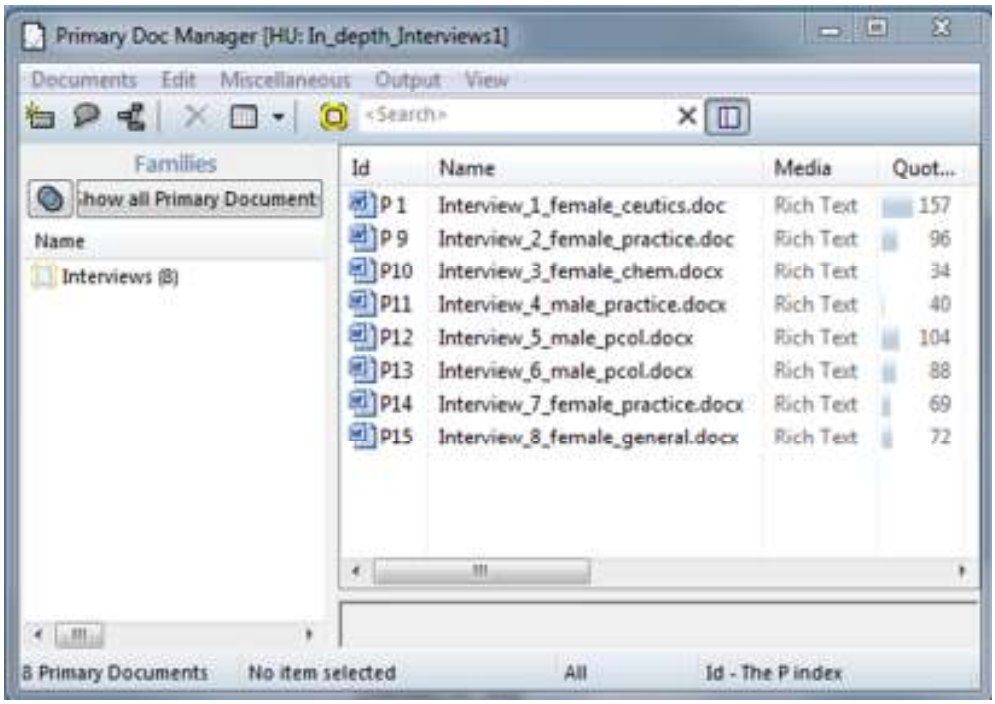

Figure 4.2: Screenshot from Atlas.ti® showing the eight transcripts as primary documents within a hermeneutic unit

Thereafter, each transcript was read through again and key items were highlighted as quotations, which served as the elementary units of analysis (Konopásek, 2008). The second stage of the analysis involved the systematic "coding" of each quotation. Codes are "conceptual labels" which can be used to "grasp and manipulate" the quotations (Konopásek, 2008). In Atlas.ti® codes can also be effectively annotated through a "comment" facility, which allows a description of the code to be attached to it. Commenting on codes both serves as a means of remembering the intention of the code but is also key to the interpretation of data, in that it preserves some of the thinking behind the way in which the data are interpreted (Konopásek, 2008).

In this study the primary documents or transcripts were coded, and where appropriate comments were attached to the codes. Figure 4.3 shows the manner in which codes are recorded using Atlas.ti®.

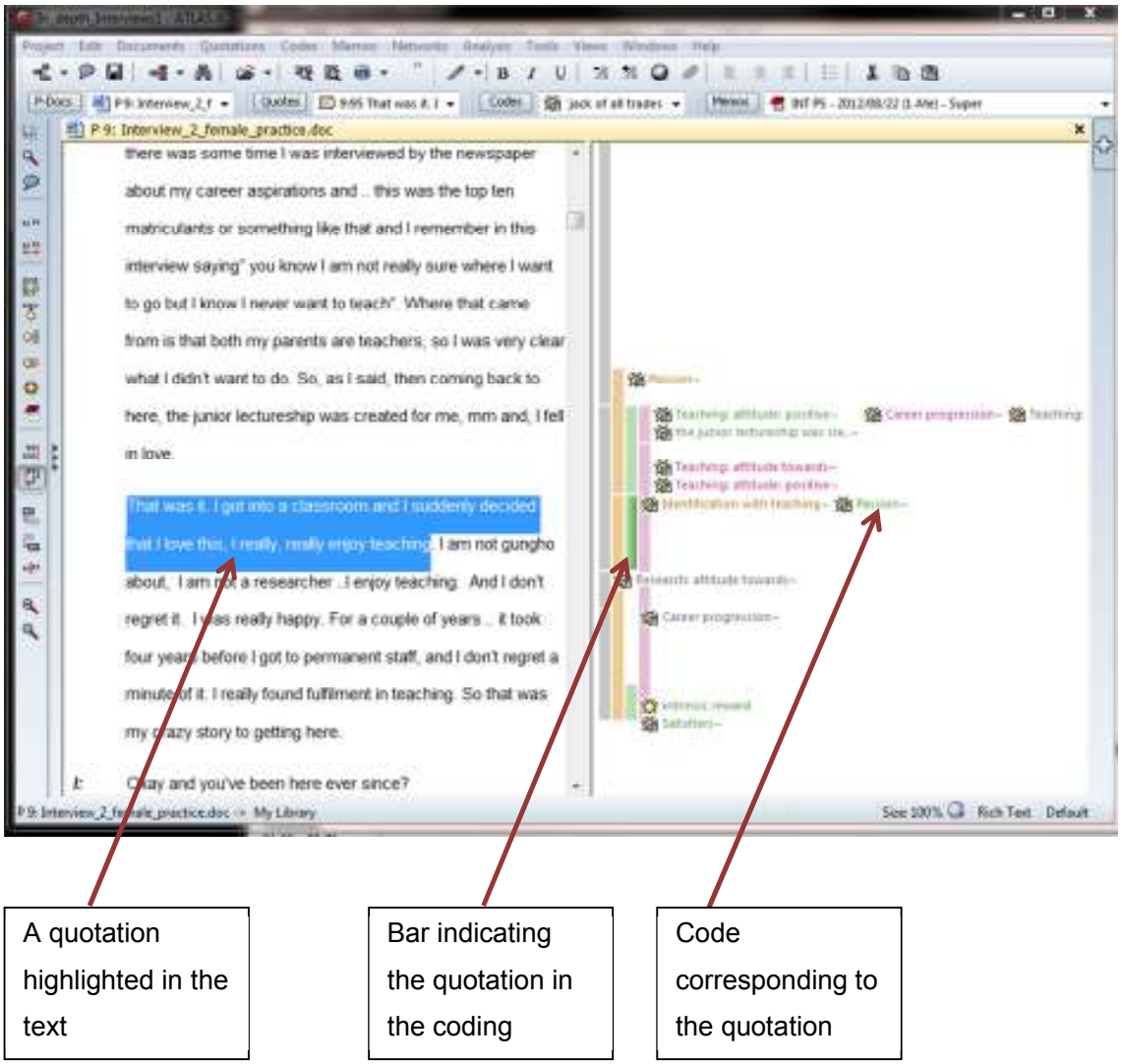

Figure 4.3: Annotated screen shot from Atlas.ti® showing the manner in which codes are attached to quotations

Figure 4.4 illustrates the details which are attached to the codes. In this example the code name was “passion”. For the purposes of maintaining an audit trail of the analysis, the date on which the code was both created and modified is recorded. The number of code families to which the code is assigned is indicated (1) and the actually code family name (Key determinants of identification) is provided. The number of times the code is linked to a quotation is provided (4) and the list of all linked quotations is easily accessible. Lastly the comment attached to the code is also reported (As defining who one is).

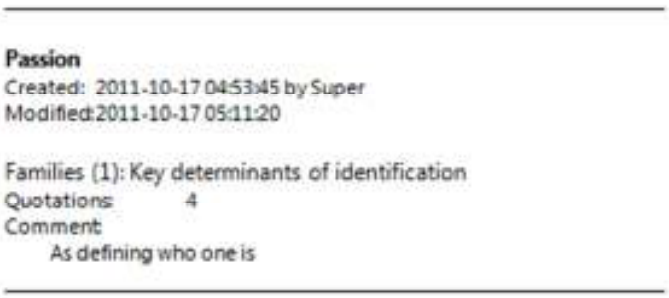

Figure 4.4: Example of code details available within Atlas.ti®

The code book that was generated for this phase of the research is provided in Appendix F.

The third stage of thematic analysis, involves collating codes into potential themes and gathering together all the data relevant to these themes. Using Atlas.ti, the themes were identified and created as code families. The relevant codes were allocated to the code families.

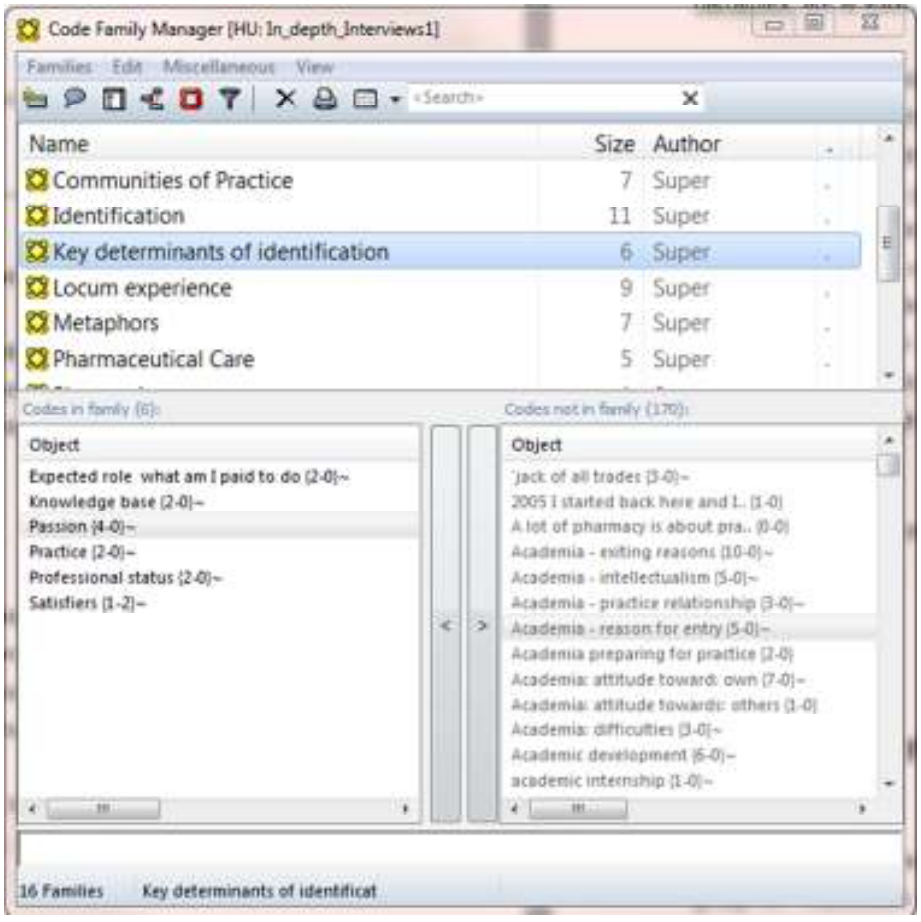

Figure 4.5: Example of codes allocated to a code family within Atlas.ti®

In Figure 4.5 the six codes: expected role; knowledge base; passion; practice; professional status, and satisfiers are shown as having been allocated to the theme “Key determinants of identification”.

Each code family or theme was reviewed in the sixth stage of the analysis through the generation of network maps. An example of a network map relating to the theme “Key determinants of identification” is provided in Figure 4.6.

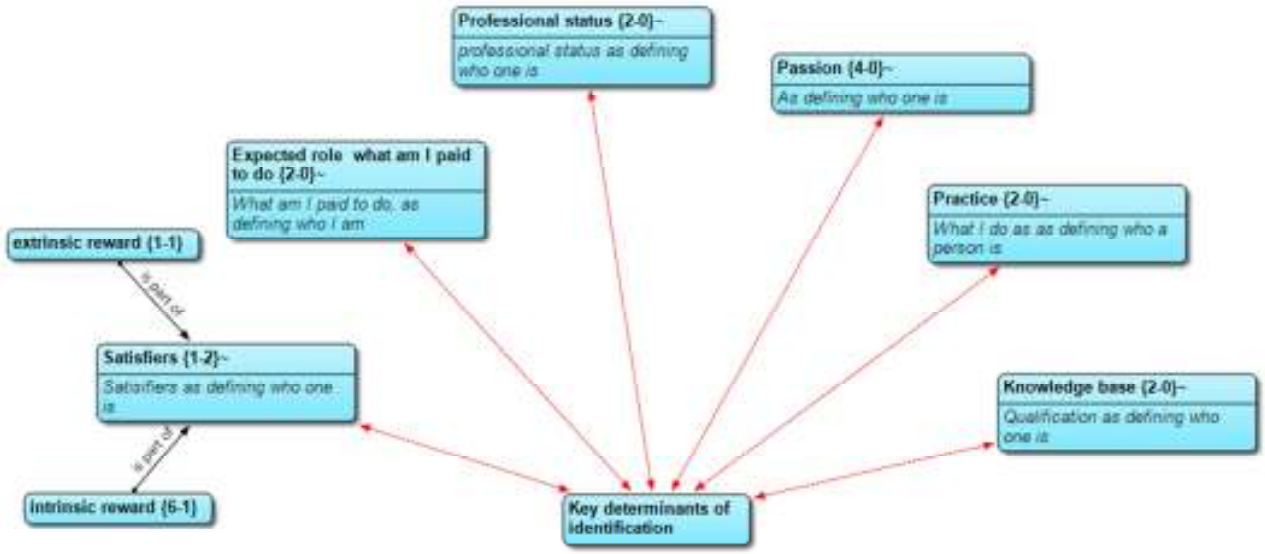

Figure 4.6: Example of a network map relating to the code family or theme – key determinants of identity

In the fifth stage (defining and naming themes) the list of themes and sub-themes was refined by deleting or combining some categories and by identifying connections and relationships between the themes and sub-themes. The network maps were revised accordingly. The network maps were also used to retrieve data from the transcripts in the form of quotations. In the sixth stage (reporting) the network maps and the retrieved quotations were used as the basis for reporting the results.

Clandinin and Connolly (2000) suggest that there is a tension between analysing and reporting a narrative that reliably conveys the individual and unique experiences of the participants, and creating a generalisable theory. In creating generalisable theories the diversity and richness of the individual narrative experiences can be lost. It needs to be

noted that the aim of this study was to understand the individual perspectives of participants and not seek a generalisable theory. Consequently each interview transcript was analysed separately and reported on individually, before any attempt was made to develop a synthesis of the results. In the next chapter, an in-depth reconstruction of each of the participants' stories is provided and this is followed by an individual interpretation of each of them, based on the thematic analysis. Thereafter, a synthesis of the interpretations, based on a combined thematic analysis is provided. Although referred to as participants, each participant was allocated a pseudonym and through the results chapters they are referred to by these pseudonyms.

Trustworthiness of the analysis process (explained in Section 4.4) was verified by having an independent reviewer code selected portions of three of the interview transcripts. The coded themes and sub-themes identified by the independent reviewer were then compared with those generated by the researcher and discussed with the researcher. Although the codes used by the independent reviewer and the wording of the themes were quite different, in many instances the essence of the themes was similar. In discussion it was apparent that the independent reviewer did not disagree with any of the additional themes identified by the researcher and furthermore had not failed to identify any major themes recognised by the reviewer. There was an acceptable level of agreement between the independent reviewer and the researcher, thus indicating a satisfactory level of trustworthiness.

A second method of testing trustworthiness which involved what Johnson and Waterfield (2004, p. 125) describe as "respondent validation" or "member checking" was also employed. Each participant was asked to read through the interview transcript generated from their interview together with the reconstruction of their story and the analysis thereof, to determine the extent to which they considered the transcript to be an accurate reflection of the interview and whether they agreed with or challenged the themes and sub-themes generated by the researcher (see Section 5.10).

4.3.2 Phase 2: Focus groups

Focus groups have been defined as "structured or semi-structured meetings with a small group of individuals (i.e. ''informants'' or ''participants'') that allow for the exchange of information, opinions, and feedback related to a single topic" (Huston & Hobson, 2008, p. 187). Focus groups provide a means to clarify and illuminate often implicit suppositions, within "natural conditions and settings", in order to provide insight into an area of study (Grant & Fitzgerald, 2005, p. 40). As Bloor and co-authors (2001, pp. 5-6) suggest, "the

group is a socially legitimate occasion for participants to engage in retrospective introspection to attempt to tease out previously taken for granted assumptions".

Focus groups rely on interaction within the group, based on topics that are supplied by the researcher. The key characteristic which distinguishes focus groups is the insight and data produced by the interaction between participants. The concept underpinning focus group methodology is that group processes assist participants to both explore and clarify their ideas in a manner that may be less easily accessible in one-on-one interviews. When the dynamics of a focus group work well, the participants are able to work collaboratively with the researcher, and are able to take the research in new and often un-anticipated directions (Kitzinger, 1995). Munday (2006) cautions that although it is the participant interactions in focus groups which make them a unique interview technique, it is this self-same aspect which often gets overlooked when focus group transcripts are analysed and reported.

In this second phase of the study, two focus groups were used for a deeper exploration, within a wider interactive context, of some of the factors identified by participants in the first phase, as contributing to the development of professional identity. Opinions about pharmaceutical care and pharmaceutical education were also explored in the focus groups.

4.3.2.1 Context of the focus groups

The focus groups were held at the the Academy of Pharmaceutical Sciences of South Africa's (Academy) Annual Conference, in Durban, in September 2011. The Academy is the sector of the Pharmaceutical Society of South Africa (PSSA) whose primary membership is pharmacists who have a major focus on education or research in pharmaceutical sciences (Academy of Pharmaceutical Sciences, 2006). It was therefore felt that this would be an ideal opportunity to get a diverse group of pharmacy educators together, who are normally located all over the country. With the permission of the Academy and the Conference Convenors two focus groups were scheduled to be held within the bounds of the conference programme.

Although the original intention was to hold the focus group sessions in a comfortable setting, with participants seated in a circle, in order to create a relaxed atmosphere, the conference environment did not allow for this. Consequently a conference room was used in which tables and chairs were moved to create a round table forum.

4.3.2.2 Focus group participants

The ideal size for a focus group is between four and eight people (Kitzinger, 1995), and the intention was to hold two groups with approximately six participants in each. A convenience sampling approach (Patton, 2002) was employed to recruit participants for the focus groups. With the permission of the Academy and the Conference Convenors, all attendees at the 2011 Academy conference who met the inclusion criteria were invited to participate (Appendix G). The inclusion criteria were the same as those for the in-depth interviews, namely participants were required to be registered pharmacists who were teaching on an undergraduate pharmacy programme. First phase participants were excluded from participating in the focus groups. Further details regarding the composition of the focus groups are provided in Section 6.2.

4.3.2.3 Focus group process

The protocol described in Appendix J was followed for the groups. The audio aspect of the groups interaction was digitally recorded, with the same attention paid to the details of the recording, as for the recording of the in-depth interviews described in Section 4.3.1.3.1.

I facilitated the focus groups, using the same "traveller" approach as was described for the first phase of the research (Section 4.3.1.3.1). Essentially my role was to provide a clear explanation of the purpose of the group, to assist participants to contribute and to facilitate interaction between participants. I was guided in the process by the recommendations described by Gibbs (1997) for the moderation of focus groups, which include:

- Using open-ended questions to facilitate discussion
- Probing for details when necessary or when clarification is needed
- Moving conversation forward when it drifts
- Keeping the session focussed by drawing it "back on course" when necessary
- Ensuring participation by all
- Avoiding favouring individual participants
- Being non-judgmental
- Remaining adaptable and willing to "go" with the group.

Furthermore, in order to give my full attention to the groups, with the permission of all participants, a research assistant was present in the focus groups to both oversee the digital recording equipment and make notes regarding the interaction process.

A pre-focus group questionnaire was used to elicit the demographic information of participants. The questionnaire (Appendix G) requested age, gender, and length of teaching

service, nature of the current and past teaching experience, and membership and involvement in professional organisations. The questionnaire was handed to participants on arrival at the focus group and was also used as a tool to assist participants in focussing on the task at hand. Following appropriate explanation of the purpose of the groups, participants were also asked to sign the informed consent form prior to the start of the groups (Appendix I).

Due to conference programme constraints there was insufficient time to commence the groups with an intended "ice-breaker". An ice-breaker is a facilitation exercise designed to "transform the group from several individuals to an interacting group" (Debus & Novelli, 1986, p. 40). Following introductory comments with regards the objectives of the research and the focus groups specifically, the groups were commenced by asking the participants to reveal what they had written on the questionnaire when asked "What is your occupation?" It was felt that by starting with something that they had just written, the first question would not require much thought and would facilitate easy participation. In both groups this question and an explanation of the response offered did serve to facilitate both participation and interaction.

In the "main body" of the group sessions, three key, open-ended questions designed to capture the essence of the study topic and explore perceptions and beliefs which surfaced in the first phase of the study (Appendix J), were used to stimulate conversation and group interaction. In adopting an emergent or flexible approach to the study (Section 4.3), any unexpected relevant themes or sub-themes, which emerged during the focus groups, were further explored.

The transcriptions of the recorded focus group sessions were conducted in the same manner as that described for the in-depth interviews (Section 4.3.1.3.2). During the transcription process the field notes, made during the sessions by the research assistant, were used as a guide to determine the source of the various voices on the recording. Group interaction data, indicating instances within the focus group when participants supported and encouraged each other, expressed agreement with or indicated a sharing of opinions, ideas and experiences, or entered into debate with each other or expressed disagreement, irritation or frustration were also included in the transcripts (Duggleby, 2005).

The same thematic approach to analysis as that employed for the analysis of the in-depth interviews (described in Section 4.3.1.3.3) was also used in the analysis of the focus group transcripts. Throughout the analysis awareness of the three different levels of data as described by Duggleby (2005), namely: individual data level; group data level; and the group

interaction level, was maintained. However, there was no attempt within the groups to achieve any degree of consensus and so most of the data were at the individual and at group interaction levels, and there was very little data at a group level. In addition to the inductive approach to analysis used in the first phase, the group transcripts were also analysed deductively, by imposing on the data set some of the codes identified as contributing to key themes which emerged in the first phase (see Section 5.11 for the key themes).

In a similar manner to that in first phase of the study, an independent reviewer was used to determine the internal trustworthiness of the focus group transcript analyses. Trustworthiness of data was further checked by inviting a participant from each of the groups to determine the extent to which they agreed or disagreed with the completeness of the transcripts and with the themes and sub-themes identified by the researcher. Although access to the transcripts and the report emerging from the analysis of them, were offered to all the other participants, none of them deemed it necessary.

4.3.3 Phase 3: Questionnaire-based survey

The third phase of the study involved the use of a purpose-designed questionnaire, developed from the insights which emerged in the first and second phases of the study, to explore with pharmacy educators in South Africa, their self-perceived professional identities, attitudes, beliefs and practices related to pharmaceutical care and the socialisation of students into the pharmacy profession. Although this phase extended the research study to a greater number of pharmacy educators, the focus was on developing the understandings and insights revealed in the first two phases, rather than seeking out generalisable theories.

4.3.3.1 The questionnaire

The questionnaire (Appendix K) was essentially qualitative in approach and beyond some demographic questions in the first section; the questions were open-ended in nature. A summary of the focus of each of the five sections of the questionnaire is provided in Table 4.3. The questionnaire was created as both a form in Word® 2010 which was emailed to participants and as a web-based form which was made available for completion via the university's survey site. The questionnaire was anonymous and no names of participants were required, collected or attached to the questionnaire. Online completion of the questionnaire ensured that participants had the option of remaining completely anonymous, since the researcher was unable to identify the identity or location of the respondents.

Table 4.3: Description of the sections contained within the questionnaire

SECTION	FOCUS
1. About you	Demographic details including gender, age, academic qualifications and years of registration and practice experience as pharmacist
2. Employment in higher education	Attraction to and experience in higher education, role priorities, positive and negative aspects of work, utilisation of personal and professional strengths within higher education, communities of practice external to the higher education environment
3. Perception of a self as a professional	Self-labelling as a professional and use of metaphors to describe oneself, role within the wider university and pharmacy profession, academic pharmacy as a speciality
4. Perception of pharmaceutical care	Feeling regarding the concept of pharmaceutical care and its impact on teaching
5. Educating future pharmacists	Role in educating the next generation of pharmacists, perceived impact of teaching on practice and the relationship of education and practice with regards change

Both versions of the questionnaire were piloted by two respondents, who were pharmacy educators and held pharmacy qualifications but who were by virtue of not being registered with the South African Pharmacy Council, not eligible for participation in the study. Minor comments with regards the wording of questions were received and used to revise the questionnaire accordingly. Furthermore, the questionnaire appeared to be both credible and dependable (see Section 4.4).

4.3.3.2 Questionnaire respondents

Convenience sampling was adopted to select participants for this phase of the study. The heads of the eight pharmacy departments, schools and faculties were asked to circulate, via email, the invitation for participation (Appendix L) to all eligible pharmacy educators within their universities. Potential participants were, wherever possible, also identified from the university websites and contacted directly via email. The Academy also issued an invitation for participation via their email distribution list.

The inclusion criteria were the same as those for the first two phases of the study; namely participants were required to be registered pharmacists who taught on an undergraduate pharmacy programme. All respondents were asked to indicate previous participation in the

first two phases of the study. Respondents who had participated in either of the first two phases, were not excluded, however their previous participation was noted and taken into account in the analysis and reporting phases of the study; for example, if a participant in the first phase offered a metaphor to describe him or herself, and participated in the third phase by completing the questionnaire and offered the same metaphor this was not reported as a new finding. In this phase of the study, pharmacy educators were termed respondents, in order to distinguish them from the participants in the first two phases of the study. For ease of reporting each respondent was allocated a unique identifier (R1 – R32).

A summary of the demographic details of the 32 pharmacy educators who responded to the questionnaire is provided in Table 6.2 (see Section 6.3.1). Two of these respondents had participated in the first phase of the study and a further two in the second phase.

4.3.3.3 Analysis and reporting of the questionnaires

The returned questionnaires were collated into a single document, with the responses to each question grouped together. However, each response remained attributable to the appropriate respondent, because of the unique identifier which preceded all the responses.

Using the same thematic process of analysis described in detail in Section 4.3.1.3.3, the data were coded and themes were identified. The process was largely inductive, although some of the codes from the first two phases were imposed on the data in a deductive manner.

In the reporting of the data, where appropriate, use was made of percentages and numbers. Although these can be viewed as providing insight into the prevalence of codes and themes, it was essentially a qualitative study, and greater emphasis was placed on the meaning of the responses. Furthermore, in the context of a constructivist-interpretive paradigm where the world is viewed as a socially constructed reality comprising multiple perspectives, the values, perceptions, and beliefs of all the respondents, even the “lone voices” needed to be respected and to be considered (Schwandt, 1994).

4.4 Trustworthiness of the data

In constructivist qualitative research constructs that translate the four standard quality criteria of quantitative research (internal and external validity, reliability and objectivity) into trustworthiness and authenticity are often described (Shenton, 2004). Guba (1981) describes four such constructs, namely:

1. credibility - demonstrating that a true picture of the phenomenon under scrutiny is being presented (paralleling internal validity);
2. transferability - providing sufficient detail of the context of the fieldwork in order to determine justifiably if the study is applicable to other settings (paralleling external validity/generalisability);
3. dependability – assessment of the quality of the integrated processes of data collection, data analysis and theory generation (paralleling reliability);
4. confirmability - demonstrating that findings emerge from the data and not the researchers own predispositions (paralleling objectivity).

A summary of the way in which these four constructs were addressed in the study is provided in Table 4.4.

Table 4.4: Provisions that were made by the researcher to address Guba's four criteria for trustworthiness of data

QUALITY CRITERION	PROVISION MADE BY RESEARCHER
Credibility	• Adoption of appropriate, well recognised research methods, including narrative and thematic analysis, focus groups • Methodological triangulation • Use of independent reviewer to verify data analysis • Member checks of data collected and interpretations thereof
Transferability	• Provision of background data to establish context of study and detailed description of phenomenon in question to allow comparisons to be made
Dependability	• Employment of "overlapping methods" – use of individual interviews, focus groups and questionnaires • In-depth description of research design and implementation
Confirmability	• Methodological triangulation to reduce effect of investigator bias • Making explicit the researcher's beliefs, experiences, position and subjectivities • Identifying and acknowledging of the limitations and shortcomings in the methods and their potential effects • In-depth methodological description allowing integrity of research results to be scrutinised

4.5 Ethical considerations

Ethical approval for this study was obtained via the Faculty of Health Sciences' Research, Technology and Innovations Committee from the Nelson Mandela Metropolitan University's Research Ethics Committee (Human) (REC-H), prior to commencement of any data collection (Reference number: H11-HEA-PHA-006) (Appendix L). Permission was also sought from the heads of the pharmacy departments, schools or faculties, at each of the eight universities offering pharmacy undergraduate programmes, prior to potential participants within these departments being invited to participate in the study (Appendix B).

In each of the three phases of the study, ethical measures in accordance with the Belmont Report's Ethical Principles and Guidelines for the Protection of Human Subjects of Research (United States National Commission for the Protection of Human Subjects of Biomedical Behavioral Research, 1978) were observed. The ethical considerations and methods employed in this study were considered in five categories suggested by Kvale (1996, p. 119), namely: 1. potential beneficial consequences; 2. informed consent of participants; 3. protection of confidentiality; 4. potential harmful consequences, and 5. researcher's role.

4.5.1 Potential beneficial consequences

In Section 3.1.2.4, the role of narrative in the construction of identity was discussed. As James (2007, p. 964) proposes, narratives have the potential to reveal and illuminate a deeper understanding of life drawn from the telling of lived experience, which might otherwise remain concealed. It is through the telling and re-telling of one's story that an individual's perception of his or her identity and self-concept can be constructed and made sense of. Citing Williams (2000), James (2007, p. 965) suggests that identity formation becomes "the product of, and is realised in, narrative accounts of individuals' past present and future". She concludes that

> The study of academics' lives from their perspective, in which they actively and socially develop their identities, not only provides a lens through which they can be understood as shifting constructions of identity, but allows them to rethink who they are and have become.

Palmer (1998, p. 10) argues that well-formed self-knowledge is central to good teaching, since good teaching is more than method and technique, but arises instead "from the identity and integrity of the teacher". For the participants themselves, this study had the potential to

allow them to more fully understand who they are within the professional context, and consequently provided new opportunities for potential growth and change in their lives.

In the broader context, this study provided valuable insights into how the professional identities of pharmacy educators in South Africa were formed through the communities of practice within which they engaged. It also afforded opportunities to better comprehend "who it was" that taught within our faculties and schools of pharmacy, and the potential impact this had on the professional socialisation of future pharmacists.

4.5.2 Informed consent

Since all the participants in the study were educators teaching on undergraduate pharmacy programmes in South Africa, the heads of pharmacy departments, schools and faculties were asked for consent to invite participation from the educators within their departments (Appendix H). Although all the heads consented, in some universities, such as University of Kwazulu Natal (UKZN) this consent had also to be sought from higher university structures (Appendix M)

In phase one and two of the research, participants were provided with a written preamble explaining the study (Appendices C and G). Participants were also verbally briefed about the purpose and procedure of the interviews and focus groups respectively and informed that participation was voluntary, and that they had the freedom to withdraw at any stage. Prior to commencement of the interviews and focus groups, participants were asked to sign informed consent forms (Appendices D and I), which stated the pertinent aspects of the study. In the third phase of the study, pharmacy educators were invited by email to participate (Appendix L) and in a preamble to the questionnaire were briefed about the nature and procedures of the study. The invitation to participate also clearly stated that consent to participate in the study would be implied by return of the questionnaire to the researcher, or by completion of the online version of the questionnaire.

4.5.3 Protection of confidentiality

Confidentiality and anonymity of participants were given careful consideration, and as far as possible were maintained and protected, at all stages of the study, and in any reports, publications or presentations arising from it. However, it needs to be noted that in qualitative research and particularly narrative inquiry, it is difficult to convey detailed accurate accounts of the participants' context and still protect the identities of the participants (Kaiser, 2009). Kaiser (2009, p. 1632) warns that since qualitative studies often include in-depth descriptions

of participants, breaches of confidentiality via "deductive disclosure" are of particular concern. She further notes that despite repeated emphasis in the research design literature; there are very few specific, practical guidelines on how to conceal participants' identities such that deductive disclosure is prevented.

Prior to data collection in all of the three research phases, participants were informed that in so far as it was feasible, all identifying characteristics, such as name, city, university would be removed or pseudonyms used. Given the importance of academic discipline within the academic environment, concealing the discipline may limit the scope of interpretation available to the researcher (Jawitz, 2007). However, since the pool of pharmacy educators in South Africa is reasonably small (in the region of 100), and there are essentially only four major disciplines, revealing disciplinary affiliation could lead to deductive disclosure. This had the potential to be a problem, particularly during the narrative analysis phase, since the data were reported in-depth. However during the "member checking" process participants were specifically asked to review the stories and interpretations thereof to ensure that they were satisfied that there identity had not been disclosed. Although all the participants were comfortable with their discipline being revealed, two of them requested minor changes in order to protect their identity.

Throughout the data collection, transcription, and analysis stages, the need for participant confidentiality was constantly weighed with the need for sufficient detail necessary to make meaningful interpretations. Prior to each interview, participants were advised that they would have access to and control of their data, and were encouraged to view both the transcripts and the subsequent analysis.

4.5.4 Potential harmful consequences

In analysing participants' stories, I as the researcher was at risk of imposing my own interpreted meaning on the lived experiences of the participants. Although, as Bell (2002, p. 210) suggests, good research practice requires that the researcher confirms their narrative constructions with participants, "participants can never be quite free of the researcher's interpretation of their lives". In qualitative research, we are dealing with the "real lives of real people" and as Josselson (2007, p. 559) cautions:

> We can never know for sure at the outset that we will not have an impact on them that could be in some way painful. We can never know that what we publish will not be in some way distressing to them. We have a lot of evidence that most people find our interviews with them healing, integrative,

> useful, and meaningful, but this does not guarantee that nobody will ever have a less sanguine experience.

It was therefore of utmost importance that I as the researcher took care in the analysis and in the reconstruction and interpretation of the stories, to maintain utmost “respect for the dignity of participants as individuals.”, and to recognise that what may have been to me, data, a unit of analysis or an example of a conceptual or theoretical point, was in fact “a very personal narrative to the person whose story it is” (Josselson, 2007, p. 550). One of the responses received from a participant during the member checking process in the first phase of the study, highlighted the importance of this issue and the potential in a study of this nature to inadvertently cause pain (see Section 5.10).

CHAPTER 5

PROFESSIONAL IDENTITY OF PHARMACY EDUCATORS, CONSTRUCTED THROUGH NARRATIVES

5.1 Introduction

In this first phase of the study, in-depth narrative interviews were conducted with eight pharmacy educators, in order to both describe their professional identities and understand how their experiences, attitudes and beliefs have contributed to the formation of their identities. Based on the interview transcripts, the story of each participant is told. Following each story, my interpretation, based on a content analysis of the transcripts, is provided.

In an effort to verify the credibility of each story and my interpretation thereof, the transcripts, stories and interpretations were returned to each participant for comment. The outcomes of this process were collated and reported in Section 5.10. Although a synthesis of the stories, highlighting similarities and differences between them is provided in Section 5.11, in keeping with a constructivist-interpretive research paradigm and in order to preserve the diversity and richness of each story, no attempt is made to draw generalisable conclusions about the professional identity of pharmacy educators.

As was described in Section 4.3.1.2, in order to protect their identity, each participant was assigned a pseudonym. These pseudonyms, together with basic demographic features of each participant, are summarised in Table 5.1. Identifiers were used to reference quotes included in the text taken directly from the transcripts, for example (1: 10) is a reference to the tenth paragraph of Tia's transcript.

Table 5.1: Summary of the participants' pseudonyms and demographic details

PSEUDONYM	GENDER	AGE (YEARS)	TEACHING DISCIPLINE	IDENTIFIER
Tia	Female	32	Pharmaceutics	1
Vinetra	Female	55+	Pharmacy practice	2
Zita	Female	29	Pharmaceutical chemistry	3
Kiron	Male	45	Pharmacy practice	4
Abbot	Male	40+	Pharmacology	5
Zeth	Male	50	Pharmacology	6
Idania	Female	58	Pharmacy practice	7
Hypatia	Female	40	Generalist	8

5.2 Tia's story

Tia is 32 years old and first registered as a pharmacist about eight years ago. She completed an academic internship whilst doing her Master's degree. This was followed by a community service year[4], after which she spent a few months working in a hospital pharmacy, prior to returning to the academic environment with the primary purpose of completing her doctorate. In order to support her studies she accepted a post as a lecturer and is currently teaching pharmaceutics.

Through her high school years, Tia had aspirations of becoming a medical doctor. However, these aspirations became "nullified" (1: 12) when she realised that she had developed a fear "not of blood, but the fear of pain" (1: 12). Her mother, who worked at the local hospital organised a work-shadow experience for her with the chief pharmacist, which she really enjoyed: "I liked it, I really did" (1: 12). This convinced her that she should study pharmacy. She applied to several universities and accepted the first offer she received. At the introductory lecture the presence of a young female lecturer sitting in front caught her

[4] A year spent working in a public sector facility, with limited registration, after internship and prior to registration with the SAPC as a pharmacist.

attention and she found herself thinking, “I wonder what you would have to do to get to where they are sitting?” (1: 12). She suggested this sowed the first seed with regard to a future in academia. However, in the three years that ensued she did not give it much more thought.

Her first real experience of research was an individual research project in her fourth year of study. Although she cannot say why she decided to take on the project, she found herself really enjoying it. Despite this positive experience of research, she had no intention of doing postgraduate studies immediately after her final year, sensing that it would have been hard on her parents financially and feeling that she “wanted to earn some money, and live the life” (1: 16). However she felt that “fate intervened” (1: 16), and she was offered the opportunity to do a Master’s degree, which she accepted. She completed an academic internship, carrying out her required 400 hours practice-based experience in the same hospital in which she had obtained her work-shadow experience; and again she really enjoyed the hospital environment. In contrast, she said that “at some point when I did my internship hours, I did go into retail pharmacy and I lasted two days” (1: 203).

Having attained her Master’s degree she knew that she wanted to do a doctorate. However, at that point in time, she did not make the connection between a doctorate and a career in academia. Prior to returning to the university to embark on the doctorate she completed a year of compulsory community service and then worked in a hospital for six months. The realisation that doctoral studies would entail having to “stop working” (1: 16), was where “lecturing came in” (1: 16), as a means to finance her doctorate. As she suggested: “lecturing was secondary, I must admit, to the research; right from the start I had never really ‘married’ the two; it was only when I had to get an income, and it was related to pharmacy” (1: 16).

Feeling that she was plunged in at the deep end, with little or no guidance and an incomplete set of notes from her predecessor, Tia described her first experience of lecturing as “difficult, difficult, it was really difficult … with nobody holding my hand through the process, it was just the module ... and go!” (1: 16). She described having to resort to using both the materials and the methods she had experienced while being taught as a student in her fourth year of study, as a basis for her own lecturing She found the preparation for lecturing very time consuming, although it was also a growth experience: “I spent many a night writing, especially for lectures and preparing, but it was an experience and now I have grown into it and now totally rearranged the module and changed this and changed that, and can say that it has been good” (1: 16).

Although when she first started at the university, teaching was "not high on [her] agenda" (1: 24) she found that her focus shifted to teaching due to her desire "to make it right … to make a difference" (1: 24), and for the sake of the students she did not "want it to be boring" and she really wanted it to be in a way that was "helpful to the student" (1: 24). Feelings of unpreparedness for teaching, highlighted by the recognition during a new lecturers' induction course that "I am not a teacher" (1: 32) resulted in her attending teaching workshops and "familiarising" herself with the "whole other world" of teaching. She felt that she has developed in her teaching, "put a lot of energy into it" and "done it justice" (1: 195).

Although Tia had experience in various aspects of pharmacy, she did not consider herself to be specialised in any specific area; not even in academia, where the majority of her experience lay. This was primarily because she considered a doctorate, which she had not yet completed, as the minimum requirement for academia: "the PhD is a minimum, that's how I view it, and that's what is driving me, and getting that basically in terms of academia, that's it!" (1: 56). Her understanding of the doctorate as "a minimum" was supported by the way in which she, although acknowledging it as "a joke" (1: 20), described a cartoon that represents academic development from undergraduate to doctoral level in terms of the "stages of development of man" (1: 20) from ape to *homo sapiens*, as having "meaning … a hidden message" (1: 20). Tia considered specialisation in academia to encompass getting a doctorate, having experience in lecturing, and fulfilling the various requirements of research, including applying for research funding, attending research meetings, and writing research papers.

Tia performed regular locum work as a pharmacist, outside of the university environment, to such an extent that whilst filling in her tax return forms, she realised that "I have four IRP5s[5], one from the university, one from industry, okay so the university as a teacher, industry as a production pharmacist, Medi-Rite[6] as a local pharmacist, and I have another one from Clicks[7] as well, as a locum pharmacist, so I'm all over the show" (1: 48). Unfortunately her locum experiences have resulted in a fairly negative view of the manner in which pharmacy, in many sectors, is practiced. Tia believed that in both industry and community pharmacy too much responsibility and power has been delegated by pharmacists to pharmacy assistants and untrained staff. In production pharmacy, in terms of her experience she suggested that 90% of the work is done by pharmacists' assistants and pharmacists are "just 'there' because the law says you must be there" (1: 68). In that environment, she did not feel

[5] An IRP5 is the standard form used to file a tax return in South Africa
[6] A corporate chain of pharmacies in South Africa
[7] Another corporate chain of pharmacies in South Africa

valued, saying pharmacists' assistants in industry view pharmacists as irrelevant to the work that is done;

> … we studied for years and we pharmacists are proud of the profession of being a pharmacist. And then you get to a place where pharmacists are, "Oh, okay so another one. Alright so how long are you going to last – the others stay for two months? We'll see how long you last but the rest of us carry on whether you are here or not". (1: 88).

Similarly, in the retail or community pharmacy environment she stated that, "the way that the pharmacies are being managed, you find that the post-basic pharmacists' assistants dispense almost everything – okay maybe not schedule six, but they dispense a lot of things and sometimes they even assume pharmacist responsibilities" (1: 88). In addition she was of the opinion that the responsibility for the manner in which pharmacists' assistants acted beyond their scope of practice lay with the pharmacists, suggesting that it "is the practising pharmacists who are the ones who give all the powers and all the responsibilities to the post-basic pharmacist assistant" (1: 108).

Tia was of the belief that this undesirable practice of pharmacy diminished the value of the profession and the pharmacy qualification, and had an adverse effect on students' opinion of pharmacy:

> … those who start working in retail, especially early on, even those who start late, come to think of it, the value of their degree is diminished, because I have worked with some of our students, and the stories that they tell and the things that they are expected to be doing, some of them say that they started in pharmacy and they are going to be pharmacists, but it's not what they had expected, and a couple of months back I found out that one of my international students from Kenya, graduated, she went home, she did her internship – she's in construction now – so she's not working as a pharmacist. So it's a shock, it's a shock for them, and it can be depressing. (1: 104)

She nevertheless expressed the belief that the "shock" which students experienced in practice, could, to a certain extent be countered by preparing the students for what they would encounter by both "reprogramming existing pharmacists" and:

> …making them [the students] more aware of what to expect once they do graduate, and how to overcome that. So you know that when you graduate

> and you do become a pharmacist you are going to find a post-basic pharmacist assistant that has been working for five years who has been given all the powers in the world and is going to challenge you. But you know what the law is, you know what the guidelines are, you know what the standards are, and the thing is to stand up for those things and defend them. (1: 108)

Tia was of the conviction that it is important to prepare students for pharmacy, both as it is currently practiced, as well as for how it might be practiced in the future, since, "in essence they are the ones that are going to create the future, but they are graduating into what is happening currently." (1: 112). She suggested that the key to doing this is teaching students "flexibility" (1: 112). We need to say to the students:

> … this is what is going to happen to you, this is what is currently happening, but if you don't make a change and you are not flexible enough – if you realise what is happening and don't change it or start the process, then it's never going to change, and it's never going to happen.(1: 112)

She expressed a relatively strong opinion that the change we should be preparing students for is necessary:

> So the way that pharmacy is structured now, I don't know how long – the way I feel there's got to be a switch – there's a switch that needs to come or is already in progress where we need to redefine ourselves as pharmacists. Because currently, if we continue the way that we are continuing now, the value is going to be eroded, I mean give it another 10 to 20 years, at least that's my feeling – I could be completely wrong, but ... having been in practice… (1: 88)

Despite Tia's negativity toward the industrial and community pharmacy sectors, and her recognition of the need for change, she expressed a particular passion for hospital pharmacy, for the reason that it was "so hands on – especially when it's done right" (1:116). She used examples from her own experiences of interdisciplinary teamwork, mutual respect between healthcare professionals, and feelings of being valued, to explain her bias toward this sector. The comment that "if all hospitals were run that way I would go and work there tomorrow" (1; 160), suggested however, an acknowledgment of her experience of hospital pharmacy as being relatively unique.

Tia viewed interdisciplinary teamwork, such as she experienced in the hospital environment, as being important for the future of pharmacy, “if I could see in the future my feeling is really, … that pharmacy flourishes in an integrated team like that; if it is going to be ‘stand-alone’ that’s not the best place”. She believed that pharmacy has a unique contribution to make and that it is in the “clinical setting … where pharmacy can really, really make a huge difference” (1: 120). It was in the context of teamwork that she also described her understanding of the concept of pharmaceutical care as supporting the work of other healthcare professionals, particularly medical doctors:

> … my understanding of pharmaceutical care is that it’s got to do with the pharmacist, along with the patient, managing their condition, and not taking over from the doctor, because obviously you can’t diagnose and you can’t take over from the doctors role, especially for chronic medicines for those patients who see the doctor once every six months, so along with the patient, handling … basically monitoring their condition with the medicines, ‘how are you feeling?’ – basically following up in between the doctor’s visits. (1: 132)

She did however view pharmaceutical care as having very little impact on her teaching, although she acknowledged that it was not entirely unrelated to her subject area of pharmaceutics, “I’ve never included pharmaceutical care. I’ve never … not directly … I mean there are opportunities where I could make mention of it, but no I must admit, I haven’t.” (1: 138). This was supported by her expressed primary focus in her teaching being teaching pharmaceutics, rather than developing pharmacists. Tia did, however, express that she derived a level of personal satisfaction from watching the students develop into pharmacists, and recognised her contribution towards this, through the teaching of pharmaceutics:

> … that’s the thing I see myself as teaching pharmaceutics … this year I was going through a lot of introspection, and I wasn’t feeling particularly positive about things, until we had the oath ceremony. And it’s at those times that I realise, you know what, I have made a big impact because I’ve been part of the group of people who have helped the students from first year right up to fourth year, and now they’re pharmacists going out into practice, and I have in my small way impacted on them. Whichever way that is … each and every one even if it’s really small. I did interact with them for at least for two years and there’s an impact and they are going out there. So that’s when I do realise, ‘you know what? I’m part of a bigger team that develops pharmacists. But most of the time it is mostly about ‘ceutics. (1: 152)

Tia did not feel very well connected within the broader university environment, viewing her academic work as fairly isolating, conducted largely within the confines of her office and the lecture room, “we each have our own office – go into the office in the mornings, switch on the computer .. work, go and give a lecture or two, come back to our office sit down until it’s time to go home” (1: 144). However, recent structural changes within the department resulted in her being office-less for a period, and found her needing to move out into the wider university campus. This resulted in the welcome recognition that she was part of a wider university community.

Although she expressed a vague feeling of belonging within the pharmacy department, she viewed the department as being relatively “individualistic” (1: 144). She said that because she was “not terribly extroverted”, she felt comfortable within the department, but added that if a colleague was looking for a sense of companionship within the department, they probably would not find it “an individual who wants to interact with colleagues, who wants to go to tea and sit and chat – then no, they would not have felt part of the department” (1: 144). She suggested that this was, in part, due to the individual office structure of the environment, but also related it to her own introverted nature, and to the introverted nature of many of her colleagues.

> … it’s the environment, I suppose, that would make one not feel part of the department. But no person in the department has made me feel as if I don’t belong. So the personalities of the department have not made me feel like that, it’s just … no-one has necessarily made me feel like I belong. They haven’t been warm. It’s like, okay we’ve got another person, so that’s it. I suppose that we are really just all introverts. (1: 144)

She also suggested that the absence of a “unified mission” (1: 145) within the department could contribute to feelings of isolation and of disconnectedness. She acknowledged however, that there had been moments of real connectedness within the department, particularly around the unexpected celebration of a personal event in her life.

Tia described her relationship with the students, as being relatively formal, but open, “Formal yes, I mean I do lecture them, so there’s that relationship. But I try to keep it so they feel free to come and talk to me” (1: 064). Although she said that she is open to her students talking to her about more than their academic work, they don’t normally do so, and she was not certain how she would manage it if they did, “I don’t know how I’d handle it if somebody came to me with problems about their boyfriend” (1: 064). She was of the belief that her students viewed her primarily as a lecturer of pharmaceutics, rather than as a pharmacist.

They did not often engage in conversation with her about becoming a professional, or becoming a pharmacist; apart from the occasional conversation with a student who was preparing him or herself for an internship interview, particularly in industry.

Until recently Tia had not belonged to any pharmaceutical professional organisations, but the recognition that "something needs to change professionally, I need to grow as a professional" (1: 171) had steered her toward joining the PSSA. The realisation of a need to start networking beyond pharmacy, to gain "exposure to what's out there – who's doing what and not just to be limited to pharmacy" (1: 140), had also resulted in her recent membership of a local Business Women's Association.

Tia viewed the university as allowing her, within the boundaries of their policy, relative freedom to be involved in other organisations and work-related activities, such as locuming. However, despite the feeling that "I'm not hindered to do anything" (1: 179), she also did not feel specifically supported in doing so, "there's nobody championing me to go ahead and do it" (1: 179).

Although at that point in time, Tia was not certain of her professional future, she saw herself as moving out of the academic environment and perhaps into the field of public health administration. She said that while "research remains my love … something I want to do" (1: 183), academic research "doesn't speak to me anymore" (1: 183), and she would like to do research that "shapes current policy" (1: 183).

5.2.1 Interpreting Tia's story

5.2.1.1 Tia's self-perceived professional identity

Tia identified herself professionally, first and foremost, as a pharmacist, "I am a pharmacist and I'm something else secondary: it's my base line, it's almost like my home base. That's where I start, I'm a pharmacist". Although she viewed her then current role in academia as encompassing both teaching and research on a fairly equal basis, her bias was toward research. As she stated in her story, it was something that, in the future, she would like to do full-time. However her envisaged future, as a researcher in public health administration, was also viewed in the context of her primary identity as a pharmacist, "that's where I am turning my attention to … but then again … as a pharmacist within that" (1: 183).

Tia used several metaphors to describe various aspects of her professional self, but the overall metaphor would be that of a "jack of all trades" (1: 43). The dictionary definition of a "jack of all trades" is a "handy versatile person", who "can do passable work at various tasks"

(Merriam-Webster.com, 2012). Tia used this metaphor to describe the various roles she played as a pharmacist, including academic pharmacist, production pharmacist and community pharmacist.

Although she did not include it, the phrase "jack of all trades" is often coupled with the addendum "master of none" (Martin, 2012), which would clarify the dictionary use of the term "passable" (Merriam-Webster.com, 2012) when describing the work of a "jack of all trades". Interestingly, Martin (2012) suggests that the first time "jack of all trades, master of none" appeared in print it was to describe an early pharmacist:

> Charles Lucas's *Pharmacomastix*, 1785: 'The very Druggist, who in all other nations in Europe is but Pharmacopola, a mere drug-merchant, is with us, not only a physician and chirurgeon, but also a Galenic and Chemic apothecary; a seller of drugs, medicines, vertices, oils, paints or colours poysons, &c. a Jack of all trades, and in truth, master of none'.

This would suggest that Tia was unwittingly identifying herself with an age-old concept of pharmacists as being multi-skilled, and yet not particularly specialised in any one field. "Master of none" was perhaps the sentiment Tia expressed when she described herself as not yet specialised in any particular aspect of pharmacy, including research or academic pharmacy.

Even though Tia taught and as she mentioned, had put considerable effort into it, taking steps to develop her teaching, she did not view herself as a teacher, "I'm not a teacher – I am a teacher - I have the BPharm qualification and I have the M[8] – but I'm not a teacher" (1: 32). She viewed teaching as a "means to end"; part of the "package" (1: 193) of doing a doctorate and "not where [her] focus is" (1:195). The metaphor she used to describe herself as a teacher was that of a "distant aunt". In this metaphor she specifically described herself in terms of her relationship with her students, viewing herself as someone who the students "visit for a period of time – and they gather whatever they need to gather, and then go back home" (1: 60). In elaboration of the metaphor she suggested that the "aunt" aspect illustrated the "personal family connection" (1: 64), whilst qualifying it with the adjective "distant" which suggested that it was "not too personal" (1: 64) and only for a restricted period of time. The metaphor of "aunt" would also suggest someone who is older and wiser, who is willing and able to share their knowledge with others; "You go to visit your aunt for two weeks and you get there, and depending on what her rules are, she might teach you how to cook, sew, and

[8] Master's degree

then send you back home" (1: 64). It was this specific metaphor by which Tia described herself, that gave rise to the pseudonym "Tia", since "Tia" is the Spanish term for aunt (Merschat.com, 2012).

While acknowledging teaching as one of her functions, Tia did not see herself as a teacher, and viewed her central focus in teaching, as teaching her specific discipline – pharmaceutics, rather than that of developing pharmacists. By suggesting that it would be difficult for a person who was not a pharmacist to teach pharmaceutics, despite having all the necessary knowledge and experience, she implied that her identity as a pharmacist was an important aspect of her teaching. She furthermore stated that "it's almost taken for granted everybody there is a pharmacist who lectures" (1: 160).

Although Tia never directly identified herself as researcher, she did say "that research remains my love" (1: 183), and suggested that research, albeit outside of the academic environment, is where her future lay. Perhaps it is also pertinent to note that although there is a very subtle relationship between the two; Tia did not teach subject matter directly related to her area of research. And while she did not say it, this may serve to explain her hesitancy in describing herself as a researcher, in addition to her seeing teaching as a "means to the PhD" and not integral to it.

Tia used the metaphor "tomato", to describe her experience as a production pharmacist. This can also be seen in terms of her relationship with others in the production work environment. Explaining her choice of tomato as a metaphor she said: "when I open the fridge, if the tomatoes are out, I just pick a tomato, so there's not much difference between the tomatoes in the fridge, and that's exactly how I felt in industry when compared to the pharmacist assistants" (1: 68). This metaphor describes the way in which her sense of herself, as a pharmacist in industry, is that of being under-valued.

Similarly with community pharmacy, Tia used an image of the "pharmacist with the white jacket … behind the counter" (1: 76) to describe herself in relationship to the customers. It is a cold, clinical image of a relationship in which she felt that as a professional she was again under-valued; "The interaction with the patients is miniscule … most of them know what they want, they are not really interested in what you are going to say about it" (1: 76). She furthermore felt that many of the functions which she viewed as pertaining to the scope of practice of a pharmacist were actually performed by pharmacists' assistants.

Although in the past, Tia did not view professional associations such as the PSSA as contributing to her identity; her recent membership did imply recognition of the future role which they might play in her growth as a professional. Similarly, she recognised that

networking organisation, outside of the pharmacy domain, such the Business Women's Association which she had also recently joined, offered similar opportunities.

5.2.1.2 "Pharmacist" as core to Tia's professional identity

Tia had a strongly expressed self-perception of her professional identity as being that of a pharmacist, evidenced in her repeated references to this. Without denying the multi-faceted nature of her professional character, her identity as a pharmacist could be considered to be a core or central identity that appears to inform all other perceptions of her professional self. Tia appeared to express all the facets of her professional identity in terms of this core identity, which apparently thus rendered her professional tasks and functions meaningful: "I see myself as a pharmacist, but I'm a jack of all trades – so I can be anywhere and bring it down to pharmacy" (1: 171). .

It does, however, seem incongruous that this core identity was expressed within the context of Tia holding negative views about both the manner in which the profession, for the most part, was being practiced and her perceived view of its future. Although Tia appeared to identify with the knowledge base or domain of the industry and community pharmacy communities which she inhabited, for the most part she did not identify with the shared practices within either community. Her sense of belonging, indicative of the extent of her identification with the community, was therefore weak and she furthermore may not have felt capable of contributing to and forming meaning within these communities. It is, however, through participation in communities of practice that identity is negotiated and as Wenger (1998) argues, it is in the tension between identification with, or the sense of belonging, and negotiability, or the individual's capacity to contribute to meanings that matter within a community, that identity is formed. Therefore, although Tia could be participating in industry and community pharmacy practice communities, her participation could be considered to be on the margins or the periphery and she did not have a strong identity within either community. It is not surprising, therefore, that the one pharmacy-related community of practice for which she expressed the greatest affinity, and also the greatest identification in respect of their shared practice, was the hospital sector. It is also notable that this was the one community to which she felt she could make a significant future contribution, through her research.

5.2.1.3 Importance of academic qualification

The literature, as discussed in Section 3.3.4, would suggest that it is relatively common for well-established professionals making career changes into academia to maintain a strong

core identity with their previous practice experience. However, there does not appear to be much in the literature that explains the sources of, or reasons why, a younger person such as Tia, who did not have a strong practice-based experience prior to academia, might cling to such a core identity. It would however seem logical that a younger person, who has relatively little professional work experience, might require other foundations on which to ground and form his or her identity. And Tia's story may suggest that one of these sources is the academic qualifications or professional knowledge-base of the individual.

Although in her locum work Tia participated in many communities of practice, it was peripheral participation (See Figure 3.3), and resulted in her relatively negative experience of various aspects of pharmacy practice. Consequently, Tia's core identify as a pharmacist did not appear to emerge from her peripheral participation in pharmacy related communities of practice, but rather appeared to be strongly linked to the value she placed on her knowledge base and her "BPharm" - her academic qualification as a pharmacist: "we studied for years and we pharmacists are proud of the profession of being a pharmacist" (1: 88).

In a similar vein, she viewed the attainment of her doctorate as an important progression in her professional development and identity. Her expressed idea that a doctorate "says to people you are able to conduct research" (1: 183), could suggest that achieving or acquiring her doctorate might result in her identifying herself more explicitly as a researcher. Tia envisaged her future in research, and she strongly associated getting her doctorate with both demonstrating her ability to do research and as means of accessing a research career, outside of academia. I suggest that her focus on research, which can be seen as the generation of new knowledge within a discipline (Henkel, 2007), supports the idea that her primary source of professional identity lay within her professional knowledge base. Notwithstanding the fact that she might have seen her doctoral studies as developing and demonstrating her research skills, it was also possible that she viewed her studies as growing her knowledge base and thus positively reinforcing her professional identity.

Although her focus has always been on research, and initially the relationship between research and teaching was not clearly evident to her, Tia's doctoral studies have provided her with both exposure to, and development in, other aspects of academic work such as teaching. However without proper guidance and mentoring in the process of learning to teach, and in balancing the teaching demands with her research programme, Tia has been left with the sense that she has been "chasing this PhD for so long" (1: 20) that she has not really been able to fully develop as an academic. Tia's expressed lack of integration into and sense of belonging within the academic communities of practice in neither the department nor the university, may also have contributed to her hesitancy to adopt an academic identity.

This begs the question: had there been a clearly defined career path, adequate mentoring in both teaching and research offered to Tia, and greater effort made to include and integrate her within the department and university, when embarking on her doctorate, would an academic career not have appeared to be a more attractive option for her, than it presently does?

5.2.2 Tia's perceptions of pharmacy and pharmacy education

As previously stated (Section 5.2), Tia's practice experiences have left her with a negative concept of pharmacy and the manner in which it is generally practiced. She particularly felt that the profession is being devalued by the way in which pharmacists allow pharmacists' assistants too much freedom to act outside of their scope of practice. Within this milieu she believed that change was necessary and the pharmacy profession needed to redefine itself by accepting responsibility for practicing ethically within the boundaries of the law. She also believed that moving toward offering clinical pharmacy services within an integrated healthcare team would allow the unique skills of pharmacists, to come to the fore.

I would suggest that although she believed pharmaceutical care has a contribution to make to the care of patients, particularly within the context of a multi-disciplinary team approach, her choice not to include aspects of pharmaceutical care in her own teaching implied that she neither fully embraced it as a guiding philosophy herself nor offered it to students as such. This is consistent with her stated understanding of her primary teaching focus being that of teaching her discipline, pharmaceutics, rather than developing pharmacists. If, as I suggested earlier, her own personal primary source of professional identity lay in her professional knowledge base, it would also follow that she might have viewed sharing this knowledge base through teaching as central to her contribution to the education of pharmacists. She did derive a fair level of personal satisfaction and meaning from seeing students develop into professionals: "that's when I do realise, 'you know what? I'm part of a bigger team that develops pharmacists. But most of the time it is mostly about 'ceutics[9] …" (1: 152).

Despite her own acknowledgement of focussing primarily on her subject material, rather than the socialisation of students into the profession, based on her own experiences of practice and those of her students, Tia recognised incongruities between the manner in which pharmacy was taught and the way in which it was commonly practiced and she acknowledged the dilemmas and difficulties that this created for the students: "it's a shock for them, and it can be depressing" (1: 108). She did, however, still have hope for the situation:

[9] 'Ceutics is a commonly used abbreviation for pharmaceutics, within the academic environment

offering that by making students aware of the incongruities, and preparing them to be change agents, the “situation is not completely dead” (1:104) and “there’s a lot that can be done” (1: 104).

5.2.3 “Who” is Tia?

Tia has a strong core identity as a pharmacist – grounded in her professional knowledge base as embodied by her academic qualification. She has not made an occupational commitment to academia, or to being an educator, and in keeping with her passion for research, is still exploring her career options. Her participation, on the boundaries of multiple communities of practice, typified by the metaphor “jack of all trades”, and as expressed through her practice experiences, has shaped her concepts of the pharmacy profession and also the direction in which she is exploring future career options. She views the attainment of her doctorate as a means of accessing a career in research, rather than as an entry into academia

In her role as a pharmacy educator, she sees her primary focus as providing students with a solid knowledge base within her discipline. She does not specifically see her role as developing pharmacists. However, she recognises the importance of preparing students to face the realities of practice and to make a contribution to changing the manner in which pharmacy is practiced She does also derive personal pleasure in being part of a team which develops pharmacists.

5.3 Vinetra’s story

Now in her late fifties, and nearing retirement age, Vinetra has spent more than 30 years teaching pharmacy. Except for a year of internship in community pharmacy, which followed the completion of her undergraduate pharmacy studies, her entire working life has been within the university environment.

Vinetra was very young when she left school and had “no idea” (2: 13) of what she wanted to study. She was under pressure from her parents to do medicine but as she stated “I knew that I didn’t want to do it” (2: 13). In response to her parents’ disappointment at her failure to submit application forms to study medicine, she decided to apply to study pharmacy: “at the time my sister was dating a pharmacy student, and I thought, ‘well that will shut them up - I'll do pharmacy for four years while I figure out what I want to do with my life’” (2: 13). She also thought studying pharmacy would give her time to “grow up” (2: 13). Four years later she

completed her pharmacy degree, which she "quite enjoyed" (2: 13), and started an internship in community pharmacy.

Three months into her internship, Vinetra received a phone call from the head of the pharmacy school where she had completed her undergraduate pharmacy programme, inviting her to consider undertaking postgraduate studies. Although by this time, she had already applied to another university for a further undergraduate degree, her response to the invitation was: "that sounds like fun, but I need a job" (2: 13). Two weeks later she was offered a junior lectureship as a means to financially support herself whilst completing a Master's degree, and she accepted the offer. This was despite her having categorically stated, when being interviewed on completion of her matric[10], "you know I am not sure where I want to go, but I know I never want to teach" (2: 13); a sentiment Vinetra suggested was rooted in the fact that both her parents were teachers, and she "was very clear that [she] didn't want to do it" (2: 13).

Vinetra took up the junior lectureship and "fell in love" (2: 14);

> That was it. I got into a classroom and I suddenly decided that I love this. I really, really enjoy teaching. I am not a researcher ... I enjoy teaching. And I don't regret it. I was really happy. For a couple of years, it took four years before I got to permanent staff, and I don't regret a minute of it. I really found fulfilment in teaching. (2: 14)

She found such fulfilment that academia has been where she has remained ever since - at the same institution, teaching pharmacy students; with the single exception of a short spell of four years at an overseas institution, where she completed her doctorate. She was granted unpaid leave during this period and remained on staff at the local university.

The focus of both her teaching and research has, however, not remained the same. Vinetra began her academic career in pharmaceutics with a strong bias toward the pure sciences, specifically microbiology. Her Masters' research, was the area "where I needed to be at that time. I was very shy, very insecure, and the lab was a safe place to be" (2: 80). Having completed her Master's, she began a doctorate in a similar subject area, but as she suggested: "I didn't get very far, because by that time I'd developed a little bit and I knew that wasn't where I wanted to be" (2: 80). She completed an honours programme in epidemiology and biostatistics, and then, in choosing the subject for her doctoral studies, she "went left base" (2: 80) and moved into the social science arena. She had no regrets about starting off

[10] Matric is a South African abbreviation for matriculation and refers to the final year of school

in the pure sciences, stating that “the timing worked … I needed to start off there” (2: 80). Vinetra considered herself to have been “extremely lucky” (2: 80) that her return to the university on completion of her doctorate was also timeous, coinciding with the “genesis of pharmacy practice” (2: 80), a relatively new discipline area grounded in the social sciences. The fact that she “could move, and there was a new discipline starting” (2: 80), and that she “could be the person really involved” (2: 80), left her feeling that she was “extremely fortunate” to be “in the right place at the right time” (2: 80).

Vinetra has moved through the academic ranks, to the professorial level, and found herself as Director of the School of Pharmacy, a position she did not enjoy: “I was extraordinarily burnt out after I was director of the school for five years, it was the worst five years of my life ... I hated every bit of it” (2: 56). During the period that she was Director of the School, her involvement in the wider university was extensive: “I sat on a lot of cross-faculty things. I used to be involved, then I was on management committees … I’ve served on the transformation forum, I've been in senate assessments and things like that” (2: 56). However she has deliberately withdrawn from positions of management, stating that, “I don’t like management, I don’t like the admin, I don’t ... it’s a necessary evil I find it ... and I just got to the stage now where I reckon, I am old enough and close enough to retirement to do what I want to do” (2: 56). Throughout her career she has felt, and resisted, the pressure to assume increasingly greater managerial responsibility. In the past, she has questioned whether this pressure was a consequence of her competency, or of her gender being female at a time when there was a drive to promote female participation in university management:

> When I was younger, I’ve been part of it, and I knew that wasn’t where I wanted to be. There was a lot of pressure on me to apply for the deanship of the faculty, lots and lots of pressure. I think being female is part of it, and being around when there was really the start of a push to get females to take their place and sometimes I resented the pressures being put on - you should do this because .. and you sort of think, is it because I’m capable or because I’m female? And I know that when I refused to do things, they don’t interest me, I didn’t want to do it, it’s almost as if I was letting down the female side, but I have to be true to myself. I mean, I could have been sitting in upper management now; I didn’t want it. (2: 56)

Her dislike for being in positions of management stemmed from the fact that she disliked the pressure of “always having to represent a constituency” (2: 58) and because they removed her from her primary passion of teaching, “I missed the students, I missed teaching, because it had to come second because I was so busy doing all the management stuff, my teaching

load was cut right down and I missed it" (2: 58). Having withdrawn from managerial roles, Vinetra viewed the School as her university community and felt both comfortable and supported in this: "I have a lot of support. It's accepted here … our director … and I make it quite clear, this is what I want to do, I don't get pushed, and I'm much happier" (2: 58). She also acknowledged the need for a balanced life as one of the motivating factors in her decision to withdraw from management and focus on work which she enjoyed and found fulfilling:

> I just feel that I have a responsibility outside of my job, I have a responsibility to have quality of life outside of it. I feel very strongly about that, and I can't have that if I'm not happy at work and if I don't feel fulfilled. (2: 60)

Vinetra does not practice as a pharmacist outside of the university environment, having "last practiced when there weren't even dispensing systems in community pharmacy" (2: 40). When she returned from completing her doctorate overseas, "after the gap of four years …I came back and was asked to do a locum and I panicked. The whole system scared me and I got such a fright, and I had such a horrible day, and I have just never been back" (2: 40). This lack of practice experience has left her feeling "out of touch with pharmacy" (2: 40), and it is "something that bothers [her]" (2: 40); however, she is "dead scared to go and practice" (2: 40). Her lack of practice experience has also made Vinetra "more and more aware that maybe I am irrelevant as a teacher, because I am not out there at the coal face" (2: 40). Although she expressed this awareness as "a deficiency" (2: 40), she did however go on to suggest that it was not a major concern, because of the nature of the subject matter she teaches, "I suppose in the things I teach it is not that important. I am not teaching therapeutics; I am talking human interaction, and that doesn't change over the years" (2: 40). She also considered this "deficiency" to be countered by very active involvement at both a local and national level in pharmaceutical organisations, such as the Pharmaceutical Society of South Africa and the South African Pharmacy Council;

> I think also the involvement at branch level of the pharmaceutical society, with being involved with portfolios at the Council[11], and being part of the research study there. I think I see that making up for the deficit I recognise within myself. So I am a little bit involved … I'm not at the coalface but at least I can bring something … you know … to this place. (2: 40)

She also viewed her involvement in professional organisations as providing a positive role model for the pharmacy students whom she taught:

[11] A common term used by pharmacists when referring to the South African Pharmacy Council.

> It's useful being at the cutting face where the discussions are happening ... I think it's interesting. I think it helps. Without being overt, when the students see your involvement, I think it's important in terms of the role modelling. We don't have to go out there and preach, but they see our involvement and they see it as part of being a pharmacist, and I hope that they are inspired to emulate that. So I think from that perspective, I tend to share with them, I think we all do. A lot of us here are on one or other ... all kinds of bodies, and I think collectively we think it's important in the School to tell the students when we are away, what we are doing, so they just see this as a normal natural part of pharmacy, of being involved. So from that perspective I think it is important, it is an important role. (2: 38).

Vinetra felt that the university has never hindered her involvement in professional organisations, "no never, never over the years ... in all the years I was on the Academy[12], I was on the Academy Exco[13] for nine years, and now back on PSSA[14] , no, we have a lot of support" (2: 52). In addition she expressed the opinion that, at the university professional involvement is "almost expected of us …we get a lot of support ... we're almost expected to be involved in our professions" (2: 52). She has experienced the university as recognising professional involvement as an important aspect of community outreach and unlike many other universities considers community outreach, along with teaching and research, as an important criterion for promotion;

> They actually weigh the community outreach the same. This university I think has moved probably earlier than some of the others to looking at the value of community outreach, and involvement in your profession and that kind of thing. So it's held in pretty high regard; I mean I would never have gotten promotion on research obligations; okay, I basically got it on teaching and community outreach, so that shows that they do consider it. (2: 54)

Vinetra has also participated in local and international conferences, although, with the occasional exception of an educational or public health conference, her participation was normally within the pharmacy education and practice domains.

Vinetra viewed her specific role in teaching as the development of future professionals: "in teaching, I think I'm far more interested in teaching, not as in imparting content and knowledge but in terms of developing a professional persona. That's what I see as my role"

[12] A common term used to describe the South African Academy of Pharmaceutical Sciences
[13] An abbreviation for executive committee
[14] An abbreviation for the Pharmaceutical Society of South Africa

(2: 26). This is also where she has derived her sense of fulfilment, “that’s what makes me, and it’s when I get feedback, when I get an email from an ex-student coming back and saying this is what I'm doing and thanks you inspired me! That I think is the pinnacle.” (2:26). She acknowledged that teaching, within the discipline of pharmacy practice, has allowed her the opportunity to fulfil her perceived role. “I suppose I am happy because I don’t really teach pharmacy, I’m just teaching human interaction … I’m very much grounded within pharmacy practice, and I’m quite happy. I don’t think I would want to see myself anywhere else” (2: 76). She also expressed a preference for the teaching methods, for example, highlighting her use of assessment methods, that she perceived were possible within a social science based discipline, such as pharmacy practice. “I even look at the way the science stuff is assessed, I couldn't do that because it just … it doesn't talk to a person that you teaching … I much prefer the kind of assessments that we do, ... and developing the individual person” (2: 80).

Vinetra’s “second level passion” (2: 90) and fulfilment in her work, is in raising “the next generation of teachers” (2: 88). She has been specifically mentoring three younger academics and has derived considerable enjoyment from “seeing them grow” (2: 96) and from giving them “the space to grow” (2: 96). She described how her active withdrawal from meetings and arenas where important decisions are being made, has opened up opportunities for her mentees to develop:

> We as a school are going through, you know, every couple of years we go through a whole new re-curricularisation process. That’s where we are at now. I've made a conscious decision to pull out of it. I said, ‘You guys, you make the decisions, you sit with the other disciplines. I maybe won't agree with everything, but I will support whatever you guys decide.’ I want them to have the space, and the freedom to determine the future. (2: 96)

Although Vinetra is “very passionate about pharmacy”, and expressed a belief in the central message of pharmaceutical care as “a closer relationship with the recipient of that care”, she had concerns about the implementation of pharmaceutical care in practice, and the manner in which she perceived pharmacy is often practiced:

> I think pharmaceutical care also brings out for me the fact that we need to individualise our interactions with patients …I think we have to open our minds to the fact that we can have four patients there with the same prescription but they are different people. And the outcomes are going to be different depending on who they are, what their lifestyle, their circumstances,

> their beliefs, and all of those things … and I think unless as a pharmacist you open to seeing a patient as more than a hand that takes a box that says 'take one three times a day', then we are not practicing pharmaceutical care. It's that openness to seeing this person as a person and not just as … as somebody who is fetching a prescription. And that is why it saddens me because I think we have bandied this around but they haven't made that mind-set shift. That's what saddens me about the profession. (2: 34)

Furthermore, she was concerned about the disparity between attitudes with regards existing practice: the attitudes which students encounter from pharmacists in practice, as opposed to the changing practice that she and her colleagues at the university are trying to teach and impart to students

> I'm not that unhappy with the product that we send out into the world; I mean 'we' collectively. I worry what happens when they interact with disillusioned pharmacists. That's the interface that we don't have control over. When students come in here ... they're crying because they get negativity … A typical interaction: 'Why you studying pharmacy? There's no future' and the bottom line I think is while they are students they can buy into this. Then they get into the real world, and then they are not empowered, they don't have tools, they're not mature enough at that stage to try to take this idealism and put it into practice. (2: 36)

Her concern was for the impact that this incongruence has on young pharmacy graduates: "We've got a young student going out, we've got your idealistic professors here, and you've got the guys paying their salary, and that is the dilemma" (2: 36). Furthermore she was not sure how the gap could be bridged: "I don't know how we address that" (2: 36), although she was not entirely without hope in the situation:

> I think as more and more younger pharmacists, who they interact with, have had the same experience ... I think the tipping point ... it's not too far in the future, where there will be more of those that can socialise them differently at an undergraduate level. I'm optimistic that the tipping point will come. Maybe not in my lifetime, but it will come. (2: 36)

Although Vinetra could not have foreseen how her career would develop; "We're not the masters of our destiny and things happen, and you don't understand them at the time. And I just believe things were set, I couldn't see it, but the challenge is just to embrace what comes" (2: 100), she was very positive about the way that it had unfolded. She concluded

that “I do count myself extremely fortunate in being happy and fulfilled in my job; I love it” (2: 100). While she was starting to think about retirement and expressed the feeling that she would like to retire “before I lose the passion” (2: 84), she did not see this happening in the immediate future; “I don't think I am talking about retirement; I wouldn't be able to ... not yet ... I've got a couple of years to go” (2: 84).

5.3.1 Interpreting Vinetra’s story

5.3.1.1 Vinetra’s self-perceived professional identity

Vinetra has spent more than 30 years in academia, and yet she was struggling still to describe her occupation: “So I’ve never in all these years actually become comfortable with how to describe it … , thirty years later, I still don’t know really what I do” (2: 18). She said that, depending on the context, more specifically on who was asking the question, she would sometimes describe herself as a pharmacist; but she believed “that’s a lie - because I’m registered as a pharmacist, but I don’t … I'm not a pharmacist” (2: 18). She based this assessment on her lack of practice experience in a patient care setting, “I can't go out there and practice pharmacy in a patient care setting” (2: 18).

However, she was also not comfortable labelling herself as an academic, educator or professor. The term academic she described as “pretentious” (2: 18), educator as “bureaucracy speak” (2: 18), and “professor” she perceived as “just a rank” (2:18), which did not describe what she actually did. Her discomfort with each of these labels may also be related to the dis-ease that she felt at the perceived elevated status attributed within the pharmacy profession to academics, particularly those of professorial rank. She described this dis-ease in terms of “the feeling of being a fake” (2: 64) and, “I think its phoney” (2: 70), that resulted from “an automatic elevation in status” (2: 64) to that of “super being” (2: 70) within the profession, which she said “doesn’t sit well with me” (2: 64), and which she viewed as “a lot of nonsense” (2: 66). She was unsure how it was best to be dealt with; “sometimes it irritates me … sometimes I giggle at it … but I am very aware of it” (2: 66). She suggested that at times this elevated status was actually cultivated by academics themselves but it was something that she was certainly not comfortable with;

> I just want to say “Hello, it’s a job title’, but I think it is a sad thing ... and I know what I am saying to you now is probably not a universally held view, because a lot of my colleagues irritate me intensely because they elevate themselves and that to me is … ‘Get real! ... You’ve just chosen a different

path … you not anything special you know, you just doing what you've decided to do'. (2: 74)

Vinetra also stated, very specifically, on more than one occasion, "I am not a researcher" (2: 018; 2: 084). She said that research was not where her "passion lies" (2: 018), and that "it's not me" (2: 084). She also recognised that her promotion to professorial level was not related to her research activities but rather to her community outreach - a consequence of her high level of involvement with the pharmacy profession and also related to her teaching: "Okay I basically got it on teaching and community outreach" (2: 54).

Archer (2008) views identity as "disrupted processes" (p. 387), which are not only about "becoming", but also "unbecoming" (p. 387), which would certainly appear to be true of Vinetra, who often tried to describe who she was, in terms of who she had come to recognise herself as *not* being: "I am not a pharmacist" (2: 18), and "I am not a researcher" (2: 18; 2: 84). Furthermore, Archer (2008) states that "becoming an academic is not smooth, straightforward, linear or automatic, but can also involve conflict and instances of inauthenticity, marginalisation and exclusion" (p. 387). This too, appeared to have been part of Vinetra's experience, characterised by her inability to adequately describe her occupation; her recognition that she can no longer "practice pharmacy in a patient care setting" (2: 18), and her use of the words "fake" (2: 64) and "phoney" (2: 70) with respect to herself.

5.3.1.2 Vinetra the teacher and mentor

Although Vinetra never actually stated "I am a teacher", when describing her occupation, she usually said to people "I teach" (2: 18). This hesitancy to label herself a teacher may stem from her early determination that she never wanted to be a teacher, associated with the fact that both her parents were teachers. She did, however, suggest that it was the teaching aspects of her occupation that carry the most weight when trying to define who she considers herself to be: "I do focus on the teaching aspects being who defines what I am" (2: 18). In keeping with the notion that professional identity is associated with feelings of "personal adequacy and satisfaction" in the workplace (Trede *et al.*, 2012, p. 10), Vinetra's "love" (2: 13; 2: 14) for teaching, and the sense of satisfaction she received from it, "I enjoy teaching" (2: 14) and "I really found fulfilment in teaching" (2: 14), appeared to provide the basis for her professional identity.

The metaphor Vinetra offered to describe herself professionally was that of a "mirror" (2: 21), which she explained in terms of her relationship with her students; "I hope that I can see the students who have passed through me as a reflection and that they would be able to reflect some of the values I have tried to impart" (2: 24). The metaphor also needs to be understood

in the context of Vinetra having described the development of the students' "professional *persona*" (2: 26) as the primary focus in her teaching, rather than the transfer of "content and knowledge", and her expressed hope that she served as a "role model" for students:

> That's why I think I used the mirror. … I hope I am a role model ... I hope to inspire and I try to get people to develop a professionalism, that's what I aspire to. You know you don't ... I don't think it works with everybody but if you get one or two a year ... that's it! (2: 26)

She furthermore clarified how, in light of her own self-identified lack of practice experience, she perceived herself as providing a role model for the students:

> I try, even though I don't see myself as a practicing pharmacist. I think I have a passion for the profession which has developed and I do try to share that. Inspire the students with it - a passion. A passion for people and a passion for just putting your heart and soul into what you do. (2: 28)

In keeping with her identity as a teacher, Vinetra also expressed a passion for mentoring or raising "the next generation of teachers" (2: 87). The sense of joy and fulfilment she experiences in the process affirms her in her role as teacher: " … just seeing the growth. So that's probably also what I'm enjoying now ... and its good fun. I'm enjoying. I'm granny now. Yes, I suppose it's the teacher coming out" (2: 98). And it is at the interface between teaching – providing a "role model" for students, and mentoring – and raising the next generation of teachers, that Vinetra described as a defining professional moment in her life:

> I think that the defining moment in my life was a student walking into my office a couple of years ago, in final year; not a student I knew particularly well, coming in here and saying "I've just come to tell you that I've made some decisions about my future" and she says, "I want to become you". That is powerful. She's sitting two offices down. (2: 94)

The pseudonym "Vinetra" was chosen in an attempt to capture the central focus of the defining moment described in the above quote and the essence of her professional identity. "Vinetra" is a Sanskrit word meaning "guide" and "teacher" (Merschat.com, 2012).

5.3.1.3 Grounded in the discipline

Vinetra expressed a strong identification with the discipline within which she taught – pharmacy practice. When it was first introduced Vinetra was involved in the development of

pharmacy practice and instrumental in the development of the curriculum. She described the fulfilment and enjoyment she gained through being central to the process:

> … that was the genesis of pharmacy practice. I've been extremely lucky. I was in the right place at the right time … there was this new discipline starting, and I could be the person that was really involved. So I count myself as being extremely fortunate … there is nothing that I am teaching today that I was taught, nothing that I am teaching existed in the curriculum. So I've had free reign basically. And that's been very fulfilling as well. And having the space to do things that were never done before, and that's been fun. (2: 80-82)

Although Vinetra started her academic career in a science-based discipline, it was her doctoral studies which saw her make the move toward a more social science based domain, "my PhD went left base" (2: 80). Although Becher and Trowler (2001) propose that doctoral studies are often viewed as the last stage of socialisation into a discipline and are integral to disciplinary identity, for Vinetra it was her doctoral studies which served as the stimulus for her movement to a new discipline. Her studies could also be viewed as having enabled Vinetra to take advantage of the opportunity to move to a discipline with which she could more fully identify and to be integral to its development. The identification aspect is what Vinetra highlighted when she said that she was "very grounded in pharmacy practice" (2: 76). However as Wenger (1998, p. 188) suggests, the formation of identity depends not only on identification but also on one's capacity to negotiate meanings that matter within a context; what Dison (2004, p. 90) terms "ownership of meaning". It was perhaps this "ownership of meaning" that Vinetra was talking about when she said that she found great fulfilment in having "free reign" and "having the space to do things that have never been done before" (2: 82). It is interesting to note that by providing the young academics whom she was mentoring, the "space and the freedom to determine the future" (2: 96) of the discipline, and to support them in their decisions, Vinetra apparently, perhaps subconsciously, recognised the importance of having the freedom to negotiate "ownership of meaning".

5.3.1.4 Participation in communities of practice

Having been part of the School of Pharmacy for more than 30 years, five of which she served as its director, Vinetra was a core participant in the School, which she called her "university community". It is in the context of this community that her identity as a teacher was negotiated. She assumed various roles within the community and over time moved from the peripheries in the post of junior lecturer and Masters student to the core of the

community as a leader and co-ordinator. As a key player in its development and growth as a discipline, Vinetra's participation within the pharmacy practice community has also been core. In both of these communities Vinetra represents what Wenger (2000, p. 241) describes as a "paradigmatic trajectory". In her mentoring of younger academics and providing a role model, such that those on the periphery can look at her and say "I want to become you" (2: 94). Vinetra was offering to newcomers a basis for constructing their own trajectories into the community. Furthermore, as Wenger also proposed, the encounter between Vinetra and the newcomers – the younger academics - has been mutually beneficial, in that the "identities of both are expanded" (Wenger, 2000, p. 241). Vinetra's professional identity has expanded to include the role of mentor and she has provided the opportunity for newcomers to both envisage a "possible future" (Wenger, 2000, p. 241) within the community and to grow into that future, by providing them the freedom to actively determine it: "I want them to have the space, and the freedom to determine the future" (2: 96).

Although she previously participated more fully in the wider university community, her active decision, taken several years ago, to withdraw to the peripheries of this wider community has seen it assume a less prominent role in her identity. This is understandable since, as Wenger (2000) argues, meaningful core membership is only possible across a fairly limited number of communities and while Vinetra was Director of the School, and more fully engaged in the wider university community, she "missed teaching since it had to come second because I was so busy doing all the management stuff" (2: 58). Withdrawing to the periphery of the university community provided the opportunity to re-immerse herself in teaching - what she viewed as one of the key practices within her School and Discipline communities.

Notwithstanding the fact that Vinetra viewed her lack of practice experience with concern, she did maintain a keen interest in and knowledge of practice through her active involvement in other pharmacy-related communities of practice, such as professional organisations. "I think particularly in practice[15], it's useful being at the cutting face where the discussions are happening" (2: 38). This again provides a "paradigmatic trajectory" or "possible future" for students, which is important for their socialisation into the profession:

> Without being overt, when the students see your involvement, I think it's important in terms of the role modelling. We don't have to go out there and preach but they see our involvement and they see it as part of being a pharmacist and I hope that they are inspired to emulate that. (2: 38)

[15] This is a reference to the academic discipline Pharmacy Practice

Furthermore, although she did not seem to recognise it, the status afforded her by the practicing profession, with which she expressed discomfort, may be viewed as evidence of the value they place on her occasional participation, in what they apparently perceive as an "expert role" (Wenger & Trayner, 2012).

5.3.2 Vinetra's perceptions of pharmacy and pharmacy education

Vinetra was "very passionate about pharmacy" (2: 76) and although she did not view herself as a "practicing pharmacist" (2: 28), she said she had a "passion for the profession which has developed, and I do try to share that. Inspire the students with it; a passion for people, and a passion for just putting your heart and soul into what you do" (2: 28). This encapsulated how she viewed her role in pharmacy education. She saw herself as primarily focussed on trying to develop the students' "professional *persona*" (2: 26), rather than "imparting content and knowledge" (2: 26):

> I think I'm far more interested in teaching not as in imparting content and knowledge but in terms of developing a professional persona. That's what I see as my role. That's what makes me, and it's when I get feedback, when I get an email from an ex-student coming back and saying 'this is what I'm doing and thanks you inspired me', that I think is the pinnacle … I hope I am a role model … I hope to inspire and I try to get people to develop a professionalism, that's what I aspire to. … I don't think it works with everybody but if you get one or two a year, that's it. (2: 26)

It is, however, within the context of both her passion for pharmacy and her desire to inspire and develop professionalism with the students that she also expressed disillusionment with the way she perceived the profession being practiced. This is perhaps best illustrated by giving consideration to her perceptions of the term "pharmaceutical care". Although Vinetra expressed belief in the core principles of pharmaceutical care:

> If you really look at the concept of pharmaceutical care it means a closer relationship with the recipient of that care. More than being just a recipient of medicines; it's looking at what are those medicines going to do; who is this person; how is this person likely to experience these? And that then feeds back and tailors the way in which you interact. I think pharmaceutical care also brings out for me the fact that we need to individualise our interactions with patients. (2: 34)

She thought that the term had “lost its impact” (2: 30), that is it had become “simply a throw away and everybody's using it without actually interrogating what it means. It’s lost its value” (2: 30), in the sense that whilst “everybody’s talking pharmaceutical care” (2: 30), she didn’t think “that people are internalising what it means” (2: 30):

> I don’t think that the core concept which is that the pharmacist goes that little bit further and actually tries to really focus on the outcomes of the patient; I don’t think I see that happening in practice. But I hear a lot of pharmaceutical care speak, but it’s not necessarily happening. And I think perhaps if we were in a situation where we didn’t have this handy label, it would be easier to get pharmacists to think that way; now we just talk pharmaceutical care. It has just become a synonym for interacting with the patient. But I think it’s lost its meaning. (2: 30)

She suggested that the profession seemed to have lost the “core” of pharmaceutical care, and the understanding of how it made “our formulation of pharmacy different from the previous formulation, where we talked about patient centered care and different from what we saw in the past when the pharmacist was the compounder of medicines” (2: 30). It was the lack of substantial impact which the concept had made on practice which particularly concerned her:

> Unless as a pharmacist you are open to seeing a patient as more than a hand that takes a box that says “take one three times a day”, … then we are not practicing pharmaceutical care. It’s that openness to seeing this person as a person and not just as somebody who is fetching a prescription. And that is why it saddens me because I think we have bandied this around, but they haven't made that mind-set shift. That’s what saddens me about the profession. (2: 34)

She suggested that at the root of the failure to make the “mind-set shift” which she believed was necessary for pharmaceutical care, was the professions lack of self-belief in its capacity to add value to healthcare and to society:

> I see a lot of pharmacists that don’t believe in themselves; they don’t believe in their value, and the value that a pharmacist can give to society. They see themselves as dispensers, and I think it is because they haven't internalised it. They just don't practice it, in terms of looking at this patient: What value do I add to this person's life? What can I do? And I think until we see as

> pharmacists our role; the tremendous role that we have to add to the health care chain; then I think we are a little bit in trouble as a profession. (2: 34)

From the standpoint of a teacher, one of Vinetra's major concerns was therefore the negative impact this had on students: "I worry what happens when they interact with disillusioned pharmacists; that's the interface that we don't have control over" (2: 36). She saw students who were "brow beaten by people who are negative" (2: 36), and it concerns her. Although she acknowledged the difficulties that the pharmacy profession had endured: "I'm the first one to accept that pharmacy has had a hell of a hard time lately; it seems to be knocked from all sides" (2: 36), she did not view this as an "excuse for negativity" (2: 36), and she expressed disquiet at the incongruities that it created for the students: "we've got a young student going out; we've got your idealistic professors here; and you've got the guys paying their salary; and that is the dilemma" (2: 36). However Vinetra appeared to suggest that if we continued to educate students capable of changing practice, a "tipping point" (2: 36) would be reached, at which practice will change:

> I think as more and more younger pharmacists who they interact with have had the same experience; I think the tipping point - it's not too far in the future - where there will be more of those that can socialise them differently at an undergraduate level. I don't think we're there yet. But I think it's going to be a question of numbers; and I think there are going to be more and more, and I think more and more as they do their clinical rounds and their experiential work, service learning … they have these different experiences as undergraduates; I'm optimistic that the tipping point will come. Maybe not in my lifetime; but it will come. (2: 036)

Intrator and Kunzman (2009, p. 514) propose that it is "vital teachers—engrossed, tuned in, and purposeful" that "effectively navigate the on-going, ever-shifting relationship between the self and the work". They suggest that "this vitality is linked to a set of ineffable, hard-to-codify qualities that can reveal itself to students as a quality of presence" that they term "vocational vitality"(p. 514). They furthermore describe the capacity to "wrestle with questions of authenticity, the on-going negotiation of personal identity and purpose with the work and context of teaching" (p. 514), as being integral to vocational vitality. I suggest that in her story, Vinetra offered many signs of "vocational vitality". Despite her struggles with issues of authenticity – being a "fake" (2: 64) and a "phoney" (2: 70) - and issues of relevance - "ivory tower" (2: 34), "idealistic" (2: 36), and "out of touch" (2: 40) – and her ability to offer criticism for her profession, she still strongly expressed her passion for both teaching and for pharmacy. She also remained hopeful that the "tipping point" (2: 36) would come when the

efforts she and her colleagues in pharmaceutical education made would bring about changes in practice. The career-long struggle to name her professional occupation, the ability to step down from managerial positions in order to pursue her passion for teaching and her desire to balance her personal life with her work life such that she could find fulfilment in both, are all indicative of an on-going negotiation of her personal and professional identities in the context of her life and work. The "quality of presence", identified by Intrator and Kunzman (2009) as evidence of vocational vitality, may also be what led one of Vinetra's students, now one of her colleagues, to say to her "I want to become you" (2: 94).

5.3.3 "Who" is Vinetra?

Vinetra's professional identity has been formed over more than 30 years by the range of practice experiences afforded her within the university environment and by discovering through that experience who she is – teacher and mentor – and also who she is not – director or manager. It has also been shaped by her occasional participation, as a perceived expert, in professional pharmacy organisations. However, after all that time, Vinetra was still not comfortable with how she described her occupation. She was very clear about what terms she did not like – academic, educator and professor – and although she identified herself with teaching, she appeared hesitant to call herself a teacher. She did, however, acknowledge that it was the teaching aspects of her work which "defines who I am" (2: 18). Depending on the context, specifically who was asking, she did sometimes call herself a pharmacist; however, her lack of practice experience made her reluctant to do so.

She is a core member of her discipline – pharmacy practice – and of the School of Pharmacy, although she has actively moved to the periphery of the broader university community. Her role as mentor to new younger academics within her discipline has seen her modelling a "paradigmatic trajectory" into the community of practice, empowering these newer academics to envision "possible futures" in academia.

Her passion for pharmacy is the source of her desire to develop the professional *personae* of her students, seeking to inspire them to high levels of professionalism, and to grow within them a similar passion for the profession. Notwithstanding the fact that she recognised the incongruities between the idealism she sought to impart to the students, and the manner in which she saw pharmacy being practiced, she was hopeful that by raising sufficient numbers of inspired new-generation pharmacists, a "tipping point" (2: 36) would be reached and pharmacy practice would be changed.

Although Vinetra admitted to wondering, at certain times in her career, “where’s this going to?” she felt that she could look back and say “of course that was meant to be”. She considered herself to be “extremely fortunate in being happy and fulfilled in her job” (2: 100), for which she expressed a real passion and love.

5.4 Zita’s story

Zita, is a 29 year-old pharmacist who, after registration five years ago, has been in a lecturing position. Prior to lecturing, she completed an academic internship while doing her Master’s degree in pharmaceutics, followed by a compulsory year of community service required by the Department of Health in South Africa. She is currently appointed as a lecturer in pharmaceutical chemistry and is registered for her doctorate in pharmaceutics.

Zita’s attraction to pharmacy was based on her perception of it as a career and route of study which would combine her major areas of interest, namely science, business and health: “Pharmacy was something I chose because it combined science as well as business and …. it amalgamated all that, and I knew that I wanted to do something that involved the health sciences as well” (3: 11). During her undergraduate studies she came to the realisation that she enjoyed research, which prompted her decision to continue with postgraduate studies: “It was then that I decided that I enjoyed the research side of it, so I decided then to do my academic internship here” (3: 11). She finished her Master’s degree whilst completing an academic internship. After the community service year, she made the decision to enrol for a doctorate: “I decided that I wanted to do my PhD as well” (3; 11). She returned to the university to continue her studies in pharmaceutics and took up a lecturing post in pharmaceutical chemistry. The decision to return to the university was primarily motivated by her desire to do research and accepting the lectureship was simply a means to support it financially. However, she had grown to enjoy the teaching aspects: “for me it was the research really. Of course the teaching component is something I enjoy now. But it's not initially why I did come back to be a lecturer” (3: 14).

When she started lecturing, Zita did not feel that she was fully prepared, although she acknowledged that the training that she had received during her academic internship from her supervisor had been helpful in preparing her: “during my Master’s, in my academic internship I had also done some lecturing training with my supervisor. I did have an okay background” (3: 29). She was of the opinion that “lecturing is something that you will learn over time; it's not like teaching at a school where you've learned to kind of teach. It's something you have to learn over time” (3: 29).

In her lecturing role, Zita was very aware of the fact that she was teaching future pharmacists, who needed to have a body of knowledge which they could apply in a practical setting:

> I think we are always cognisant of the kind of student that we're sending out into the environment; like once they've graduated … we want to know that they haven't just learned a whole bunch of stuff that cannot be applied in any way when they graduate. I think that for us especially now, we are a kind of quite concerned about how they're doing when they get into the outside world. (3: 49)

She therefore expressed the belief that "you can't just teach chemistry like that in isolation" (3: 45) and described how she consciously tried to integrate the chemistry that she lectured with other aspects of the pharmacy curriculum:

> When I'm doing the actual chemistry we are looking at pharmaceutics as well, pharmacology and then pharmacotherapy. You try and tie in with case studies as well. So when you are teaching chemistry to pharmacy students you want them to know that it's kind of specific to pharmacy. What I teach in fourth year especially; its very pharmacy related, because it's about all the drug molecules and why you using them, that kind of thing. (3: 45)

Her recognition of the need for application and integration of knowledge in practice appeared to inform the manner in which she lectured: "that's why our lecturing is becoming a little more problem-based, not just parrot learning and not really understanding why are they learning something … that they can actually apply it in the end" (2: 49). This same value for application also appeared to have led her to the belief that: "it's important to have people who are actually pharmacists lecturing pharmacy students" (3: 49).

Zita said that when it came to preparing students for practice, in some sectors, such as the retail sector, academia needs to be responsive to changes happening in the practice environment:

> In terms of the way that pharmacy is changing, for example in the retail sector, I'd say in that instance you can't [drive change], you have to respond to changes that are happening, you know, outside of the university, and that you can modify your course in relation to that. (3: 51)

While in other sectors, for example the industrial sector, academia needs to actively drive change by preparing graduates capable of changing practice:

> When I look at how things are in South Africa and with my focus on drug delivery systems, there's not a lot of progress outside in industry and stuff like that. And so I'd say to some degree it [change] must be self-initiated, that you want to drive it forward from an early stage with the pharmacy student. (3: 51)

It was her belief that her university was graduating students sufficiently prepared for current practice, particularly in the retail sector, and furthermore that they were capable of bringing about progressive changes in practice:

> Even with Masters students that have just finished with us, they are starting their own innovative company in terms of drug development … students who have gone into industry and are taking the lead as managers. In retail as well, where they are bringing about positive changes, as well as doing things differently. (3: 53)

She expressed satisfaction in hearing positive feedback from such graduates; “they do actually come back and talk to you about what they're doing and what they have achieved so far. So it is very good to hear that” (3: 51).

Zita also acknowledged the role that structured exposure to the practice environment played in preparing their students for the realities which they faced after graduation:

> Our students have a pretty good idea, because we are right next to the hospital, and our students are in contact with medical students all the time. And because we send the students to clinics twice a week, they are kind of exposed to the environment a lot. (3: 59)

She also viewed the students’ work experience in the retail sector as having contributed to their preparedness for practice: “they are already working in pharmacies as well, in their spare time. I'd say in terms of retail, they are well equipped” (3: 59). While she acknowledged that industry may be “a bit of learning curve” (3: 59) for new graduates, she felt that they were fairly well-prepared for a possible future in academia, “In terms of preparing the students to go into research and academia afterwards, we try and give them a good overview of that during their undergraduate years, you know, in presenting research that we are doing, you know, that kind of thing” (3: 59).

In terms of her own preparation for academia, Zita viewed her Master’s programme as having prepared her adequately, especially for research, and she spoke specifically of the very supportive mentoring she had received from her supervisor:

> I'm very research-focused, so he's put me in lots of situations that seem tough, but are important for development … to develop yourself as an academic. I've been exposed to many things. [Our university] is very research based, so it's not just about your lecturing and stuff, it's about the work that you are producing from research as well. And so we are always trying to push ourselves forward a little more, in terms of that. And I think my supervisor has encouraged that quite a lot. (3: 61)

She did acknowledge, however, that at times she was not completely confident in her role as an academic, but recognised that this may come with time; "I'm still a little unsure of what I'm trying to do, compared to people who have been in academia for a long time" (3: 63).

Zita was not practicing in any other pharmacy domains; she was participating exclusively within the academic community. She was a member of the Academy of Pharmaceutical Sciences and regularly attended national and international conferences in her research area. Although the funding for conference attendance came from sources external to the university, the university was generally supportive of conference participation:

> In terms of financial support, that is really from external organisations and that kind of thing, but in terms of other kinds of … I don't know what you can call it, just general support? I suppose they encourage it, they always like to hear of your achievements, if you did well at a conference or whatever. So I would say yes, to a degree they are quite supportive. (3: 41)

5.4.1 Interpreting Zita's story

5.4.1.1 Zita's self-perceived professional identity

Although Zita identified herself primarily as a researcher; "I'm very research focused" (3: 61), when asked her "profession" she described herself as a lecturer, because that was her official job title and it was what she was paid to do:

> I think that's basically what I been paid for, so that's what I write. Yes, even though I am a researcher, that's not like my primary profession. Or pharmacist as well; you know if I write pharmacist, that's not really right because my pay check says lecturer. I suppose that's what I say. (3: 33)

Although she recognised that "pharmacist" is something she could call herself, she did not identify with the role sufficiently to label herself as such. However, her suggestion that "it's

important to have people who are actually pharmacists lecturing pharmacy students" (3: 49), may be indicative of an identification with the profession which she sensed was foundational for the synthesis of her knowledge and accumulated skills.

The consciousness with which she drew a clear distinction between calling herself a lecturer as opposed to a researcher, suggests that Zita was equating being a lecturer with the teaching aspects of her role; those aspects of her role that she was actually paid for. It is, however, highly likely that her job description included research as an aspect of her academic role, as the Green Paper for Post-School Education and Training (Department of Higher Education and Training, 2012, p. 58) states that academics at South African universities are both teachers and researchers and their role is "knowledge creation, innovation and skills development". It is also notable that Zita consistently used the words, "lecturer" (3: 11; 3:14; 3: 33), "lecture" (3: 43), "lectured" (3: 11) and "lecturing" (3: 11; 3: 29; 3: 49; 3: 61), and infrequently used the words "teacher" or "teaching" to describe the "teaching" aspects of her role. This is significant in the context of Zita also having suggested that she did not view lecturing and teaching as being the same: "lecturing is something that you will learn over time, it's not like teaching at a school where you've learned to kind of teach" (3: 29).

According to Menyhárt (2008), a lecturer is generally focused on the subject material and lecturing is about the transference of information, knowledge and data; whereas in teaching, a teacher concentrates on and is more concerned about the students. To use the term lecturer or lecturing in preference to teacher or teaching may suggest greater identification for Zita with the subject matter or knowledge, than with the students. It is possible that this focus for Zita is in some way related to her strong research orientation and her part in "knowledge creation". Furthermore, Zita's preferred orientation of lecturing, as opposed to teaching, can also be seen to reflect Rowland's (1996) suggestion that researchers in higher education tend to be perceived more as self-driven, perseverant and information focused, while those with an orientation toward teaching are perceived as being more student focused.

The metaphor of "innovator" (3: 26) used by Zita to describe her professional self, appears to further reinforce her emphasis on her identity as a researcher. She did, however, suggest that the metaphor was also applicable to her teaching: "we are always striving to achieve. For example with our research and even with lecturing, you know, you are trying new methods and that kind of thing" (3: 26). The pseudonym, Zita, which is of Greek origin, meaning "seeker" was chosen as it reflects aspects of the researcher, innovator and "striving to achieve" nature of her identity (SpellCheck.net, 2012).

In the context of Zita's self-identification as a "researcher" and an "innovator", it is perhaps significant to note the distinction in agency Zita perceived academia having in the retail pharmacy sector, as opposed to the industrial sector. In the retail sector, Zita perceived academia as needing to be responsive to changes in the practice environment, rather than driving changes; whereas she was of the opinion that, in the industrial sector, academia needed to drive change actively. This may be indicative of a developing strength and clarity with regard to her own sense of agency as linked to the research-focus of her own presently constructed identity and to her identification of herself as an innovator. However, it may also be linked to her young age, or even to her relatively limited experience in academia.

5.4.1.2 Zita the apprentice

It is interesting to note Zita's repeated use of the collective pronoun "we" with reference to both her teaching and research, for example: "*we* are always striving" (3: 36); "*we* are encouraged" (3: 39); "*we* should be doing" (3:39); "*we* are always cognisant" (3: 49). Academic identity is relational, since it is "interwoven into the fabric of personal experiences and relationships" (McAlpine *et al.*, 2010, Kindle Location 2966), and formed through engagement with other academics (Qualter & Willis, 2012), and Zita's repeated use of "we" may suggest the importance she places on these relational aspects of her academic identity. Monrouxe (2009, p. 42) argues that the "notion of positioning is important" in the consideration of narratives and identity, because the language used, particularly pronouns, are an indication of relationships and suggestive of a level of identification and commitment. The use of "we" could suggest positive commitment and identification with her academic colleagues and the academic communities within which she participates, but the use of "we" could however, also be suggestive of a low sense of "self-agency" in her development as an academic (Monrouxe, 2009, p. 42).

Zita described her relationship with her doctoral studies supervisor, who was also her tutor while she was completing her Master's degree and academic internship, as being significant in her development as an academic. "During my Master's, my academic internship, I had also done some lecturing training with my supervisor" (2: 29). "He's put me in lots of situations that seem tough, but are important for development, to develop yourself as an academic" (2: 61), and

> It's not just about your lecturing and stuff, it's about the work that you are producing from research as well, and so we are always trying to push ourselves forward, a little more, in terms of that. And I think my supervisor has encouraged that quite a lot. (2:61)

Although Zita was already in a lecturer's post, the relationship with her supervisor and the opportunities for growth which he has provided, suggest that her postgraduate studies, both the Master's and the doctoral degrees, can be considered as part of an "academic apprenticeship" (Backhouse, 2009, p. 4). This can be seen as preparation for a career in academia. Zita was still a young academic and because, as Healey and Hays (2011, p. 1) suggest, the formation of professional identity is a "developmental process that facilitates a growing understanding of self in one's chosen field, enabling one to articulate her or his role to others within and outside of the discipline", it is highly likely that her use of the pronoun "we" refers to Zita's identification with her supervisor and the academic community that he represents. Further, this could be evidence of a low claim to "self-agency", in the sense that she still considered herself to be participating on the periphery of the academic community in which she remains an "apprentice". However, her acknowledgement that lecturing was something she would "learn over time"; that she needed to be challenged in order to "develop [herself] as an academic" (3: 61); and, that confidence in the academic role came with time, are also all suggestive of the recognition that she was on an inward trajectory within the academic community, that would ultimately lead to full membership and participation (Wenger, 1998).

It is noticeable that Zita did not particularly identify herself with any other communities of practice, although she would be on the periphery of the Academy of Pharmaceutical Sciences and other similar pharmaceutics and drug delivery professional organisations, with occasional participation through conference attendance.

5.4.2 Zita's perceptions of pharmacy and pharmacy education

In her teaching, Zita was aware that she was preparing pharmacists for future practice, as opposed to simply teaching pharmaceutical chemistry:

> I'd say it's pretty important and I think we are always cognisant of the kind of student that we sending out into the environment, like once they've graduated. I know we want to know that they haven't just learned a whole bunch of stuff that cannot be applied in any way when they graduate. (3: 49)

She therefore spoke of adopting an integrated approach, in which she included aspects of the other pharmaceutical disciplines into her teaching of chemistry; "I try and tie in all aspects of pharmacy" (3: 45). Similarly she had a holistic view of pharmaceutical care which extended beyond direct patient contact to include the development and manufacture of quality products by the pharmaceutical industry:

> It doesn't necessarily have to be with medication or anything like that, perhaps, you know, just basically enhancing patient care in the ways that pharmacists can through counselling, if that's the case, or with the provision of medication. Or I'd say even in industry, where you are actually enhancing the efficacy of high quality medicines for the treatment of a patient. (3: 55)

She viewed “imparting the [pharmaceutical care] message on to students” (3: 55) as being a fundamental aspect of her teaching. She also spoke of the manner in which the concept of pharmaceutical care informed her research:

> Whenever we are developing something, it's with pharmaceutical care in mind; it's just not about delivering a drug delivery system, it's about making a system that is going to enhance the care of the patient and in, hopefully, the efficacy for a patient. (3: 57)

Beyond the views Zita expressed regarding the preparedness of the students for the practice environment, and the extent to which academia should be driving or responding to changes in the practice environment, she did not provide any further comment on the pharmacy profession and her perceptions of how it is practiced. This may be a consequence of her lack of practice experience outside of the university, beyond her community service year.

5.4.3 “Who” is Zita?

At 29 years-old, Zita is a young, relatively inexperienced academic, who acknowledges that she is “still a little unsure of what I'm trying to do” (3: 63). Although her academic interest is primarily research and she sees herself as a researcher, it is to be noted that she did not call this her primary profession. Rather, she associated her primary profession with that of “lecturer”, relying on what was her given job title, and what she considered herself to be remunerated for.

When viewing how her doctoral studies became her main motivation for returning to the academic environment, and her study supervisor being her academic mentor, her doctorate can be viewed as an academic apprenticeship and, at this stage in her development as an academic, Zita can be considered to be an apprentice. Although currently participating on the periphery of the academic community, she is on an inbound trajectory, with the future possibility of full membership.

5.5 Kiron's story

Forty-five year old Kiron has been a pharmacist for about 20 years and has been teaching pharmacy practice for approximately seven years. After 13 years of working in research and development in the pharmaceutical industry, Kiron returned to university to complete his doctorate. He has been in academia ever since.

Although Kiron's first choice of career was medicine and the decision to study pharmacy was a hasty last-minute one, he was very satisfied with the way in which his career has developed:

> I wanted to seriously go into medicine and then at the last minute things went completely wrong and I was given an hour or two to decide whether I was going to go into pharmacy. I pitched up at the university and they said 'you've got a choice it's now 12 o'clock and the first class is at two, are you going to do this or not?' And I decided, okay 'I'm not going to get into medicine - I'm going to do pharmacy'. So I studied pharmacy and then I started working, and actually I'm very happy as to where I ended up. I really enjoy it. (4: 10)

Kiron had a very successful pharmacy career in research and development, where he moved through the ranks to the level of deputy director. When he renewed his contact with the university 13 years later, to complete his doctorate, it also included an opportunity to experience academia. He discovered that he enjoyed academia, and furthermore, that he "would actually prefer to stay there" (4: 10). Kiron expressed his continued enjoyment of academia, "at this stage I'm very happy with where I am and very satisfied and very happy with my job" (4: 10). He especially remarked on the pleasure he found in teaching, "I love teaching the students" (4: 10).

"Trying to teach pharmacists to be better than I am" (4: 10) is how Kiron explained his teaching philosophy. It was this goal of raising students to be better pharmacists than he is, that motivated Kiron's teaching and provided him with deep satisfaction, "I want to get my students to be better than I am, and then I feel I would have accomplished a lot" (4: 10).

Kiron stated that "pharmacy is my passion" (4: 14) and went further to suggest that "actually pharmacy defines who I am" (4: 14). He took the professional nature of being a pharmacist very seriously, and suggested that "it's a way of life, it's a way of thinking, it's a way of being" (4: 14). He further explained this by stating how he viewed the responsibility of being a professional as penetrating every aspect of his life:

> If you take a look at the laws and the ethical regulations and things like that, it covers you not only when you working, but outside that scope as well. So everything that you do, you have to be there as a professional, so you've got to be very careful with everything that you do and in every aspect of your life. (4: 14)

As a teacher, he was of the strong belief that it was his obligation to instil that same professional ethic into his students, "… you become a professional, and I truly believe that you have to instil that into your students" (4: 14). He was also of the opinion that the development of student attitudes was just as important as the imparting of knowledge:

> I'm really trying to instil that same philosophy that I've got, that you're a pharmacist not only at work but in every way, into them. Once you're a pharmacist, you are a pharmacist. And I really try to instil that into the students. And I've had quite a lot of students that have actually come back and said thank you for that, because it does make a difference in their lives. It does put you on a level as a professional, and I'm really trying to convey that and instil that in the students. (4: 33)

Although Kiron felt that people coming into academia as lecturers were not generally well prepared for the task of teaching, he considered himself to have "had a very big advantage because of my background" (4: 21). This background included lecturing part-time whilst doing his Master's and also exposure to teaching through being "very heavily involved in my church. And over there it's part of our standard practice to get people to participate and actually take classes" (4: 16). Furthermore, he was of the opinion that he "had enough experience to not only be able to do it [teaching], but to do it well" (4:16). He also expressed the understanding that the students who came through the pharmacy programme at his university, "have definitely got an advantage" (4: 21) when it came to preparedness for an academic career, because they "do a lot of workshops, and they do a lot of presentations" (4: 21), which involved "having to stand in front of the class and do public speaking and that kind of thing" (4: 21). He did, however, still have reservations with respect to how fully prepared they would be for academia: "I think that they would be better prepared, but even then, I still have a little bit of doubt" (4: 21).

Kiron regularly worked as a locum in the evenings in a community pharmacy and found the practice experience invaluable in enriching his teaching:

> I'm actually using the locums to teach my students what current practice is and what is currently required, and trying to combine that with sticking to the

> law and the legal aspects, using them to enhance my teaching, telling them about experiences and all of that. (4: 12)

From this perspective, he was of the opinion that practice was at the time determining and driving what was taught in pharmacy education, “In reality, it is practice that drives academia” (4: 12). Although he thought that “academia can in theory, drive practice” (4: 12) and that “it would be good” (4: 21) if it did so, he added: “I don't think it's going to happen, because things don't quite function that way, at least not the way I see it now” (4: 12).

Beyond his locum work in community pharmacy, Kiron also consulted and trained for industry, and was involved in research and development. The experience he gained in this sphere impacted on the work he did with his postgraduate students, which he hoped to expand to include contract work:

> I'm also doing consultancy work for industry and also a little bit of research and development. It's also my main aim for the research that I'm using for my postgraduates, and we're trying to develop an institute again, where we actually do this on a contract basis. (4: 23)

Although he viewed the university as encouraging outside work such as locums and consultancy work, he was of the opinion that the support was more of a theoretical nature, as opposed to practical support. In terms of the locum work, he had not had problems getting permission from the university to do it - with the constraint, however, that it was done after hours, since “they say you are employed by us fulltime, it mustn’t clash” (4: 25). With respect to the consultancy work, he said that although “the university actually encourages us to do outside consultancy work and theoretically you've got quite a number of hours available to do that, practically those hours don't exist” (4: 25).

Kiron had some involvement with the professional organisation – the PSSA, specifically with respect to attendance of continuing professional development (CPD) events, a few of which he had actually organised and presented. He was not involved in any educational forums, although he had taken a keen interest in the education related research work of others at his university into the “correlation between performance and our admission criteria” (4: 31), particularly as it related to his teaching:

> They did studies to see which one correlated the best, and I think stuff like that is very important, because the quality of the student that we get in basically influences the mechanism that we use to teach. It obviously

> influences their success rates tremendously, so I'm very interested in the educational aspect. (4: 31)

In terms of his development as an academic, Kiron felt that he was well supported by both the university and his department. He said that the university had "a lot of things that they do to actually help you" (4: 27), and moreover they offered many free courses that they "encourage you to go and attend" (4: 27). Furthermore, he suggested that support for attendance of courses from the "department's side is very, very good", stating that his "head of department is very, very helpful in assisting us to do that - she'll do everything she can to possibly assist". He did, however, indicate that there were some limitations with regard to support for conference attendance but that he did not view these as unrealistic: "The university has some rules about participating in conferences, but they are only fair and reasonable and I actually agree with them" (4: 27). On the whole, he expressed general satisfaction with the opportunity and support the university offered with regards development: "the opportunities are there, there are quite a few courses at the University, and you can go and do something if there is a need and you can keep yourself trained. And so I'm actually very happy with what they offer" (4: 27).

5.5.1 Interpreting Kiron's story

5.5.1.1 Kiron's self-perceived professional identity

When asked to describe himself professionally Kiron stated: "Lecturer, I am a lecturer" (4: 14). Although he came to academia from a successful career in research and development, to complete his doctorate - a research degree - it appeared that the aspect of lecturing he most identified himself with was teaching: "I love teaching the students" (4: 10). The pseudonym of Kiron – of Greek origin - meaning "teacher" was chosen to reflect this facet of Kiron's identity. Kiron's expressed passion for teaching was, however, in the context of a continued strong identification of himself as a pharmacist; "I'm there to teach people; it's just that I'm teaching in pharmacy; but pharmacy is my passion, actually pharmacy defines who I am" (4: 14).

Locating one's identity within the profession for which one is preparing one's students is not uncommon among those academics teaching on professional programmes, particularly those like Kiron, who previously had well established careers within the profession (Boyd & Smith, 2011; Holroyd, 2000; Shreeve, 2011). As Hurst (2010) proposed, the experiences and formation of academic identity, for educators such as Kiron, is often heavily influenced by both professional practice and life experiences and by the support mechanisms within the

university environment. It is interesting to note that, although Kiron's experience in research and development would have been valuable preparation for the research aspects of his academic work, Kiron related his preparedness for teaching particularly to his life experience within the church environment, "So I had more than an appropriate background to go into teaching, and I felt I had enough experience to not only be able to do it, but to do it well" (4: 16). He also viewed his continued practice experience, through locums in retail pharmacy and consultation work with industry as enhancing his undergraduate and postgraduate teaching, respectively. In addition he expressed very positive views with regard to the developmental support that he received from both the university and the department. Kiron saw the pharmacy profession as underpinning his identity but nevertheless categorised himself as a lecturer, suggesting that he has been able to adopt an academic identity.

Kiron's choice of pharmacy as a career was a rushed decision, made with very little exploration of other options, or what is termed "occupational self-exploration" (Skorikov & Vonracek, 2011, p. 696); "I was given an hour or two to decide whether I was going to go into pharmacy" (4: 10). Although it has been suggested that commitment to an identity without exploration, described by Marcia (1966) as foreclosure status, can lead to an "underlying fragility" and the need to forcefully defend one's position (Kroger & Marcia, 2011, p. 35), this did not appear to be the case with Kiron. His decision did, however, appear to have been confirmed by exposure to a positive community of practice experience: "I started working, and actually I'm very happy as to where I ended up" (2: 10). Similarly, his move to academia was not planned, but a positive experience of the academic community led to the decision to remain: "…and then went back to academia especially to go and finish [his doctorate] and found out that I enjoy academia and that I would actually prefer to stay there" (4: 10).

5.5.1.2 Participation in communities of practice

Although some have proposed that it is difficult to participate in multiple communities of practice, leading to tensions which often see the vocational role being given preference over the teaching role (Smith & Boyd, 2012; Viskovic & Robson, 2001), Kiron did not appear to have struggled in this regard. Beyond the academic community he continued to participate in several other communities of practice: the retail pharmacy community through his locum work; the pharmaceutical industry through his consultancy work; and professional organisations such as the PSSA through his involvement with CPD. All of these served to both strengthen his identity as a pharmacist and also enhanced his teaching role, thus strengthening his academic identity. His experience was in line with Wenger's (1998) argument that the experience of multi-membership is central to the concept of identity. Furthermore as Wenger proposed identity is dynamic and "extends in time" (Wenger, 2000,

p. 241). However, work of reconciliation is necessary to nurture and sustain an identity across community boundaries. It was perhaps this kind of reconciling work emerging from Kiron integrating his practice experience and learning into his role as lecturer, which has given rise to his strong identification with the concept of professionalism.

5.5.1.3 Kiron the professional

Although expressed in the context of his identity as both a lecturer and a pharmacist, Kiron apparently placed great emphasis on the professional responsibilities associated with both of these roles. He expressed the belief that being a professional is “a way of life, it’s a way of thinking, it’s a way of being” (4: 14). Moreover, “everything that you do, you have to be there as a professional, so you've got to be very careful with everything that you do and in every aspect of your life” (4: 14). Although his professional *persona* was to some extent grounded in the laws and ethics governing pharmacy, “if you take a look at the laws and the ethical regulations and things like that, it covers you not only when you’re working but outside that scope as well” (4: 14), it appeared to stem from a more fundamental concept of “care” and the responsibility of “caring for others”. This was evident in the manner in which Kiron extended the professional responsibility of pharmaceutical care to his role as a teacher:

> You can't teach students about pharmaceutical care, and try and instil that in them, and you don't practice it toward your class; you have to care for your students, what they do, how they do it. It's sometimes quite difficult to handle that, because conflict situations do arise; but that's normal in any work situation, normal in any experience in life, so it has to be there. You have to practice what you preach or teach. (4: 41)

Kiron also translated the concept of “care”, within the context of being a professional, to acting in the best interests of others: “even if somebody doesn't like you, as a professional, as a pharmacist and as a teacher, you have to do your best for that person, because you are influencing the rest of their lives and where they're going to go and their whole philosophy” (4: 47). He was of the belief that as a pharmacist, “you are there to make a difference in society, otherwise you shouldn’t be a pharmacist” (4: 39). Based on his comment where he concluded “You have to practice what you preach or teach” (4: 41), I would suggest that he would feel the same way about being a teacher.

5.5.2 Kiron's perceptions of pharmacy and pharmacy education

Kiron perceived the concept of pharmaceutical care as still being highly relevant to pharmacy, suggesting that it was "one of the main aspects of our whole profession" (4: 37). It was the patient-centred focus of pharmaceutical care that he highlighted as being very important, "For me what is very, very important is the way that you handle patients" (4: 39). However, he also recognised the responsibility of pharmacists to follow up patients as being integral to the provision of pharmaceutical care:

> … and then of course the follow up, part of that is defined in GDP[16] and includes that aspect; to follow up is very important and you are compelled, if you are providing over-the-counter medicines, to tell the patient, 'if this doesn't improve in two or three days, come back and see me', or refer the patient to a doctor, tell them what to do. And all of that is enhancing care. (4: 39)

Although Kiron did not express an opinion about the manner in which he viewed pharmacy being practised, he was of the firm belief that it is the responsibility of pharmacists to make a difference in society through patient care, "You are there to make a difference in society, otherwise you shouldn't be a pharmacist" (4: 39).

The importance Kiron placed on pharmaceutical care was apparent in the extent to which he had developed the modules he taught around the concept:

> …so for me, yes... pharmaceutical care is an absolutely essential part, and it's so built into and integrated into all the modules that I teach; that concept has to be there, it's actually the basis of everything else. You start there and then you add the rest. (4: 37)

Furthermore, Kiron believed that pharmacy educators should model pharmaceutical care to students through the manner in which they taught: "You can't teach students about pharmaceutical care and try and instil that in them, and you don't practice it toward your class; you have to care for your students, what they do, how they do it" (4: 41). What Kiron described here was comparable to the concept of educational care proposed by Popovich (1991), which suggests that pharmacy educators need to change their approach to education in order to model care, in an effort to nurture and develop caring students (See Section 2.4.6). In an educational care paradigm, the role of pharmacy educators is to teach, mentor and serve as role models for students such that students are empowered to "think

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critically, solve problems, and make ethical decisions that will ultimately improve patient care" (Becker & Schafermeyer, 1993, p. 6). Kiron appeared to understand and grasp the potential impact he had on the students as a role model in the manner in which he stated: “I really try my utmost best, to do my best for my students. I really think it's very important because the way you project yourself, the way they see you, is extremely important” (4: 47).

According to Hagemeier (2010) (see Section 2.4.7), there are two primary characteristics of pharmacy educators necessary to develop pharmacy student attitudes that promote patient care, and these are: integrity, which he defines as firmly adhering to moral principles which keep patient care as the central focus, and awareness, which is a knowledge of the environment in which patient care happens. These are both characteristics which Kiron manifested. It is the concept of professionalism with a strong ethical basis, which Kiron identified with, that appears to underpin his teaching, and which he believed was so important in pharmaceutical education. He also believed that pharmacy education was as much about developing the professional attitudes of students as it was about imparting knowledge:

> For me, because I'm really involved in the teaching and the practice side, I'm involved in the legal aspects and the ethical aspects, and I'm really trying to instil that same philosophy that I've got - that you’re a pharmacist not only at work but in every way, into them. Once you’re a pharmacist, you are a pharmacist. And I really try to instil that into the students. And I've had quite a lot of students that have actually come back and said thank you for that, because it does make a difference in their lives; it does put you on a level as a professional, and I’m really trying to convey that and instil that in the students. (4: 33)

In addition, his experience of practice through his regular locum work strengthened his awareness of the practice environment, which ultimately enhanced his teaching:

> I am also doing locums and I'm actually using the locums to teach my students what current practice is and what is currently required, and trying to combine that with sticking to the law and the legal aspects, using them to enhance my teaching, telling them about experiences and all of that. (4: 12)

5.5.3 “Who” is Kiron?

Kiron is a lecturer who is passionate about teaching, together with a strong identification with the pharmacy profession, stating that "pharmacy defines who I am" (4: 14). He places a very

strong emphasis on being a professional, and on embodying the commensurate ethics and responsibilities in all aspects of his life: “Everything that you do, you have to be there as a professional, so you've got to be very careful with everything that you do and in every aspect of your life” (4: 14). In addition, he views the imparting of this philosophy to his students, as a central focus of his teaching. He therefore views the development of professional attitudes within the students as being as important as imparting pharmaceutical knowledge.

Through regular work in community pharmacy, and consultancy work within the pharmaceutical industry, he continues to participate in multiple communities of practice. This serves to strengthen his awareness of the practice environment and to enrich his teaching. Kiron subscribes to the concept of pharmaceutical care, particularly its patient-focus, through which he believes pharmacy can strengthen its professionalism and “make a difference in society” (4: 39).

5.6 Abbot’s story

Abbot, who has been registered as a pharmacist for approximately 15 years, and has been in academia for eight years, is now in his forties. Pharmacy was not Abbot’s first choice of career. On leaving school he began studying medicine, however, as a consequence of his political activism, these studies were prematurely curtailed. After a period of studying, he returned to register for a science degree, which was followed by both an Honour’s and a Master’s degree. The discovery of new enzymatic products during his Master’s research and the desire to formulate them into pharmaceutical products brought him into pharmacy. After completing a BPharm degree, Abbot spent seven years in the pharmacy practice environment before being appointed as a lecturer in pharmacology at a university.

When Abbot started his medical studies, it was with the intention of eventually entering a caring profession. However, the events which led to the curtailment of his medical studies left him feeling "very angry with everything, so I didn't really want to go back into medicine. I was too angry and I thought that it would be a bit dishonest to carry all that anger into a profession of caring" (5: 10). For this reason he “went off and did a BSc” (5: 10), which he described as "a huge change around" (5: 10); he however stated that he "loved it" (5: 10) and "enjoyed the scientific discipline" (5: 10). It was this enjoyment that led him to do both an Honour’s and a Master’s degree.

During his Honour’s degree, he had a “wonderful supervisor” (5: 12) who had a strong influence on his academic development in that everything that he taught Abbot “he taught me to do thoroughly” (5: 12). Abbot recalled that the supervisor “lived his life by the maxim:

‘measure twice - cut once’, like an old carpenter” (5: 12), which instilled “scientific discipline” (5: 12) in Abbot. It was the isolation and mutation of enzymatic products during his Master’s degree, and his recognition of these as potentially therapeutic agents in creams and lotions, that brought him into conversation with the pharmacy department and ultimately led to his study of pharmacy:

> I came across to see [the professor] who was the dean of pharmacy then, and she said you know this is a good idea, why don’t you come and do pharmacy? Because if you are going to make pharmaceuticals it would be a good idea if you know what’s behind them; the amount of formulation and the attention to detail there. And I thought this is a good plan. So after my Master’s I came across here and I did a pharmacy degree in about two and half years, because I got some bits of it off. (5: 12)

After completion of his BPharm degree, Abbot’s internship in a large urban township hospital was a cross-cultural experience. Motivated by a need “to understand how these people live” (5: 27), he gave himself fully to the experience:

> I stayed in the hospital. And I was the first non-African pharmacist who was brave enough to do it. Everyone thought I was mad, they said what are you trying to do? And I said ‘when I work here, these are the people I am serving, I must understand their lives’. So I stayed in the township for a year and I loved it. (5: 27).

He “had the same hardships, took the same taxis, walked the same muddy roadsides” (5: 27); he “did everything in that hospital that anyone else that lived in the area would do” (5: 27), despite being “in fear of my life many times” (5: 27). Although it was a very difficult year Abbot noted that he was “glad I made the decision to do it, because that year changed me” (5: 27) and as a consequence of the suffering he continually witnessed in the environment, he believed he “developed a compassionate, caring kind of nature” (5: 27).

The internship year, which he described as a “watershed year” (5: 27), provided Abbot with insights into the person he was and the opportunity to reconsider what he wanted from his career. He said that “when I left varsity I was a bit arrogant, I thought I knew everything” (5: 27). He recognised, however, this was “just a symptom of who I was”. Coming from a “privileged background”, he “had some money, a car” (5: 27) and had already completed a postgraduate degree. Furthermore, he had a “game plan” (5: 27), he was “going to open a factory” (5: 27), “make cheap drugs” (5:27), “get government tenders” (5: 27) and “sort it all

out" (5: 27). He believed that within five years he would "have all the trappings of wealth" (5: 27). However, as he stated:

> I went to work there, and I thought 'no, hold on; there is a whole other world. There are people for whom my career means nothing; my idea of success means nothing to them. For them the idea of success is to eat a meal that day, to get to hospital, take their drugs, and not to be killed on the way home. That for them is success'. And I thought 'okay I'm measuring my success in the wrong way'. So I put that all aside. (5: 27)

Thus shortly after that year, Abbot decided that he "didn't really want to practice pharmacy, I wanted to teach it" (5: 12). He went to see the then Dean of the Faculty of Pharmacy at the university at which he had studied, about the possibility of an academic career in pharmacy; to which he received the following response:

> 'If you feel like academia is for you, I want you to do one very important thing, I want you to go home and lie down until the feeling goes away'. Those were his exact words because he said 'it's really not as nice or as glamorous as people think. It's a lot of hard work, it's under-paid and you are under-appreciated. But if, after that, if after lying down for a while, you still feel that you want to do it then come and see me'. (5: 12)

Abbot's reaction to this response was to return to the practice environment. He "did lots of locums and managed a hospital dispensary" (5:13), and also "ran a pharmacy in a group for a while" (5: 28). His experience of running a community pharmacy was again a cross-cultural experience and one in which Abbot was working in a lower socio-economic suburb. Abbot suggested that during that time he "learnt more than compassion, I learnt how to relate to people who were completely different from me" (5: 28). He regularly encountered drunk and abusive clients but he "learned to deal with them" (5: 28); "I was very confident and I realised that you had to stand up to them. You couldn't back down if they were confrontational. I had to put them in their place, so I learnt those skills and that changed me" (5: 28).

With time, however, he "knew that I didn't want to do that with my life" (5: 29) and so he went to "work for a pharmaceutical manufacturer" (5: 13), where he eventually "worked myself into a management position" (5: 13). In the manufacturing environment he "learned completely different skills" (5: 29), essentially how to manipulate people, but they were skills he "hated" (5: 29) and furthermore, as he suggested "I despised myself for having those skills, because they are very dishonest. I like to think that I'm nice to people because I want to be nice, not because I want something from them, so I despised myself" (5: 29). Despite being a "senior

manager" (5: 29); "doing brilliantly" (5: 29); and, making "a lot of money" (5: 29), he "knew that it wasn't me" (5: 29).

His work experience reinforced his desire to teach pharmacy: "I decided you know I really do want to do this [teach pharmacy], I still want to do this" (5: 13), and resulted in him again approaching the university about the possibility of an academic career. There were however no posts available at the time, until "eventually somebody resigned … And they said 'Okay, we will take you" (5: 13). Consequently, he was appointed as a lecturer, even though he had "no prior experience of lecturing. All I had was a Master's degree in an unrelated field and a BPharm" (5: 13). He believed that his eventual appointment to an academic post "was purely by accident, a combination of circumstances, and being in the right place at the right time" (5:13). He did, however, consider himself fortunate to have been appointed and expressed great satisfaction in his work: "I'm loving it, I'm enjoying it" (5: 13).

Abbot considered teaching to be the most important aspect of his academic role. However he viewed teaching as encompassing far more than just the imparting of knowledge and stressed the importance of teaching skills on a vocational programme like pharmacy:

> We do teach students more than just knowledge; we teach them skills, we impart skills. A lot of pharmacy is about practicing certain things, doing certain things, knowing how to do things. …There are some things which are not negotiable - you must know how to take a blood pressure; you must know how to take the pulse; you must know how to recognise if somebody is sick - and these are skills that come from experience. And we teach by imparting skills directly. Unlike standing up and giving a planned lecture, like sociology for example, for a sociology lecturer research and teaching would be very close because the entire field is based on ideas and new ideas. Often you really can't do much more than think in that field and dream up new things. But pharmacy is very grounded in the sense that we teach people to do specific things - we teach them to make a cream; we show them how to make a suppository; we show them how to dose an infant or to calculate the dosage for an infant; we teach them pharmacokinetics. (5: 15).

In addition, Abbot explained the extent to which he drew on his practice experience as a source of knowledge for his teaching; "I find what drives me is experience, I've worked in retail, and I've worked in hospital, and I have worked in the industry so I've got these years of experience and I can impart the knowledge" (5: 15). Furthermore, he was of the opinion that teaching would be difficult for educators who lacked practice experience; "Someone who's

never left university, who's never worked anywhere else, they would battle in the experience department" (5: 15). Although he did acknowledge that they might have experience of the academic environment and research which would be useful to share with newer academic colleagues.

He acknowledged the research component of pharmaceutical education as being important: "I think it's important that we do research in pharmacy because new evidence comes out all the time, and it's important that we keep ourselves at the coalface" (5: 15). However, he extended his concept of research to include literature-based research: "Research is also a media thing anyway, in the sense that you spend a lot of time, not in the lab, but on the Internet reading about new drugs working out new mechanisms, having new ideas in your mind - whatever" (5: 15).

Abbot bemoaned the fact that work load pressures and time restraints did not permit the kind of reflection that he perceived was necessary in the academic environment:

> One of the challenges for teachers in this country is that we are all under-resourced and, because you want to get through the work, you are in such a hurry to get through the work and at least give them the basics, there's no time to reflect and think broadly, or whatever, so the philosophical side of things gets left behind - not because you want to, you bow down to the practical pressures. (5: 15)

Consequently he suggested that "some of the finest research that happens here goes on in my head and never sees the light of day because there's no time to do it". (5: 15)

Abbot believed that the goal of pharmaceutical education was to prepare pharmacy graduates with both the knowledge and skills necessary to make an immediate contribution in the practice environment; "When our students leave you want them to hit the ground running. If you go into industry, you want them to be able to make things easily; getting to hospital you must be able to dispense and give advice and do all the things that the Act[17] says you should do" (5: 15). He did, however, recognise that his role as a teacher was broader than the transfer of knowledge and skills: "A lot of teaching is about guiding outside of the syllabus" (5: 23) in other words, providing leadership and guidance to students of a nature that was different to that offered in the classroom:

[17] Abbot was referring to the legislation governing the practice of pharmacy in South Africa – The Pharmacy Act, (Act 53 of 1974).

> The syllabus is what you do in the 45 minutes in the classroom, and I do that 200 times a year, but a lot of the time outside of the class I spend talking to people. There is a knock on my door and someone says 'I'm pregnant', or 'I have a problem with alcohol' or 'my mother has died'; things like that. So a lot of the leadership I provide is pastoral as well. (5: 23)

He viewed his pastoral and caring role as being an integral facet of his role as a teacher. In a similar fashion, he believed that reflection was a very important aspect of being a teacher and that the academic environment should be one that promoted reflection:

> You're in a fairly reflective environment - a lot of what you do involves reflection. You know, I come out of the lecture and almost every single time, I am devastated. I have to spend an hour reflecting on the experience. I have to ask myself 'did it go well, did I do my best, was I honest in what I said to my class, did I prepare well enough to understand, did they get what I put into it?' Otherwise the exercise is wasted. (5: 23)

The reflective aspects of academia only became evident to him once he became a lecturer:

> I didn't realise this before I started lecturing, I thought lecturers had a wonderful life. You go and then you deliver your lecture for an hour or two …and then you can go to the beach or whatever. Now I realise a lot of time is spent questioning myself, asking myself how I am doing. (5: 23)

Abbot believed that constant reflection is particularly important in the assessment process, which he found very difficult. He recognised the extent to which assessment can be very subjective; "You find that as the evening draws on you drift towards being nice, or not so nice, depending on how your life is going at the time" (5: 23). However, he was of the firm belief "that students shouldn't have to suffer because we are human" (5:23) rather "they should benefit from our humanity" (5: 23). Therefore, he stressed that "everything is about reflecting" (5: 23), and at every stage of the assessment process the educator should be asking of himself: "Am I fair? Have I given everyone the best opportunity? Have I given them a chance to defend themselves?" (5: 23).

The emphasis that Abbot placed on his pastoral role as a teacher was also particularly evident in the assessment process, specifically in the attitude that he had toward the need to sometimes fail a student:

> I see failing a student as the most traumatic thing. I do, if I really, really need to, but I hate it. It is like losing a patient. Failing a student is just the same. I

> agonise about it, I can't sleep for days after it, thinking how have I changed this person's life, maybe they'll become a criminal, maybe they'll get excluded, maybe their parents can't afford to send them back. Have I done the right thing? Sometimes it is not negotiable, sometimes you have to fail some people, but it's still agonising. A very, very difficult thing to do and I particularly battle with that. (5: 23)

It was also his understanding that teaching students to be reflective was a very important aspect of preparing them to be effective lifelong learners. Although he believed that at university level, educators can provide students with a core of knowledge, he recognised that "pharmacy is continual training" (5: 25) and that "we learn all the time" (5: 25). Consequently, he said that we need to cultivate within students "the discipline of things like reading every day, of wanting to be in touch with information" (5: 25). Nonetheless, he added that:

> To teach them to learn is the hardest thing, everything else is easy. I can teach them to repeat things back, but to teach them to learn by reflection, to get them to think 'Am I good enough to do this?', to be self-critical, to be self-aware, that is the hardest part. (5: 25). He was however of the opinion that "if you can get it right, if they get that lesson, then you've won, because they educate themselves after that. They dive into the information, and they want to know, they see how important it is to know it" (5: 25).

Abbot suggested that the academic environment had taught him many things. The "compassion and care" (5: 30) which he learnt during his internship has been reinforced. In addition he had "learnt acceptance" (5: 30):

> Here you accept things you can't control. I can't control if my students study, I can't control that they want to do what I'm making them do. I've learned to accept that, but I can control other things; I can control the amount of enthusiasm I bring to the course; I can control how exciting my lectures are; I can control how much input or how much work I do before a lecture. So, I control what I can and the things I can't control I just have to accept. (5: 30)

He had "learned fairness" (5: 30), particularly in relation to student assessment, and also the importance of "attention to detail" (5: 30). "Communication skills" (5: 30) had been another learning for Abbot, especially "how to listen" (5: 30) and "how to relate to my students" (5: 30). He "loves the interaction with students" (5: 30) and suggested "that's the part that keeps me doing the job" (5: 30). He specifically explained how the memory of his own student experience was helpful in understanding his students: "I was a particularly difficult student

myself, so I bring that to the table" (5: 30). Insights into his own behaviour: "a lot of my arrogance was because I was insecure" (5: 30) and how this "cut myself off from learning", had empowered him in his approach to his students:

> Now that I teach and I see it in students, I don't dislike them, I actually reach out to those ones because I think they need my help. All the arrogant ones, the ones that have this hard exterior, they probably need more help. And then you get students who are just naturals, so you leave them alone and let them enjoy their lives. (5: 30)

He had a specific passion for lecturing, which is where he derived a great sense of satisfaction, saying "I get a high every time I stand up in front of a class and I think that's what I want to do" (5: 30). There were, however, aspects of academia, which he said he didn't enjoy. One of these being the assessment of students - particularly the need to sometimes fail people: "I don't like failing people" (5: 30). He also expressed dislike for attending meetings: "I can't stand the meetings. Meetings I think are a complete waste of time because they rehash information and nothing ever gets done". Furthermore, he expressed strong opinions about his perceptions of the corporate aspect of university administration:

> I've learnt that the corporate side of the university is a complete waste of time. It really is a political game, a big political game that is played by very small people, who unfortunately don't have any real power, so that their power is assumed. And so people try and make you miserable, angry, because they think they can. And of course there is always the ambitious kind of person. (5: 30).

He appeared not to have any personal ambitions of academic leadership or management:

> One of the things I made clear when I started here was that I didn't want to be anything in terms of leadership. I didn't want to be a manager of any sort. I've done that. I've been in the corporate world, and I've realised how soul destroying it is. I don't want to do it again. (5: 31)

What he did want from the academic environment was the opportunity to "teach students" (5: 31), "to do some research", (5: 31), and "to learn, I want to learn, I want to read every day" (5: 31). He believed that being in academia had taught him the "value of learning" (5: 31) and furthermore "taught me about myself" (5: 31).

At the time of the interview, he was not working as a pharmacist in any other practice environments, stating, however, that he had “tried a while back to do locums, in grand style, for free, because I needed to keep my hand in” (5:33). These efforts appeared to have been halted by an apparent lack of support from his department, “That’s not gone very well because the department seems to view that in a very negative light, for some reason” (5: 31). In his professional capacity he did, however, engage in regular community work, giving talks in schools and on the wider university campus. He also served as a consultant to the university on various levels involving pharmaceutical issues, including drug abuse cases, poisoning incidents and development of the Campus Health Centre’s drug formulary and the university medical aid formulary. He was heavily involved in the university residence system and served as a “consultant for the residence group in terms of pharmaceutical issues” (5: 33). He was also part of university “inter-faculty meetings”. However he viewed his primary role at these as “raising pharmacy’s voice, from a professional point of view” (5: 33)

Abbot has also served in an advisory capacity on provincial pharmaceutical-related committees and been involved in a national research project on behalf of the SAPC. He felt that the research project, in particular, was “a great exercise” (5: 33) in that it provided him with the opportunity to “travel to many pharmacies throughout the country” (5: 33), and to hear the experiences of what he termed “salt of the earth pharmacists” (5: 33). Although he expressed “enormous respect” (5: 37) for the PSSA, at that time he was not a member: “it's not that I've consciously decided not to [be a member], I just didn't do it. But I'll do it one of these days, though, we'll see” (5: 37).

Abbot felt that there was a “broad form of support” from the university toward engagement in other communities of practice; “This is the kind of environment where generally you get support for that kind of thing, because your voice will be heard nationally, you are moving in the right circles” (5: 39). However, he did not believe that this support was translated into any kind of practical assistance, particularly of a financial nature:

> There is very little financial support. Really the university is very happy to support you in other ways but as soon as you ask them for ten cents to contribute towards your petrol bill, or anything like that, there is a deafening silence. So I think they don't really see it as important, because if they did they would be happy to support you financially as well. They will say: ‘that’s very useful’ and ‘thanks you go and do it, and get what you can, but don't make us pay for anything’. So there's a problem in that regard. (5: 39)

Abbot was of the opinion that the general lack of university financial support, through remuneration and salaries was an issue:

> As much as you like the job or whatever else, it is a bit different from the priesthood in the fact that you have children, and you have university fees, and you have to buy a house and a car and all of that. And unless something is done I think there's a big problem. (5: 45).

He was particularly concerned about the future impact that this would have on the university's ability to attract quality staff:

> For me the risk is not so much for me but for the next generation. We won't be able to compete; we won't be able to attract people who are sufficiently qualified. So what we are going to do is we are going to settle for second best, because the best will be taken by industry and used by governments or whatever else. (5: 45)

He believed that we "are not growing people for academia" (5: 45) and that the financial implications were specifically an issue with retaining suitably qualified postgraduates; "We are growing people who see the money, even those doing research. You spend a fortune getting your PhD and then you go straight off to industry" (5: 45). He believed that broad consultations were necessary to address this issue: "The best need to come together and put their minds to this, as part of the big global resource plan for academia" (5: 45).

5.6.1 Interpreting Abbot's story

5.6.1.1 Abbot's self-perceived professional identity

Abbot identified himself primarily as a pharmacist. He suggested that pharmacy was his "primary profession" and that "I am a pharmacist, first and foremost, and lecturing is as a consequence of being a pharmacist" (5: 17). Furthermore, he added that "if I wasn't a pharmacist I'd find it difficult" (5: 17). The importance that he placed on his professional identity as a pharmacist as central to his identity as an educator or lecturer was reinforced by the fact that he didn't "believe people who are not pharmacists should be lecturing pharmacy" (5: 17). This observation he based on the opinion that: "in order for me to understand what my students need, I need that background. I need to be registered in pharmacy, I need to be in good standing with Council[18] and I need to understand the rules of the profession" (5: 17). In addition, he believed that participation in the pharmacy community enabled him to

[18] South African Pharmacy Council

“understand the collegiality of the profession and the kind of ethical behaviour” (5: 17) that was expected of him and would be expected of future graduates.

Coming into academia from a successful career in the pharmaceutical industry where he “was a senior manager … doing brilliantly” (5: 29), and with a wealth of other practice experience, it is not surprising that Abbot held fast to his identification with pharmacy - his vocational profession. In a university environment which by nature placed high emphasis on the doctorate as “the desired qualification for an academic or research career” (du Toit, 2012, p. 1) and gave greater recognition and reward to research, as opposed to teaching (Chetty & Lubben, 2010), Abbot did not have a doctorate. He only had “a Master’s degree in an unrelated field” (5: 13) and, furthermore, his emphasis was on teaching and not on research. Moreover, a change in career which necessitated a change in practice community, such as Abbot made, can impact on the knowledge and expertise, confidence, expectations, beliefs and motivations of professionals and is often accompanied by “transitional shock”, which influences - to varying degrees - professional identity (Kember, 2011) (see Section 3.3.4). Furthermore, for such academics, “the clinical practice and procedural knowledge elements” of their professional field can appear to have a “priority status in the minds and practices of these new lecturers” (Smith & Boyd, 2012, p. 64). This may be why Abbot placed great emphasis on “pharmacy being very grounded” (5: 15), in the sense that “a lot of pharmacy is about practicing certain things, doing certain things, knowing how to do things, rather than knowing how to think about things” (5: 15). He also argued that “unlike standing up and giving a planned lecture” (5: 15), “pharmacy is the kind of profession where knowledge is handed down” (5: 15) and the teaching of pharmacy is very skills-based: “We teach by imparting skills directly” (5: 15); “we teach people to do specific things; we teach them to make a cream; we show them how to make a suppository; we show them how to dose an infant or to calculate the dosage for an infant; we teach them pharmacokinetics” (5” 15). The emphasis that Abbot placed on the “the clinical practice and procedural knowledge elements” (Smith & Boyd, 2012, p. 64) of pharmacy, skills which he believed “come from experience” (5: 15), could possibly also explain why he thought that “someone who’s never left university, who’s never worked anywhere else, would battle in the experience department” (5: 15) and stated that “I don't believe people who are not pharmacists should be lecturing pharmacy” (5: 17).

Although Abbot primarily identified himself as a pharmacist, it was early in his career, “literally a month or two into practice” (5: 12), that he decided that he “didn't really want to practice pharmacy” (5: 12) but rather that he “wanted to teach it” (5: 12). He, therefore, specifically

sought an academic career, with the primary intention of being a teacher, rather than a researcher. He was of the opinion that teaching "is the most important component in the BPharm programme, by far" (5: 15) and that teaching was his priority in his role as a lecturer, "I want to do what I want to do, which is to teach students" (5: 31). He did, however, add that it was also "important that we do research in pharmacy" (5: 15) and that he did want to "do some research". Work-load pressures, however, created tension for him in this regard and militated against doing research; "so it's always a struggle in my mind. Some of the finest research that happens here goes on in my head and never sees the light of day because there's no time to do it" (5: 15). This is consistent with the findings of other researchers who found that healthcare professionals making mid-career changes to academia experienced tension from the underlying pressure to engage in research, which they viewed as a contradiction to their priority for teaching (Smith & Boyd, 2012).

5.6.1.2 Abbot the priest

Abbot used the metaphor of "priest" (5: 21) to describe how he views himself professionally. He believed that being a teacher, required of him "the same kind of ethical behaviour" (5: 21) as that required of a priest. In addition he recognised other parallels between teaching and the priesthood:

> I need to be honest; I need to be true to a set of values; I need to have a set of values. I'm practicing a very old profession and one that is fairly highly respected, and I need to guide myself and others, not just around practical things but also spiritual things sometimes. (5: 21)

Abbot was also of the opinion that much of his work was "pastoral in nature" (5: 21) and that as a teacher he often gave "guidance out of a kind of spiritual leadership" (5:21):

> I guide students through difficult decisions: things like abortion, alcoholism, drug abuse. And those are all very pastoral things. People come to talk to me about their drug addiction - it's a pastoral kind of situation really. (5:21)

The pseudonym Abbot, derived from Aramaic, meaning "father", and used to describe the head of a monastery, was chosen to represent the "pastoral" facet of Abbot's identity (The Free Dictionary, 2012). It also tries to capture the compassionate and caring aspect of Abbot's nature.

In keeping with the priestly metaphor which Abbot used to describe himself and his compassionate nature, Abbot placed great importance on values and particularly on honesty

- both his own and that of future graduates; “The biggest value we can give them is honesty and professional discipline” (5: 25). Consistent with this emphasis on values was the prominence Abbot gave to the concept of “goodness”. He believed that to be a “good lecturer and a good pharmacist, you have to be a good person” (5: 23).

5.6.1.3 Formation of identity through communities of practice

The formation of Abbot’s professional identity is further evidence of what Archer (2008, p. 387) described as “disrupted processes”, typified by both “becoming” and “unbecoming” (See Sections 3.3.3 and Vinetra 5.3.). In Abbot’s story these moments of “becoming” and “unbecoming” can be paralleled with his participation in various communities of practice. Although at the time of the interview he was not an active participant in communities of practice, beyond the university, his professional career, to that point, had involved participation in several communities of practice and he recognised that each had a role in shaping the person he was:

> It’s true where ever you are, the interaction with the place or the people, or the kind of environment; if you work in a hospital that's going to change your perception of some things; if you work in industry that will push you in another way. (5: 27)

Abbot’s initial decision to study medicine was largely based on his perception of it being a caring profession. However, when he realised during his period of political activism that he had become very angry and considered that it "would be a bit dishonest to carry all that anger into a profession of caring" (5: 10), he opted for the discipline of science studies. His move into pharmacy appears to have been motivated by his desire to develop products: enter the pharmaceutical industry and consequently make money – “have all the trappings of wealth” (5: 27). It was during his “watershed” (5: 27) internship year, where he was a participant in a hospital community of practice, that he was able to rediscover and nurture his "compassionate” (5: 27) and “caring” (5: 27) nature, and re-evaluate his career goals "and I thought, ‘okay, I'm measuring my success in the wrong way’. So I put that all aside" (5:27). His move to community pharmacy was an opportunity to further nurture his compassionate nature and to develop his interpersonal skills: “I learnt more than compassion; I learnt how to relate to people who were completely different to me”.

His move to industry and his experience of an industry-based community of practice was, however, contrary to his caring nature and when he realised that he was becoming "cunning and conniving, with the best of them" (5: 29) and manipulative - “I learnt to be nice to people that I needed" (5: 29) - he "hated it and I despised myself for having those skills" (5: 29).

Being someone who valued honesty: “I need to be honest I need to be true to a set of values” (5: 21), he recognised that the manipulative, dishonest person he was becoming in the industrial environment, which he described as a “dog eat dog world” (5: 29), was not him and that he needed to get out.

> So I learnt that skill and it was an important skill in the corporate world, but I hated it and I despised myself for having those skills, because they are very dishonest. I like to think that I'm nice to people because I want to be nice, not because I want something from them, so I despised myself. But while I was doing that I actually made a lot of money. I was a senior manager, I was doing brilliantly, but I knew that it wasn't me. (5: 29)

The career change to academia once again enabled Abbott to re-learn "compassion and care" (5: 30) and to give expression to his pastoral nature. Abbot identified being caring, compassionate and pastoral in nature with being a good person:

> A lot of the leadership I provide is pastoral as well and, in fact, I think in order to be a good lecturer and a good pharmacist you have to be a good person. If you're a bad person, you can't fake it. And I know of some people who are not good people, who have tried and they failed miserably. (5: 23)

Because of the reflective nature of the academic environment, Abbot felt that it was particularly one in which inauthenticity could not be easily concealed: “Here it is more difficult, you get caught out more easily, because you're in a fairly reflective environment, a lot of what you do involves reflection” (5: 23). This focus on authenticity, relates to the emphasis that he placed on being a “good person” (5: 23) and on being compassionate and caring: “For me it's almost inseparable: to be pastoral, to be an academic, to be a good lecturer, good teacher, good person, good pharmacist; it’s all the same thing” (5: 23)

5.6.1.4 Abbot, the reflexive practitioner

It appeared that Abbot believed in the value of reflection and was a highly reflective person: “I have to spend an hour reflecting on the experience” (5: 23), “everything is about reflecting” (5: 23). Furthermore, I suggest that Abbot could be described as a reflexive practitioner. As explained in Section 2.3.6, reflexivity can be considered as a deeper dimension of reflection, involving a process of internal dialogue “through and in which we go about formulating a thought, ‘questioning ourselves, clarifying our beliefs and inclinations, diagnosing our situations, deliberating about our concerns and defining our own projects’” (Williams, 2005, p. 40, citing Archer, 2003). Evidence of internal dialogue of a reflexive nature was obvious in

Abbot's story. Through the constant use of phrases such as: “I thought that would be a bit dishonest” (5: 10); “It is also what I needed” (5: 10); “I needed some kind of focus” (5: 10); “I needed something that made me feel intelligent again and useful” (5: 10); “I thought this is a good plan” (5: 12); “I decided I didn't really want to practice pharmacy, I wanted to teach it” (5: 12); “I think that's one of the things I struggle with in pharmacy” (5: 15); and, “a lot of time is spent questioning myself, asking myself how am I doing” (5: 23), Abbot consistently manifested evidence of engaging in a continuous process of questioning, clarifying, diagnosing and deliberating. Furthermore, his ability to constantly question and recognise the person he was, or that he was becoming - and to make life and career changes accordingly - pointed toward his reflexive nature.

It is also noteworthy that “reflexive practice” is central to what Beach and colleagues (2006) termed “relationship-centred care” (See Section 2.3.6). In relationship-centred care, which emphasises the authenticity of the practitioner and the reciprocal nature of the relationship, the personhood of the practitioner is brought to the relationship, emotions are acknowledged and the formation and maintenance of relationships have moral value. When considered in the context of his reflexive nature, Abbot’s pastoral care approach to his professional life and in particular to his teaching, could well be an expression of relationship-centred care.

5.6.2 Abbot’s perceptions of pharmacy and pharmacy education

Abbot had a strong conviction of the role of pharmacy educators in raising the next generation of pharmacists and in shaping the future of the profession. He considered “pharmacy as the kind of profession where knowledge is handed down” (5: 15) and therefore believed that "it is critical that academics realise that it's not just about teaching for four years, but it really is about furthering the profession for another hundred years" (5:25). He was of the belief that not only are pharmacy educators preparing the next generation of pharmacists, but also the next generation of pharmacy educators: “The people being taught are going to be the next generation of teachers, so we are teaching teachers as well; preparing them to teach other teachers” (5: 25). He viewed this as being "a big thing" (5: 25) and also stressed that both the continuity aspect of pharmacy education and the manner in which it contributes to the overall development of pharmacists within the wider scheme of things was important:

> The continuity is important here; we need to see that we are part of a bigger system, in the sense that we train here, and the people out there, in the hospital, in industry, are training interns, so it's continuous training.

> Pharmacy is continual training; there is no doubt about that. We learn all the time; you refresh your mind all the time. (5: 25)

It was in the context of this sentiment, that he considered teaching students to be reflective, effective lifelong learners integral to their development as pharmacists and the responsibility of pharmacy educators; “that’s the hardest part. If you get it right, if they get that lesson, then you’ve won” (5: 25).

Abbot was critical about pharmacy education in the sense that he thought that there was often not an adequate balance between practice-environment based learning and classroom based learning, suggesting that:

> That's one of the things I struggle with in pharmacy because we sometimes teach very practical things in a very abstract way and then we teach very abstract concepts and we try and teach them practically, and it's very difficult. For instance, you teach something like pneumonia and it would be easier to show them the pneumonia than to teach them pneumonia. And yet we still do it the hard way in that we teach them in a class, we show them slides, we show the pictures and whatever else. It would be so much easier to take them to the hospital and show them ‘this is pneumonia’, once you've met pneumonia once, you will never forget it. (5: 15)

Abbot subscribed to the philosophy of pharmaceutical care, particularly the patient-focus aspect of it (Strand *et al.*, 2004). He explained how he tried to convey this to the students by telling them “every patient could be your father, or your mother, or your sibling, or your child, so you have to treat every patient with the same level of attention to detail that you would your own family member” (5: 41). Furthermore, he believed that pharmaceutical care necessitated “the patient receiving the best possible outcome from the interaction” (5: 41) with the pharmacist. His emphasis on consideration and care for the patient to ensure quality outcomes was consistent with Abbot’s “pastoral” approach to his professional life.

In his characteristic reflective manner, Abbot was “always thinking about am I doing; something that is concordant with my model of pharmaceutical care, which is to make sure that the outcomes are in the best interests of the patient” (5: 43). He described how he had adapted modules and tried to adjust his teaching, such that they were consistent with the concept of pharmaceutical care. The approach that Abbot adopted was comparable to what Brown and Ferrill (2009) describe as a “patient care advocacy paradigm” (see Section 2.4.6). It was grounded on a sound professional knowledge base and competence and at this level Abbot described how he facilitated students asking themselves searching questions such

that they learnt “to relate to the knowledge widely” (5: 43). At a secondary level, which involves interpersonal capability, Abbot described putting students in situations in which they “engage with people” (5:43). Although he did not specifically describe how he adjusted his modules to address the third level, which is the character domain and is “commensurate with strong fiduciary relationships … which add the dimensions of trust and morality” (Brown & Ferrill, 2009, p. 4), the emphasis which he placed on values, honesty and goodness throughout his story, and his metaphorical description of his priestly function in teaching, would suggest that he modelled this aspect to his students.

Abbot expressed both concerns and criticism of pharmacy and the practice environment. He was worried about the impact of shortages of staff and other resources, especially within the public sector, on the manner in which pharmacy was practiced. Furthermore, he was concerned about the impact this had on new graduates:

> It worries me that my students are going to go out and work in state hospitals and they are not going to practice what we taught them, because they haven't got enough people, enough warm bodies to do the work. What’s the use of teaching them to look for interactions and that kind of thing, if they're going to go there and lick, stick and paste? And that's a great worry for me. (5: 45)

Despite believing that new graduates were capable of changing the practice environment, he was of the opinion that the issues in the workplace were of such a nature that “the system overwhelms them” (5: 47) and that it was very difficult:

> For the first six months they go out there and they're all very idealistic, but the system is so big it overwhelms them. I've had calls from graduates who are doing community service or internship and they say they have started a therapeutics committee at the hospital or they’ve started doing sterile products. And they call me six months down the line and they say “You know I'm tired of using my own money to photocopy, because the hospital’s photocopier doesn't work, so I go into town and I use my own money to photocopy. They're not going to reimburse me. I am tired of using my own cell phone to call ambulances or whatever else is needed, to call referral centres because the hospital switchboard doesn't work or they just don't bother to work”. (5: 47)

Furthermore, Abbot believed that by trying to change practice through new graduates “we are targeting the wrong boss, we are trying to teach the students to change things from the

bottom up and they are never going to do it because they aren't big enough for this" (5: 47). He was of the firm opinion that these issues needed to be addressed at a higher level:

> We've got to go to government and say: 'if you don't do this, this is the consequence. Ten years down the line; this is what your health services are going to look like. Twenty years down the line you won't have any pharmaceutical care in this country and we'll be in trouble'. (5: 47)

In addition he expressed grave concerns about the corporatisation[19] of pharmacy, which he believed led to a loss of professionalism:

> It worries me that our students are going to get into the job market which is very cash dictated. So they're going to get into the [corporate companies] and they going to earn fantastic salaries from a very young age; and, they're going to lose all that professional caring that we've taught them. They're going to become corporatised; they going to see value in pharmacy as the number of prescriptions per minute, rather than people and that worries me. (5: 45)

Abbot's concerns are not groundless, since as several authors have suggested (see Section 2.4.6), many new graduates often find themselves disenchanted and frustrated with pharmacy as a career and disappointed with their education, particularly when they encounter a large gap between the patient-centred pharmaceutical care model of practice they have been taught and the product-oriented, technical model they encounter in practice (Berg, 2007; Brown *et al.*, 2001; Duncan-Hewitt & Austin, 2005).

5.6.3 "Who" is Abbot?

Abbot is a pharmacist, whose professional identity has been moulded and shaped through his work experience and participation in various communities of practice, including hospital, community, industry and also academia. At the time of the interview he found expression for his caring and compassionate nature, within academia, as a teacher. His professional role and particularly that of teacher he compared with being a priest, perceiving them both to be old and respected professions which are values driven and serve a highly pastoral function.

A reflective person, Abbot expressed strong views about some of the problems he perceived within the profession, conveying particular concern for the impact that he perceived them to

[19] The Pharmacy Act was amended in 2003 to allow for ownership of pharmacies by parties other than pharmacists, which led to retail chain stores such as supermarkets opening dispensaries.

have on new graduates and consequently the future of the profession. He was also concerned that we “are not growing people for academia” (5: 45) and that we will not be able to attract people who are “sufficiently qualified” (5: 45), and therefore also expressed concerns over the future of academia.

He would probably have concurred with the professor who told him that academia was “really not as nice or as glamorous as people think. It's a lot of hard work, it’s under-paid and you are under-appreciated” (5:12). In addition, he possibly also has days when he wishes that he had followed the same professor’s advice “to go home and lie down until the feeling [to teach pharmacy] goes away” (5: 12). However, after eight years, in academia he still stated “I’m loving it, I’m enjoying it” (5: 13), although he did add “most of it” (5: 13).

5.7 Zeth’s story

Having been registered as a pharmacist for nearly 30 years, fifty year old Zeth has been in academia for approximately 15 years. Prior to his appointment as head of a research unit and lecturer in pharmacology, he spent several years in other environments, including a public hospital, a research unit where he completed both a Master’s degree and a doctorate and in the pharmaceutical industry.

Zeth’s decision to study pharmacy was a well-considered one, made during his final year at school. The decision was based on both his desire to do something in the medical field, although he “wasn’t convinced that I wanted to be a doctor” (6: 15), and as a consequence of “exposure to retail pharmacy as a schoolboy” (6:15), where he “had done a little bit of pharmacy work in a retail pharmacy as a high school student” (6: 15).

His undergraduate university experience was a very positive one which Zeth described as being "wonderful … it's always been a part of my life that I often think back on, and also I like to go back to the town again if there are congresses or anything like that there" (6: 15). In addition, he also highlighted the lasting effect his undergraduate studies and particularly some of the lecturers who taught him have had on his academic and research career:

> A lot of my current thinking, especially where I am now with my academic career, especially in research, was started by some of the older academics, you can almost say mentors. They were people that I looked up to and I thought ‘these guys, I'd like to do what they are doing’. (6: 15)

During the final year of his BPharm the notion of postgraduate studies started to develop for Zeth. His interest in pharmacology had been fuelled through the experience of working in a mine hospital as a student during his vacations:

> It was there that I think I developed this specific passion for pharmacology, because while I was there, I used to put together a folder of all package inserts. I used to go through the racks and get these package inserts, and I used to read up on all the different drugs. (6: 15)

In addition, Zeth had the opportunity to study microbiology as an elective course with a specific focus on “virology, especially new antivirals, new antibiotics and things like that” (6: 17), which he found “very, very interesting” (6: 17). Consequently, he approached the head of microbiology, about the possibility of “doing an MSc in microbiology with an emphasis on drug treatment, trying to look at treatment resistance” (6: 18). He received a very positive response; “He was very keen because he also had a keen interest in chemotherapy and antibiotics and looking at novel drug development, with respect to improving treatment resistant things like that” (6: 18). Zeth, however, decided to first complete his internship: “I decided, okay, I'll go and do my practical year first, the internship, so that’s what I did. And that’s when I went back into retail. I went back home.” (5: 18).

Although he had enjoyed his internship, stating “it was great” (6:19), it also brought him to the realisation that he was not "cut out to be a retail pharmacist" (6: 19). He revisited the university during his internship year and tried to negotiate a joint research study combining pharmacology with microbiology: “I negotiated a meeting with the Professors of Pharmacology and Microbiology to see if I could bring them together as co-mentors or co-promoters for a study that I wanted to initiate, something that I had thought of the year before.” (6: 19). However, it became apparent that it was not possible due to a lack of supervision capacity within the pharmacy department within his specific area of focus:

> But it became clear at that stage that it wasn't going to happen at that university - not in the pharmacy direction. If I wanted to go the pure MSc direction with microbiology that would work but I still wanted to have a strong pharmaceutical emphasis and the university weren't all that keen on going in that direction. They didn't have someone in the department who could mentor me in that direction. (6: 21)

Zeth described leaving that meeting “a little bit confused and frustrated” (6: 21) and undecided on how to take his postgraduate studies forward. He opted for completing his two

years National Service in the South African Defence Force[20]. During this period he worked as a pharmacist in various military dispensaries. However, “being a person who doesn't like to waste time” (6: 21) and feeling that he “had things to do, I had this whole sort of career planned in research and postgraduate type of development” (6: 21), he decided to enrol for part-time studies in pharmacology.

It was around the same time that clinical pharmacy had become the “buzzword” (6: 22) in South Africa. A few people had returned to South Africa from the United States, having recently completed PharmD degrees, “which everyone thought was fantastic and clinical pharmacy was sort of a buzzword that was going to happen very soon” (6: 22). With his sights then set on clinical pharmacy Zeth decided to “do a BSc Honours in pharmacology” (6: 22) believing that “it would take me much closer to being an effective clinical pharmacist” (6: 22). Consequently, during his second year of National Service he was afforded the opportunity to undertake his BSc Honours degree:

> You would come in once a week, the whole day, and you'd have practicals and lectures and things like that. It also involved a full research project, so it was quite an intense thing, but I had a whole year and what else can you do in the army? I was also doing a lot of locums to finance the course and the travel and things like that. (6: 23)

Although the Honour’s programme was a valuable experience for Zeth, “getting greater and in-depth knowledge about drug action” (6: 23), it had greater “benefit for my career” (6: 23) in that it helped him recognise that university was where he “wanted to be as far as postgraduate work was concerned” (6: 23). It was his interaction with “real big shot” (6:23) pharmacology researchers and the passion with which they taught that refuelled his desire to pursue a career in pharmacology research:

> When I met these people and I saw what they were doing; it was something about the way they would teach; the emphasis in their modules that they were teaching was very, very focused on what they were doing in their research. So you would find that the module was very jacked, much higher than one would expect for that type of level, because they were passionate about their subject and they taught you a lot more. (6: 23)

Notwithstanding the fact that he had to complete a three year bursary commitment with the provincial administration of a different province, Zeth approached the Honours programme

[20] Prior to 1994 all white male South African were required to complete two years of compulsory military service.

manager with the request, “How can I come and work here, how can I come and do a research project here?” (6: 24). The programme manager alerted him to a similar, strong research programme at a university in the province in which Zeth was required to work and, furthermore, “actually put me in touch with my [Master’s degree] promoter” (6: 24). So Zeth was able to fulfil his obligations to the provincial administration by working as a hospital pharmacist, and at the same time complete his Master’s degree:

> And while I was doing my three years in the hospital, again in the same kind way … I always have this intensity, I have to use all my time. I wasn't married at this stage, so I had a lot of time on my hands, so I decided to do my MSc part-time with this man as a promoter at the research unit. (6: 25)

Three year later he was “free at last to make a decision on where do I want to go to now” (6: 25). The research unit, at which he had been doing his Master’s degree, had offered him the opportunity to do his doctorate and “a full-time position where you can do full-time research” (6: 25). The decision, however, was not a straightforward one because his hospital experience had been “wonderful” (6: 26); “It was a fantastic teaching hospital” (6: 26), where:

> … we used to have ward rounds with some of the big shots in medicine. A lot of the big names; they would go on ward rounds and they would take the pharmacists with. And in fact I initiated this program … training of interns. So I would take them on a ward rounds and we had ward rounds in internal medicine, psychiatry and neurology, in paediatric medicine … a whole lot of things … and it was fantastic. You'd go with the really big shots in medicine, and they actually made time for the pharmacy students; they would ask them questions, they would make sure that the doctors would listen to what they were saying … the trainee doctors, the 4th and 5th years, and we even went on high-powered ward rounds with the specialists … so the level of input was at such a level it was mind-boggling. (6: 26)

Zeth having had a taste of clinical pharmacy recognised that staying on at the hospital would be an opportunity “to develop, my then goals; to be a clinical pharmacist” (6: 26). Furthermore, he “really wanted to continue in that area because I was very fulfilled” (6: 26). He felt that, as a pharmacist, he was “using what I'd learnt … I was using a lot of my pharmacology and I was learning so much more” (6: 26). In addition, he “was kind of teaching at the same time. I had a lot of input into the interns that were coming in and I could see that they were really enjoying it” (6: 26). However, at that stage he had just got married and could acknowledge that, if he stayed at the hospital, he would still have wanted to do his

doctorate part-time. The attraction of the “lucrative” (6: 26) offer from the research unit, which enabled him to do his doctorate in a full-time research post, proved too great. His decision to join the research unit “was kind of the turning point in my career because I could have gone in a clinical pharmacy or pharmacy practice oriented direction and it could have led who knows where … I don't know” (6: 26).

For three years Zeth worked for the research unit and completed his doctorate, all the time developing his passion for pharmacological research in his focus area, “So we've been doing a lot of work on that since, continuing to work on this area of research, because it's just been a field that's been burgeoning with interest, a lot of fascinating discoveries” (6: 29). During this period, his “involvement in pharmacy, especially clinical pharmacy was waning” (6: 29) and he was now “only doing the odd locum” (6: 29) because he “felt that somewhere along the line pharmacy was going to be beneficial. I needed to continue to build on that, so I was doing some locum retail work, but nothing major” (6: 29).

At the end of the three year period, the research unit he was working at was closed and Zeth was moved to another research unit, where the work which they were doing was not within his area of interest:

> … which was very depressing, because here I was, just finished my PhD and I was keen now to take on the world, and no one could offer me a job, nobody wanted me. They said ‘sorry, you know you’re just incorrectly qualified … inappropriately qualified’. (6: 29)

It was then that he was then offered a position by a pharmaceutical company as a product advisor, within their marketing division, “and that's when I said ‘Right, pharmacy beckons again’, and I went and I joined the company” (6: 29). This was again “a turning point” for Zeth, which had “good and bad things to it, the good thing was that it was an amazing company to work for” (6: 29) and he was working with products which were not only within his own research area but were also an exciting new breakthrough in therapeutic treatment - “Huge at the time” (6: 29). However, he realised that much of his motivation for joining the company had been “to eventually migrate to one of their research divisions either in the UK or the US”, which “for various reasons, just didn’t materialise” (6: 29).

Zeth also described how, when the research unit closed prior to joining the pharmaceutical company, he had explored various academic posts and, although he was “offered possibilities back in academia” (6: 30), all of them would have involved him having to relocate to other parts of the country which he was reluctant to do. It also happened that while still working for the company, he had other offers within the same city where he was located but

he “quickly realised that I'm going to be frustrated. It's not what I want to do. It's not what I specialised in and my passion, and so that’s why I stuck to working with the pharmaceutical company” (6: 30). He did, nonetheless, make very important and valuable contacts whilst working for the company and was exposed indirectly to a whole new related field of research which he acknowledged “fascinated me” (6: 30). However, “after four, almost five years with the pharmaceutical company” (6: 30), he realised that “maybe this was time for another career move” (6: 30).

Shortly thereafter, the university at which he is currently employed contacted him with an offer. They were undergoing a restructuring process with a “strong emphasis on uplifting their research profile” (6: 31) and offered Zeth the opportunity to "begin a research unit of my own, clean slate" (6: 31) with the necessary infrastructure and “start-up capital” (6: 31). The university wanted him to “come into the research division and lift the research” (6: 31) and the idea was that he “would do 50-50 teaching” (6: 31). As he suggested:

> It was just fortuitous that they had a history of [my type of] research. I came with a background of research and a desire to want to do that further. It was a win-win situation. The idea of being able to do research - but also balanced with teaching, and that's been going on ever since - that was wonderful. I came here with my family and really I can't look back. (6: 31)

Over time, as his research unit has grown and his management responsibilities within the unit have increased, he has been relieved of some of his teaching duties: “As this unit blossomed, and we became more recognised, and my management of the unit increased, the university felt ‘Right if you going to do that, then we have to take a little bit of your teaching away’” (6: 32). He has also experienced positive support from the pharmacy school and the department of pharmacology in this regard:

> The school, in fact our Director and Head of Department, were very, very accommodating to allow me to do more and more of that. And obviously one can be very thankful for the other staff members that, said ‘Okay! Pass that on to me and I will handle it’. So that's been a very positive experience. (6: 32)

Zeth recognised that he worked within a very supportive department, which he has found very helpful, especially when he first took up the post and was new to teaching:

> In this department is a very, very strong close relationship with the staff members. Everyone gets on very well and tries to assist everyone else with

> situations; when they go through, things like sabbatical periods, we stand in. There were times when I was standing in for other people, other people would go on sabbatical and I would step in and do a bit of their work as well. So it's a real process of give-and-take, but it was great … because at that stage I hadn't experienced teaching before. (6: 32)

Initially, Zeth found teaching very difficult, describing it as “an absolute nightmare” (6: 36), and stated that “the first couple of years were not so pleasant and I actually used to dread my teaching block when that came around” (6: 36). One reason for this was that he had to lecture in his second language, not his home language: “I had to do all the lectures in [my second language]. I wrote my lectures in [my home language] because that's how I thought and then I'd translate them” (6:36). He recalled feeling “so sort of vulnerable, because I couldn't get my points across” (6: 36) and “there were often occurrences that the students would actually laugh at me” (6: 36). The other factor which contributed to his early difficulties with teaching was that he “never really dealt with my own subject … because that was already taken. So I came in and I had to just do what was available.” (6: 36). It was only “after the first four years of just bouncing around and doing the odd jobs” (6: 36) in terms of lecturing load that Zeth eventually took over lecturing a consolidated portion of a module. He was, however, still not lecturing within his area of research interest. It was only within two years prior to the interview, “when the person who was giving it needed a bit of assistance” (6: 40) that he eventually “negotiated with our subject head” (6:40) and was given lecturing work which was aligned with his area of interest.

Zeth was of the opinion that “there is a huge amount of benefit in channelling some of the knowledge that you actually obtained from your research activities into the students” (6: 52). He recognised that even “though they can’t necessarily call themselves researchers” (6: 52) much of the daily practice of a pharmacist involves “some degree of research related fact-finding kind of activities” (6: 52). Therefore, “if you can instil some of this kind of thinking and some of the kinds of ideas that you have that drive a research related type of activity”, one can “help the student to be an effective pharmacist” (6: 52). Based on his own experience as a student, he was very aware of how a teacher’s passion for their subject can contribute to a student’s development of knowledge:

> My experience was exactly that. When I saw guys that were extremely knowledgeable and extremely passionate, I found that my knowledge in those areas, as a student in those days, was a lot more fulfilled and informed because of these very informed people and passionate people that were teaching me. (6: 52)

Furthermore, as a consequence of Zeth's own experience, "it's always been something that I try to convey - that same passion and influence to the students" (6: 52), it was also "why I got frustrated because I wasn't teaching [in my research area]. For 90% of my teaching career it was not in [my research area] (6: 52).

Despite the language issue eventually resolving itself and Zeth gradually feeling more comfortable with the material he was teaching, he still felt that "teaching has always been difficult for me" (6: 40). He suggested that this was, in part, due to his introverted nature:

> You know I'm not an extrovert … I see some of our staff members, and I just see how they interact and communicate with their students, and it's amazing. I just don't have that rapport with them, I'm kind of like 'here' and they are 'there' …that's the way I have always been … very distant. And I think that's kind of counted against me because the students see me as kind of aloof - maybe distant with regard to the subject that I'm teaching. (6: 40)

It is, however, something that he has been aware of and tried to overcome: "But hopefully I've tried to breach that over the years and become a bit more accessible. Certainly that's what I wanted to be" (6: 40). He believed that "teaching is a gift" (6: 76) and although he acknowledged that it is also "something you can learn" (6: 76), he stated that "I'm probably guilty in that I probably did not make the effort in learning the techniques of teaching skills and that kind of thing" (6: 76). He added, "I do know there are a lot of shortcomings. I definitely would be able to benefit if I had some sort of structured teaching on teaching, on how to lecture and all those kinds of things" (6: 76).

Zeth's return to the university also saw him resume locum work, recognising that in his teaching, he was "training a certain kind of professional person that needs to have not 'pie in the sky' knowledge" (6: 44):

> When I first started teaching, when I first came here, I re-initiated my interest in doing locums: because, having not taught before and now wanting to know what the issues at ground root level are, what do you need to convey to the students that they need to know, what's practical and relevant that's out there. (6: 44)

Zeth viewed the primary goal of his role as a researcher as making a "meaningful" (6: 56) and "concrete contribution" (6: 56) to the "knowledge base" (6: 56). He wanted to know that his research had "led to improved understanding and improved therapeutics" (6: 56) and ultimately resulted in "changes in clinical practice and in new drug development" (6: 56). In

addition, he suggested that: “when I look back when I'm retired and I say, ‘what did I actually do that uplifted mankind?’ I'd like to say that I made a contribution” (6: 56).

Zeth described being an active member of several national and international professional societies and research organisations. He suggested that they, particularly their annual congresses, “definitely have a role to play - as a forum where all the academics can get together, in all the areas of pharmacy, to interact and discuss things about the profession” (6: 64). He also viewed interaction with colleagues in these forums as a means of keeping his research relevant: “That's the kind of question we brought [into our research], just purely by being out there, talking with the other areas of pharmacy, and then filtering that back into your own research questions” (6: 64).

5.7.1 Interpreting Zeth’s story

5.7.1.1 Zeth’s self-perceived professional identity

Zeth identified himself as a pharmacologist. Although, in some contexts, he called himself a pharmacist, a profession he was still proud to identify himself with, his primary professional and academic identity was with his discipline – pharmacology.

> If I have to speak to people out there, lay people, I would say I'm a pharmacist because most people don't know what a pharmacologist is. They always say ‘what's that?’. You know when I speak to people outside then I say I'm a pharmacist. And I say that I'm still proud of the fact that I'm a pharmacist. I am a pharmacist but when it comes to what I really do, that’s when I'm a pharmacologist. (6: 88)

As an undergraduate student Zeth “developed this specific passion for pharmacology” (6: 16), and, within a year of leaving university, he knew that he was “really keen on pharmacology as the focus that I wanted to make my career on” (6: 22). Within the academic milieu pharmacology would be considered to be Zeth’s discipline and, as several authors have suggested, the discipline within which an individual is located can play a key role in the formation of academic identity and provide a contextual framework within which academics construct their values, beliefs, teaching practices, identities and sense of self-worth (Becher & Trowler, 2001; Henkel, 2000, 2005; Jawitz, 2009; Malcolm & Zukas, 2009; Neumann, 2001). Positioning herself with Wenger’s (1998) concept that identity formation occurs in the tension between identification and negotiability (see Section 3.2.1.1), Dison (2004, p. 90) suggested that it is within the discipline and the framework that it provides for making

meaning, that a doctoral student finds both a degree of identification and negotiability – "ownership of meaning". This certainly appears to have been true for Zeth and perhaps applies even more narrowly to his specific research area. As he explained, at the end of his doctoral study, the research unit closed and he was moved to another unit:

> In fact, for the last six months of my year at the unit they transferred me to another research unit which focused on a completely different area of research, which was very depressing. Here I was, just finished my PhD, and I was keen now to take on the world, and no one could offer me a job … nobody wanted me. They said 'Sorry, you know, you're just incorrectly qualified, inappropriately qualified. (6:29)

These ideas could imply that it was within the research area that had been the focus of his doctoral studies, to which he had been able to contribute to the knowledge base, that Zeth had negotiated an identity and found his own sense of self-worth. Furthermore, whilst he was working for the pharmaceutical company and was exploring options in academia and in research, he explained that:

> I had various other interviews with other departments at the universities [in the city] - the possibility to join a research group because they were interested in the contribution of the molecule I had worked on within their own research area, and so on. But I quickly realised that I'm going to be frustrated. It's not what I want to do. It's not what I specialised in and it's not my passion, and so that's the reason why I stuck to working with the company. (6: 30)

It was only when he was offered his current post and the offer to "begin a research group of my own" (6: 31), and in addition was told, "you can do what you want to do" (6: 31), that he returned to academia. It is notable that Zeth's decision to make this career move was not just an opportune choice but was rooted in a well clarified notion of what his potential contribution to the pharmacy profession could be.

5.7.1.2 Zeth the researcher

Within the context of being a pharmacologist Zeth identified himself specifically as a researcher. It is clear that Zeth has always had a passion for research and, even when he

was in the pharmaceutical industry, it was his goal to get himself transferred to the research division. When considered in the light of the literature, that suggests research is central to academic identity (Henkel, 2005), the “trademark activity of the university academic” (Lea & Stierer, 2011, p. 608), and the chief source of their “role definition, identity formation and intellectual fulfilment” (Lea & Stierer, 2011, p. 608), it is no surprise that Zeth, who made an early career decision to “go full-time into research” (6: 92), found himself as the manager of a successful university research unit; “Over the years our research blossomed and we became more recognised” (6: 32).

Dison (2004) argued that the ability to do research is more than simply about knowledge and competencies: it “arises from the capacity of the whole person” (Dison, 2004, p. 83) and is inextricably interrelated to the individual’s identity as a researcher and academic. This would certainly appear to be true of Zeth, who described himself as “constantly striving” (6: 48), as someone who has “always wanted to use my time as best I can” (6: 48), as “trying to achieve the best that I can with the limited resources that I have at my disposal” (6: 48) and as “someone driven by passions” (6: 48). He suggested that that was specifically identifiable in the manner in which he has managed his career: “I think that’s definitely come through in how I’ve managed my career and things like that” (6: 48). His role as a researcher was also driven by the higher purpose of making a “meaningful” (6: 65), “concrete” (6: 65) contribution to “improved understanding and improved therapeutics” (6: 65), and, ultimately, an “uplifted mankind” (6: 48).

It was because of his passion for research and his identification as a researcher that the pseudonym Zeth was chosen. The name Zeth is of Greek origin and means investigator or researcher (Meaning of names.com, 2012).

5.7.1.3 Inspired and driven by passion

Zeth is a man who is clearly driven by his passions. When asked to describe himself in terms of a metaphor, the words that he used to explore possible alternatives included strong words like “possessed” (6: 48) and “obsessive” (6: 48). However, he concluded that he was “driven” (6: 48), and specifically “driven by passions” (6:48):

> Well, I think, constantly striving. What would be a good metaphor? That I'm just - not necessarily possessed! I've seen throughout my life, that I’ve always wanted to use my time as best I can; so trying to achieve the best that I can with the limited resources and time that I have at my disposal. So, obsessive maybe? Driven? I'm driven by passions. There is certainly no two

> ways about it; there are certain passions that I feel strongly about. So, yes, I think that's definitely come through in how I've managed my career and things like that. (6: 48)

This "drive" is certainly evident in his story: the manner in which as new graduate he "negotiated a meeting" (6: 19) with the professors of two different departments within the university in order to try to initiate a postgraduate study; the way in which he "organised with the army" (6: 23) a posting such that he could do his Honours degree part-time; his capacity to undertake and complete his Master's degree whilst working full-time at a hospital and the ability to withstand other research-based job offers until an offer that he felt would allow him to fulfil his passions was made. However, it is a "drive" which has apparently always been fuelled by passion; a "specific passion for pharmacology" (6: 16), and more specifically a passion for his area of speciality, "It's not what I specialised in, and my passion, and that's the fact why I stuck to working with the company" (6: 30).

Not only is Zeth driven by passion but it would seem that he is inspired and motivated by the passion of others. As an undergraduate, he was influenced by "some of the older academics, you can almost say mentors - they were people that I looked up to … and I thought, 'these guys I'd like to do what they are doing'" (6: 15). During his Honour's programme, it was passionate researchers and the manner in which their passion infused their teaching, that made Zeth realise "this is where I wanted to be, as far as postgraduate work was concerned" (6: 23):

> It was something with the way they would teach, the emphasis in their modules that they were teaching was very, very focused on what they were doing in their research. So you would find that the module was very jacked, much higher than one would expect for that type of level, because they were passionate about their subject. And they taught you a lot more than for instance, what you would get in a similar module on antibiotics or whatever the case would be, just the standard kind of input that you would get elsewhere. (6: 23)

Furthermore, he suggested that it was the influence of these "passionate people that were teaching me" (6: 52), that was "something that I've taken a long way - all these years", and that had influenced his own approach to teaching: "It's always been something that I need to convey; that same passion and influence into the students as well" (6: 52). It was, therefore, not surprising that Zeth expressed frustration with the fact that "for 90% of my teaching career" (6: 52) he had not been able to teach subject matter directly related to his area of

research and his passion. This certainly contributed to his struggle with teaching, expressing his early experience “as a nightmare” (6: 36) and in addition:

> The first couple of years were not so pleasant and I actually used to dread my teaching block when that came around, and that continued for a number of years. Because I actually never really dealt with my own subject; I never taught my subject. (6: 36)

As a consequence of not teaching within his area of passion, he was also concerned that “students see me as kind of aloof - maybe distant with regard to the subject that I'm teaching” (6: 40).

Within academia, qualities of perseverance, being driven and being highly motivated, have been associated with being a successful researcher. And caring qualities, such as compassion, concern and openness, have been associated more with those inclined to teaching than to research (Rowland, 1996). However, notwithstanding the fact that Zeth is a highly motivated and driven researcher, he has recognised that, in his teaching, he does not have the “rapport” with students that he would like. Consequently, as a teacher, he has made a conscious effort to develop it and become more open with the students: “I’ve tried to breach that over the years and become a bit more accessible. Certainly, that's what I wanted to be” (6: 40). It is also possible that his frustration with not teaching within his area of passion stems from a belief that if he were able to do so, he could be more authentic and perhaps impart more “passion and influence” (6: 52) to the students. Indeed, as Palmer (1998) suggested, authenticity has the potential to create a milieu in which “vital connections” between teacher and subject, teacher and student and student and subject, are made.

5.7.1.4 Formation of identity through communities of practice

As Zeth himself acknowledged, his trajectories into, between and sometimes through various communities of practice “had certain very important contributions to my career and made me who I am today” (6: 60)

> Going through those phases of being in a hospital pharmacy, also going into industry for instance, the corporate environment, corporate pharmacy, has also made a huge contribution to how I see things today, and how I view myself as a rounded off professional. (6: 60)

Furthermore, he recognised the value of his experience of participation in multiple communities of practice in his discussions with students about their own future career opportunities:

> I have a lot of students that know that I been involved in industry and in hospital pharmacy and they want to come and hear what are the possibilities and those kind of things. That's what makes pharmacy such a very special career and that's what I tell the students when they come here and they say 'I don't want to go and count pills'. They come here with this negative image, and then I tell them that not what it is, that's not the only aspect. It's one of the very few professional degrees that offer you such a diverse area of practice, from retail, to industry, to medical aid peer-review systems, to industrial kind of synthesis, troubleshooting in drug development, all these kind of things. (6: 60)

In this sense, Zeth represents to the students what Wenger (2000, p. 241) terms "paradigmatic trajectories", that can provide the students with a basis for constructing their own trajectories into and through the various pharmacy-related communities of practice. It is interesting to note that in his comment above he did not include academic pharmacy as a possible career path; however, he is himself a direct example of this trajectory. Although cognisant of the limitations that might not make it possible or feasible, for all graduates to have the range of exposure to communities of practice which he did, Zeth was of the opinion that:

> Each one of those sections, if a person can go through those different phases, it would be so much better. I just know for myself. I have benefited so much, having gone through the different aspects of hospital, retail, and industrial; at the end of the day it's helped me see the light for myself and hopefully opened the eyes of other people who want to know more. But not everyone unfortunately has the opportunity to go through all the parts of pharmacy. But the fact remains that they are there, they are there for use and for the benefit of the population, and I think that … and it's one qualification that allows you access to all these things - they are all interrelated. And they definitely would add benefit to how you practice. (6: 60)

Although he was a core participant within several communities of practice within the university environment, including his research unit and the pharmacology department, Zeth

also remained an active participant in multiple other communities of practice, including the Academy of Pharmaceutical Sciences and the Pharmacology Society. He viewed these societies as having a definite "role to play" (6: 64), in the sense that they offered "a forum where all the academics can get together, in all the areas of pharmacy, to interact and discuss things about the profession" (6: 64). However, he was of the belief that this role of the societies is "often possibly neglected" (6: 64). Societies, such as the Pharmacology Society, he viewed as having "a strong role to play in uplifting the discipline, whatever discipline they are" (6: 64). He viewed attendance at congresses, which tend to be the annual meetings of a society, as very important: "I don't miss any of the congresses because I feel that is absolutely essential that you be there and you interact with colleagues in the different areas of pharmacy" (6: 64).

5.7.2 Zeth's perceptions of pharmacy and pharmacy education

As explained in the previous section, Zeth's perception of pharmacy has been shaped by participation in multiple communities of practice. His experience of retail pharmacy as an intern, he described as "great" even though it confirmed for him that retail pharmacy was "not really what I want to do" (6: 19). He has, however, through the years continued to locum in retail pharmacy and, from his experience, he acknowledged the important primary care role that community pharmacists can and do play:

> Even the couple of years that I was in retail, I had a couple of little things that people used to come back for. They were referring their friends to come back for various things, such as baby ointments, cough mixtures and all these kind of things that I had sort of put together. And of course most pharmacies have these little "mutis"[21] that they put together. And I found that was very rewarding because you know that people are coming back for something that you can offer, and you kind of identify with what their problem is. (6: 96)

It was this experience of retail pharmacy, coupled with his love for pharmacology, which initially attracted him to clinical pharmacy:

> The reason why way, way, way back then, when I wanted to go into clinical pharmacy, that was actually what I loved to do, was to actually be in a situation where I could first add and offer advice to people who come to the pharmacy, real meaningful advice, that they would come back to and that

[21] "Muti" is term for traditional medicine in South Africa and is a slang word used for medicines in general. In this context Zeth is using it to describe medicinal products which pharmacists often prepare according to their own formulae.

> they would refer people to later … because you have developed an expertise, either in paediatric bronchitis or whatever the case may be. (6: 96)

His three years in a "fantastic teaching hospital" (6: 26) provided him with the opportunity to experience what clinical pharmacy could be like: "I really wanted to continue in that area because I was very fulfilled, I was using what I'd learnt. I was using a lot of my pharmacology, and I was learning so much more" (6: 26). Through that experience in the hospital, Zeth also gained insight into the value pharmacists can add to the healthcare team: "When I was in the hospital, especially those three years, I clearly saw how the doctors appreciated someone with superior knowledge of how drugs work" (6: 44).

Although he acknowledged that there was "more increased awareness of clinical pharmacy", Zeth was of the opinion that clinical pharmacy has never really established itself as a discipline in South Africa, "that no longer takes place at these teaching hospitals. There's just no time. They don't have the workforce to allow pharmacists to go and do these kind of things that we did in those years" (6: 26). However, he welcomed the recent formation of a clinical pharmacy society and he was hopeful that opportunities for clinical pharmacy would "change now with these mid-level workers[22] and things like that. Because that is what I think these pharmacists are actually trained to do and they get so much fulfilment out of it" (6: 26).

Zeth believed that the concept of pharmaceutical care had impacted largely on the manner in which pharmacy students were taught, "It's definitely had a huge amount of impact, because we've seen it and we have been obliged to change the way that … and what we teach the students". (6: 96). He was, however, concerned that in the past, pharmacy educators have "trained very competent academics as pharmacists" (6: 100) who "have not been able to convert that knowledge into clinically relevant and usable information, which they can contribute back to the patient" (6: 100). He believed that the reason for this was that "we've been teaching what we think they need to know and overloading them with a lot of academic knowledge, that is possibly not always relevant out there in clinical practice" (6: 100).

Internationally, there is a school of thought that believes that "pharmacy education has a responsibility for preparing not only for the present but also for the future, even innovating for the future and guiding the course of the profession" (Maddux *et al.*, 2000, p. 13). However, Zeth was of the opinion that although in the past academia had driven practice, in the current climate academia needed to be more responsive to the practice environment, "They should respond - maybe in the olden days, they used to drive things that they think should be

[22] Mid-level workers are a new category of pharmacy support personnel, the Pharmacy Technical Assistant and the Pharmacy Technician, which have been created in South Africa.

happening out there, and maybe things have not worked out that great" (6: 100). Moreover, he added that:

> You have to be very conscious of the fact that you teach them the right things. And because they are going to be at the front line of primary health care, and all those kind of things, they have to be prepared for that. And in many aspects we often find that up to now the current curriculum is not focused enough on the fact that you are going to be putting these guys out there and with how they are going to be addressing clinical primary health care issues. And we are currently now going through the whole notion of changing the curriculum, reorganising those kinds of things. (6: 96)

His thoughts in this regard were consistent with those of the International Pharmacy Education Taskforce, who believe that, in response to a severe shortage of appropriately trained pharmacists and pharmaceutical support staff, a needs based approach to pharmaceutical education is required (Anderson *et al.*, 2010) (see Section 2.4.5.1). Needs based education is a strategy which is based on assessing the needs of the community and then developing or adjusting the education system accordingly. This suggests that pharmacy education should be focused on meeting the current pharmaceutical needs of the local population and nation which it serves. Consequently Zeth was of the belief that, "definitely we have a lot to learn from those guys out there" (6: 100), and that practicing pharmacists "should maybe be more involved in input into our teaching programmes, and our curriculums" (6: 100).

Similarly, when it came to allowing research findings to impact on teaching, Zeth was of the opinion that pharmacy educators need to restrict teaching to what is "practical and relevant" (6: 44,) and not "'pie in the sky' knowledge" (6: 44). He suggested that:

> Even though I would love to tell them about all the intricate ways that [my drug] works, is it relevant? That's been part of the frustration as well, because you want to tell them these things, but you have to kind of get to grips with 'what do these guys need to know?' (6: 44)

Zeth, however, believed that in his research and his teaching he had a role to play in the socialisation of students into the pharmacy profession. And, as Taylor and Harding (2007) suggest, it is the socialisation process which both fosters and promotes the development of a student's professional identity:

> I am acutely aware that we are training a special individual, because I came from a position where I experienced what is like to be a valued professional. When I was in the hospital, especially those three years, I clearly saw how the doctors appreciated someone with superior knowledge of how drugs work. And you know you need to instill this in these students, they need to know that they have a special knowledge, which they can convey to patients and other health professionals. So that's always been my take on the situation. I don't know if I've always achieved that or succeeded, but definitely it's been my heart. (6: 44)

5.7.3 Who is Zeth?

Zeth is a highly motivated and driven pharmacologist who is particularly passionate about what he perceives as "meaningful" research. Although he is the manager of a research unit, as an academic he recognises and takes very seriously his teaching responsibilities. However, teaching has always been a struggle for him - the reasons for which he identified as three-fold: language difficulties early on in his teaching career, his naturally introverted nature and, perhaps most importantly, not teaching subject matter within his area of research about which he is passionate. As both an undergraduate and postgraduate student, Zeth was particularly influenced and inspired by the passion of teachers, who were highly respected researchers and were simultaneously teaching within their research domain - and consequently he would like to do the same for his students.

His career and consequently his professional identity, have been formed through participation in multiple communities of practice and, as he stated; "made me who I am today" (6: 60). However, on-going participation, within the university environment and in a range of professional organisations and societies, continues to shape who Zeth is becoming. Moreover, as a teacher, his experience of multiple communities of practice, models for the students **"**paradigmatic trajectories" that can provide the stimulus for constructing their own trajectories into and through the various pharmacy-related communities of practice.

Although Zeth is a man who described himself as "constantly striving" (6: 48), "driven by passions" (6: 48) and maybe even "obsessive" (6: 48), it became apparent that he is also driven by a higher purpose of making a contribution to the upliftment of mankind.

5.8 Idania's story

Fifty-eight year old Idania has been registered as a pharmacist for 35 years and has taught pharmacy for 16 years. She came into academia with a very strong practice background from 20 years' experience in community pharmacy. Although she has taught both pharmacology and pharmacy practice, at the time of the interview she was teaching pharmacy practice to pharmacy students and pharmacology to nursing students.

As she "really wanted to do teaching" (7: 11), Idania's initial choice of study was a Bachelor of Pedagogics degree in science. However, having received her matriculation[23] results, a relative suggested that she "should rather do pharmacy" (7: 11). Despite not really knowing what pharmacy was about, she registered for pharmacy; "To be very honest I never knew what pharmacy was, remember we are talking about the apartheid times. We didn't have many pharmacies in black areas, so I didn't even know what a pharmacy was" (7: 11). As a result of having to deregister for a subject in her first year of study for pharmacy, she decided "there will be no pharmacy for me" (7: 11) whereupon she returned to university the following year to pursue her original goal of becoming a teacher. However, during that year she successfully completed the subject from which she had previously deregistered and she "just slotted back into pharmacy" (7: 11). Consequently, she always tells people "that I'm actually a pharmacist by default" (7: 12).

After finishing her BPharm degree, Idania completed her academic internship in a public sector hospital. This was a very positive experience, primarily ascribed to her being given "a very good tutor" (7: 13), who she described as a "wonderful guy" (7: 13), "who really made hospital pharmacy very interesting" (7: 14):

> I was his first intern at the hospital so he kind of looked after me there, but he was very, very nice, so I had a beautiful experience. I must say my internship was excellent. Really, really nice, I was taught nicely. He was very bright, and also he was a very committed pharmacist. When it comes to commitment, I can say he had lots of commitment. (7: 13)

Her tutor was also "very, very progressive" (7: 14) and Idania believed that through his approach to pharmacy, she was "introduced to pharmaceutical care - and I'm talking about 1977 when the buzzword wasn't even around" (7: 14). Her tutor not only taught her well and exposed her to new ways of practice, but helped develop her self-confidence and sense of worth as a person. As Idania explained: "It was still in the apartheid era and it kind of is a

[23] Matriculation is the final year of schooling – the current Grade 12 school level

complex thing because when you are in that era and people treat you poorly, you build a complex“ (7: 13). However, Idania’s tutor modelled for her “a new way of interacting with people” (7: 14) by standing up for the rights of all his staff, at the expense of making himself “unpopular with the authorities” (7: 13). This assisted Idania to “develop and get away from those kind of structures we came from” (7: 14) and helped “boost the confidence” (7: 14). In addition, Idania learnt “work ethics” (7: 14) from her tutor which have had an influence on her throughout her career:

> He would not sit in his office; if there were lots of patients in the outpatients, he would come out of his office and he would sit and he would do the work with us; so you learnt that. And, later on in life, those sorts of things impacted on the way in which I approached anything. I never look at the strata, I never look at why I am here and you are there, I've always looked at it as if we are all together for the common good of the patient. And so that's what I learned from a very young age … So I got these things from that tutor. (7: 14)

On completion of her internship, she continued to work in the hospital for a few years before she made a move into “private practice” (7: 14) where she managed a community pharmacy for a friend for three years. Despite some drawbacks to private practice, like “long hours” (7: 15) and people being more demanding, since they were “paying for the services” (7: 15), she enjoyed the experience. However, following the sale of that pharmacy, she returned to work at the hospital but left there shortly thereafter when she had the opportunity to purchase her own pharmacy; “So I got into private practice, and I stayed there for about 16 years maybe” (7: 16).

Toward the end of this 16 year period she returned to the university on a part time basis in order to complete a Master’s degree in pharmacology. She admitted that part of her motivation for her return to further study was the possibility of making a move into teaching: “I knew that teaching was at the back of my mind. It was my inner self being congruent with what I wanted to do” (7:17). Thus, when the opportunity to teach arose, Idania accepted it. Teaching part-time initially Idania continued to run her pharmacy. During this time she both “started to like lecturing” (7: 18), and was also becoming frustrated with aspects of community pharmacy:

> The medical aids were taking long to pay and then you get into problems with patients … because you want them to get better … you give them their medication and then they don't pay you. So you tend to become very cautious because you have to pay for the drugs. (7: 18)

When she realised that she was "becoming that type of person that when patients came into my pharmacy" (7: 18) and her first question was "is it medical aid or cash?" (7: 18), she recognised "that's not pharmaceutical care … that's more a financial thing. I'm asking them that first" (7: 18). She "started to think 'no this is not for me'" (7: 18). Consequently, four years later, when she was offered a full-time post in pharmacology, "I took the full-time post and then I sold my pharmacy" (7: 19).

While she was in a full-time position at the university she discovered that:

> I started liking research; I found that if you went away and you did nothing but just read and did literature background it's so interesting. I now had this passion for research. So I realised 'now I'm going to be a true academic'. I loved the teaching, I loved the research, and I loved being with my students and things like that. So I started to develop into an academic; more of an academic. (7: 19)

Six years later, however, with the intended purposes of informing her teaching practice, she returned to practice, in a community pharmacy, on a part-time basis; "So I go to the pharmacy every evening from 5:30 to 7:30 so it doesn't interfere with my academic work at all" (7: 20). As Idania suggested, "I'm enjoying two worlds" (7: 20), and in addition, referring to her current practice experience, "if I retire, then I've got something to fall back on; I won't get bored" (7: 20).

Idania's initial experience of teaching was a daunting one, for which she felt under-prepared, not having the "skills or the training" (7: 58):

> In my first lecture I was physically shaking and I went there all prepared to do this - all the overheads were ready and I put the overhead on - and I was going to start talking … you know how you imagine you must talk without looking and reading, and then I just froze. I froze and I said 'My goodness' and I quickly went and got the notes and started to talk from the notes. It took me until my third lecture before I felt comfortable; in order to not only read. But I was reading, and that wasn't a good lecturer. (7: 58)

Idania considered herself to have developed in her teaching, "through practice and gaining a lot of confidence" (7: 67). She also suggested that she always ensured that she was well prepared for lectures: "I always make sure that whatever I'm going to talk on I research and do it thoroughly so that I can talk about it" (7: 67). Further, she stated:

> Just trying to challenge yourself that you know - I'm going to impart knowledge and I need to know that they don't know that aspect of it, so this is what I'm going to teach them. So you gain confidence in that way. And then doing all the reading and the preparation and making sure that you know your topic. (7: 67)

In addition, she described how she drew heavily on her practice experience: “A lot of my teaching comes straight out of my practice” (7: 67) and in order to expose students to “real-life problems” (7: 67) and real-life situations” (7: 67), she took “prescriptions from the pharmacy and case studies” (7: 67) into lectures.

Her work as an inspector with the South African Pharmacy Council and the Medicines Control Council (MCC) also benefited her teaching:

> And now with being an inspector, it helps me a lot, because I'm doing the law all the time - and serving on MCC. You know you had to also know what is legal and what isn't legal, so I am hands-on with my law things; that helps a bit. (7: 67)

Idania also described how she did extensive community work and used the experiences which she had and contacts, which she made through that, to enrich her teaching:

> I do a lot of community work. I'm still a member of the anti-drug forum - and then I was also on the local HIV forum. That's where my interaction with the HIV patients also came through; there was this lady that was a motivational speaker that we brought to speak to the forum and then I asked her to come and speak to my students. (7: 25)

As a consequence of her practice experience and community engagement she felt that she was able to say to the students, “I don’t sit in an ivory tower and tell you what to do” (7: 30). Instead she got her “hands dirty, so I can tell them this is how it's done” (7: 30).

As a committed teacher, Idania’s primary focus in her academic career has been on teaching undergraduates, perhaps at the cost of developing her own research career. When she received a letter, about six years previously, from the Deputy-Vice Chancellor of Research, who enquired why she was not publishing, her response was, “I'm not publishing because I spend more time in my undergraduate teaching” (7: 63). As she explained further:

> To me, I need to make sure that my undergraduates get the basic degree so that they can go forward, rather than developing myself. I've already got my

> basic degree and I said 'In time, I shall do that'. But then, I find people actually doing that, neglecting the undergraduates, so they can develop themselves. Or they go away and do things and then we need to get ad hoc staff to do their lectures for them and things; it saddens me because maybe I think differently, you know, it really does sadden me. (7: 63)

However, Idania related how she had subsequently completed a doctorate and how she has been establishing a research programme and developing a team of researchers. Although she has a passion for research, she said that she has always been "very vocal" (7: 59) with regard to her perception that "the university places so much emphasis on the PhD" (7: 59). Because she had acquired her doctorate, she felt that she could be "even more vocal" (7: 59) in her opinion that a doctorate, with a very narrow research focus, did not develop a rounded academic nor contribute significantly to teaching undergraduates:

> The PhD is a postgrad degree, and it's a development of the person, but do they see how that PhD translates into you effectively developing an undergrad? To me, it's something that really bugs me because in a PhD, you focus on one special area; you may not know anything else but because you have a PhD they take you and put you on a pedestal and you have all the promotion, you have everything else. Little do they realise what you actually give to your students. I have had students in the past who actually used to come and tell me, 'You know, you're not a doctor, and yet you are a better lecturer than A, B, C or D' and then you look at the A, B, C and D and some of them may even be professors, and then you tell yourself, 'you know, it's so true!'. (7: 59)

Although Idania recognised that "research is important" (7: 62) she was of the opinion that her practice experience had a greater impact with regard to informing and enriching teaching:

> I do not believe that if you are pharmacist lecturer, that research is the only component that can keep you abreast. It'll keep you abreast in terms of new developments. But it's not going to give you the knowledge that you have to impart to those students then and there … I can see how the research was retrospectively informing my lecturing, but not prospectively, because it has to be done. But your practice as a pharmacist is current. (7: 61)

Furthermore citing specific ethical dilemmas she had encountered in practice, she suggested "that kind of ethics you can't get out of research" (7:62). Consequently, she believed that "the university should have a clear-cut division. You are a lecturer or you are a researcher;

because you find the researchers don't make good lecturers, most of the time, and sometimes the lecturers don't make good researchers" (7: 62).

Although Idania recognised that early on in her academic career she had "good mentors" (7: 71) in terms of her more experienced colleagues, "they were very nice, and if you had a problem you'd go and ask them, and then they'd explain to you" (7: 71), she expressed disappointment that more structured support for her development as an academic, from the department and the university, had been lacking:

> I can tell you honestly there are no development opportunities for you personally. What does happen is that people use every possible avenue to develop themselves. We are not given the opportunity. Even when one has developed expertise in an area of research, I am not given opportunities to develop my teaching in that area or new modules in that area. It gets done by somebody who is not even part of research in that area. There is not the support - and the support is not coming from the top. It is disappointing. (7: 71)

5.8.1 Interpreting Idania's story

5.8.1.1 Idania's self-perceived professional identity

Having come into academia from a well-established career as a community pharmacist, Idania retained a very strong identification with being a pharmacist. Although she labelled her occupation "pharmacist/lecturer or lecturer/pharmacist, depending on the situation" (7: 46), when asked to describe herself professionally she said "I think I'm an optimistic pharmacist. I'm very optimistic - an optimistic pharmacist who is committed to ensuring positive outcomes for patients" (7: 38). This self-description naturally parallels with the very high value she placed both on her identity as a pharmacist and her continuing practice in community pharmacy as a means of keeping her academic work both relevant and informed: "I must say that my practice informs my teaching a lot and, to a small extent, my research" (7: 25).

Early on in her academic career Idania recognised that her development as an academic required the encompassment of both teaching and research: "I loved the teaching, I loved the research, and I loved being with my students and things like that. So I started to develop into an academic, more of an academic" (7: 19). However, although she recognised research as an important aspect of an academic career, and she has always had a "passion for research" (7: 19), she did not identify herself as a researcher as readily as she viewed

herself as a lecturer: “I never thought of myself as a researcher” (7: 50). I would suggest that she equated lecturer with teacher, since she apparently perceived her primary obligation within the academic environment as teaching. “If I can satisfy my undergraduates, that’s my moral obligation” (7: 62) and “I said I'm not publishing because I spend more time with my undergrads. For me, I need to make sure that they get the basic degree” (7: 63). The literature suggests that it is not uncommon for new university lecturers in the health sciences, who have made mid-career changes to academia, to give the bulk of their time and energy to teaching, which they rank as their priority (Smith & Boyd, 2012; Williams, 2010).

Teaching had been her first career choice, “I really wanted to do teaching” (7: 11), and when she first embarked on postgraduate studies, “teaching was at the back of my mind” (7: 17). She viewed the opportunity to teach as “my inner self being congruent with what I wanted to do”. However, Idania described the difficulties of her first experiences of teaching and she recognised how underprepared she was for it and suggested that “we never got training as a lecturer and I think that's been the biggest gap with us” (7: 54). In the light of that it is, however, interesting to note that she did not seek opportunities to develop her pedagogical knowledge but relied on the thorough preparation of her subject material and the development of confidence to strengthen her teaching. As Williams (2010) suggested, it is not unusual for people making a career change into teaching to believe that their content knowledge is sufficient to be a teacher and that knowledge of pedagogy is not required.

Her inclination and her passion for teaching were also apparent when she described her reason for becoming an inspector for the South African Pharmacy Council: “The Pharmacy Council asked me to do inspections and at first I refused. Then I said to myself; “If I'm not going to be a policeman, if I'm going to educate the pharmacists, I'm prepared to do it’“(7: 18).

Although Idania did not offer a metaphor to describe herself professionally, she expressed the view of herself as “committed” (7: 42) and also described herself as someone who believed “in honesty. I really believe in honesty and work ethics, respect for others, justice, all the ethical principles. I think I subscribe to that totally, totally, and I mean totally” (7: 42). Moreover, she was of the firm opinion that “whatever you preach, you must practice” (7: 42) and related this very directly her teaching: “I’m scared to do and tell the students something that I’m not doing” (7: 42). This was also at the heart of why she viewed practice as central to her teaching, “I know it can be done. And that's why I can always say to them, ‘I don’t sit in an ivory tower and tell you what to do, I get my hands dirty’, so I can tell them ‘this is how it's done’” (7: 30). Her commitment, respect for others and sense of justice was also evident in

the community work which she did, having served on the “anti-drug forum” (7: 25) and the “local HIV forum” (7: 25).

The pseudonym Idania, of Slovakian origin, means “hardworking, prosperous” (Meaning of names.com, 2012), and was chosen to represent Idania’s propensity for hard-work, apparent in her ability to fulfil all the obligations of an academic career, including teaching and research, as well as community engagement, whilst still working in a pharmacy after hours.

5.8.1.2 Idania’s identity – “a nexus of multi-membership”

Idania’s professional identity has not only been formed through participation in multiple communities of practice, including hospital pharmacy, community pharmacy, academic pharmacy, several pharmaceutical organisations, as well as various community based forums but continues to be formed through this multi-membership. Idania is certainly an example of an academic whose professional identity is what Wenger (1998, p. 158) describes as a “nexus of multi-membership” and “combines multiple forms of membership through a process of reconciliation across boundaries of practice”. Whilst negotiating membership of the academic community, Idania has experienced a perhaps self-imposed, responsibility and requirement to sustain her competence as a community pharmacist - and by working in a pharmacy she maintains her level of standing within the pharmacy community. This is perhaps a result of what Smith and Boyd (2012) describe as a reluctance to relinquish practice-related identity and credibility since as Winberg (2008) suggests, it is often within occupational communities that identity is not only gained and clarified but is also socially legitimated. However, the experience of multi-membership and the “work required to “combine, confront or reconcile various aspects of our identities” can be a stimulus for personal growth, and also a “source of social cohesion”, which has the potential to build connections across communities of practice (Wenger, 2000, p. 242). In Idania’s approach of “getting her hands dirty”, where she understood first-hand what was feasible and what happened in practice and was able to communicate that in practical ways with “real-life problems” (7: 67) and “real-situations” (7: 67) in her teaching, she was building connections for the students between the academic and retail pharmacy communities of practice. Furthermore, Idania manifested a dual, “self-sustaining” (Palmer, 1990, p. 40) identity between herself as a practitioner and lecturer; the one continually sustaining the other.

5.8.1.3 The reluctant “doctor”

Idania had very strong concerns regarding the emphasis that was placed on the doctorate within the university environment. Her perception of the doctorate was that it was a research

degree that had a very narrow focus and, beyond research, the doctorate did not prepare an individual for the responsibilities of academia and, in her view, made a negligible contribution to the teaching of undergraduates. Although she acknowledged that greater attention was being given to teaching, she still believed that the doctorate was given too much prominence:

> Now they have more emphasis on teaching but still, the PhD has to be behind your name. I've seen great people with vast knowledge, who even publish so much - they are so knowledgeable and yet they haven't got a PhD. So, without a doctor in the name, the way we are all psyched this way, the way the entire academic population is psyched - but I am talking from my own experience and I can say that now that I've got my PhD …. (7: 62)

Tension created by underlying pressure on academics to complete a doctorate and engage in research, which they viewed as a contradiction to their teaching preference and priority, was highlighted by Smith and Boyd (2012) as one of the greatest difficulties faced by healthcare professionals making mid-career changes to academia. It is perhaps an experience of tension of this nature which has made Idania so vocal with regard to the emphasis placed on a doctorate. Although Idania is passionate about research, she has always made teaching a priority because of her perceived obligation to the students; simultaneously admitting that the pressure to complete a doctorate has always been there. However, having attained her doctorate Idania has remained as vocal in her concerns and, furthermore, with hindsight and "insider" experience, she was of the belief that the doctorate had made no substantial difference to the person that she was:

> At home it is a big joke, I tell my parents and I tell my husband, I say "Guess what, one day I didn't have a PhD and the next day I had my PhD - I was a different person but nothing else changed in my life. I had the same knowledge, I didn't even read more that night. It was just the fact that I've got the 'Dr' in front of my name. Was I a totally different person?' I'm not that type of a person. I don't worry about it, to me, it doesn't matter, I don't need it. It's just a matter of furthering your studies; it's like you got your basic degree after matric and you got a Master's degree and now you going for a further degree. Alright I always wanted to get the highest degree, that's it! But it was not going to influence me in terms of how I judge somebody; what knowledge I took from them, what knowledge I imparted to them. I was not going to do that at all. (7: 62)

Nonetheless, Harrison (2009, p. 26), citing Walker, Golde, Jones, Bueschel and Hutchings (2008), suggests that "doctoral education is a complex process of formation" and that "what is formed, in short, is the scholar's professional identity in all its dimensions". Consequently, I would suggest that although her doctorate did not make any substantial difference to the way Idania felt about and viewed herself, and although her priority for teaching had not changed, it may have contributed significantly to her development and confidence as a researcher. She actually stated, "in terms of research, now, I've mostly arrived" and, as she herself acknowledged, "research is important, absolutely important" (7: 62).

5.8.2 Idania's perceptions of pharmacy and pharmacy education

In her practice as a community pharmacist Idania was very patient-focused. She was motivated by servicing and meeting the needs of her client, and she described how, in her pharmacy, when she felt that financial limitations were forcing her to put money considerations before care of the patients, she had to get out:

> When I realised that I was becoming that type of person; that when they came into my pharmacy, I'd ask them: 'Is it medical aid or cash?' I said 'that's not pharmaceutical care, that's more a financial thing'. I'm asking them that first, and then I started to think, 'No this is not for me. I have to get out of here'. (7: 18)

She subscribed to the philosophy of pharmaceutical care and in her teaching she described trying to impart the philosophy of patient-centred care to the students:

> So, when they're doing the project, they must do it because they like to do it, they want to help people. I always tell them 'whatever we're doing, whether we are in practice or in research, at the end of the day the patient is at the end of that tunnel and you want a positive outcome for them. If you can achieve that, the method that you used to do that is immaterial, and who does it, and how they do it, doesn't matter, as long as you can achieve positive outcomes for the patient'. (7: 25)

Building on her own experience, she often cautioned students about becoming money-driven at the expense of patient care; "I also speak to them about money being very important. It is absolutely important but you need to learn that it should not take priority over a patient's health" (7: 26). Idania is referring here to what Palmer (1990, p. 41) terms the shadow side of professional activity; "investing long hours and much money to develop an allegedly rare ability that others can be convinced to need and to purchase at a high price". It is a dilemma

of multiple motivations that Idania was trying to alert her students to, and warn them of, at an early stage in their professional development.

It would seem that Idania's sustained insider knowledge of the practice environment makes her ideally suited to preparing students for the realities they will face on graduation and entry into practice. As Hagemeier (2010) argues, pharmacy educators often prepare students with the basic skills necessary for ideal practice settings and not for the real issues that they will confront in the practice environment, which impacts on their ability to provide patient care and ultimately also on their job satisfaction and sense of fulfilment. Idania's practice-informed approach to teaching appears to provide the realism that Hagemeier argues will overcome the dissonance between what students might be taught at university and what they experience in practice. Idania was of the strong belief that "whatever you preach, you must practice; I'm scared to go and tell my students something that I'm not doing. I'm really scared to do something like that" (7: 42).

5.8.3 "Who" is Idania?

Idania is an established pharmacist, who made a mid-career move to academia, whilst retaining strong links with her prior practice. Her academic identity is essentially that of a teacher; however, it remains firmly grounded in and infused with her professional identity as a pharmacist. Her academic identity is the product of the "nexus of multi-membership" (Wenger, 1998, p. 158) of several communities of practice and is what Rodgers and Scott (2008, p. 736) term "shifting and multiple".

Having recently acquired her doctorate, she is a reluctant "doctor" and believes that the emphasis on the doctorate in the university environment is unnecessarily inflated. Her interest in research and her research programme is, however, growing and it is highly possible that some of the focus of her passion for teaching will shift to teaching postgraduate students research skills. While, at the time of the interview, she did not perceive herself as a researcher, "I never thought of myself as a researcher" (7: 50), it is possible that, in time, she might add "researcher" to the "pharmacist/lecturer or lecturer/pharmacist - depending on the situation" (7: 46) - description she provided of herself.

5.9 Hypatia's story

Hypatia is a forty-year old woman who has been registered as a pharmacist for 13 years. After she finished BPharm degree she completed a Master's degree in pharmaceutics before taking up her first post in academia. She subsequently worked exclusively in an academic environment. However, at the time of the interview, she had recently handed in her resignation and was working out a notice period prior to moving away from academia.

Medicine had been Hypatia's career of choice, but she was not "selected" (8: 12) for medicine and had to "look at other alternatives" (8: 12). It was on the advice of her father, a pharmacist, that she made the decision to study pharmacy. She "took a year off, and (I) did biology" (8: 12) as a seventh subject through a correspondence college, prior to commencing her BPharm studies.

On completing her BPharm degree she considered going to work in retail pharmacy with her father. However, she "started to pray about getting a Master's degree project but all of the projects were taken" (8: 12). Although initially the university "did not have funds to accommodate another student" (8: 13) external funding created "an opportunity for me to do a Master's degree … one of which was the first in South Africa" (8: 13). On conclusion of her Master's degree, Hypatia immediately "decided I want to do my PhD" (8: 13).

Her choice of doctoral project required a move to a research department within another university where she "didn't work as a pharmacist" (8: 14), but as a "medical, natural scientist in training" (8: 14). On commencement of the project, Hypatia realised that the project was one that she "felt very uncomfortable with" (8: 14), since she was pressured "into doing animal laboratory work" (8: 14). She recognised that "this was not working for me" (8: 15), and she made the decision to leave and complete the practical component of her internship, as she had "one month of academic internship over" (8: 15). After registration as a pharmacist, she enquired about a post as a facilitator. However the remuneration, was insufficient to "make a living" (8: 15) and she was "desperately looking for other work" (8: 15). With the assistance of the head of department at this university, she was offered an interview and, subsequently, an academic post as a senior lecturer, at another university. Thus, Hypatia started her "career as a senior lecturer in the department of pharmacy" (8: 17). The head of department at the time was a man from whom she "learnt a lot of things" (8: 17), and for whom she had immense admiration "for everything that he's done" (8: 17). The department she worked in had a problem-based learning approach to the BPharm degree which was very teaching intensive. As a result, she found that teaching was her primary focus: "All I have been doing, most of my work that I have been doing, is teaching" (8: 29)

and she told how she "just didn't get time to do research and that is what I wanted to do" (8: 22).

Hypatia made several further unsuccessful attempts at initiating her doctoral studies: “I started numerous PhD projects, all of which I had to let go of - either funding, or you don't get the expertise, or there’s not the equipment” (8: 19). However, at the prompting of and with the assistance of her husband, who had the necessary expertise, she “started afresh” … in a new field again” (8: 22) and registered for her doctorate. Although "it went okay" (8: 22), and she finally completed it, it was not without its own struggles: “We had a lot of problems in the laboratory” (8: 22). She was the only person “working in this field within her department” (8: 20) and although she felt like she “got some support” (8: 20), she expressed frustration with her department’s seeming inability to “understand that a laboratory-based study takes more from you than sitting and working with papers; papers you can take home, work on the plane, things like that. You can't do that in a laboratory setting” (8: 20).

After 12 years in the department, however, Hypatia handed in her resignation and she was intent on leaving. She believed that this had been a well-considered decision based on numerous factors: “The reasons why I am going to leave are multiple and it's not a decision I made overnight. It's a well thought through decision and I'm very happy and content; something I haven't been for a long, long time” (8: 19). One of the reasons she mentioned was the logistics of living a distance from the university and having to travel in a lift club:

> We travel in a lift club, and obviously the more people you are involved with, the more trouble it creates. You are sitting in a confined environment in the car, close up; and if you don't want to talk, or if you want to sleep, or you want to work … you know ‘people are people’. So the distance was a problem for me. (8: 19)

She also felt that the workload within the department, especially the teaching workload, was far too great, “The amount of stress that we have in our department is terrible. We are short staffed, our student numbers have increased, so the balance - you basically just never get on top of things” (8: 19). She, therefore, had insufficient time for research, which was what she wanted to be doing; "I want to be involved in research" (8: 22). Furthermore:

> That bothered me because I am not necessarily such a people's person. I am more of an individual. If you give me a task I go and sit in my room behind my computer, and I do the work. Should I interact with people, I like to be in a position of authority. In other words, a lecturer was a good position for me to be in because I was the one who would give the lecture. So I just

> felt after 10 years because I said to myself, ‘okay, let’s get this curricula started and we move on, and then you'll have a chance to do your research’, but it never ended like that, because we will always be improving, improving, improving. Staff were leaving, student numbers were increasing, so your workload increases, therefore your teaching increases, and your involvement increases. (8: 21)

Consequently, she “didn’t feel like I was growing as a researcher at all. I got a technical report, from my Master’s project, and I got one article out of my PhD so far. So that's two articles in 12 years” (8: 19). In a university which placed much emphasis on outputs, “it was once said to us that either you ‘publish or perish’” (8: 21), and because the university rewarded staff accordingly, Hypatia felt that she “was not gaining recognition from research” (8: 30):

> If you look at prizes or you look at competitions at the university, our university, you get scored, I can't remember the ratios, let’s say 0.1 marks for each paper you’ve given in. And the total has to be 4 or more for you to qualify to become the young researcher of the year. (8: 23)

She, therefore, decided to focus on gaining recognition through her teaching:

> Again, I had to look at myself and say ‘either you can be a teacher or a researcher’. I remember standing in front of the photocopier and hearing [one of the other lecturers] saying, ‘in this place, you can either be a teacher or a researcher’. I thought about that and I thought to myself, ‘you know I'm not gaining recognition from research, so let me try this teacher thing’. (8: 30)

However, although she felt as if her whole academic career had been focused on teaching, “all I have been doing, most of my work that I have been doing, is teaching” (8: 29), she did not perceive that that had been recognised by her department: “I wasn't acknowledged enough for my contribution in the department” (8: 23). She also did not feel that her university, in comparison to others, gave sufficient recognition for teaching:

> I know at another university, well that's what I heard, if your teaching methods are of such a good quality, they would consider you for an associate professor; but I'm speaking under correction about that. And that is, unfortunately one of the things that are important for me is to know that I climbed some kind of ladder. Even if it is just to say, you will get R400 more this year. (8: 88)

In an effort to gain some recognition, she put together a teaching portfolio and entered "the teacher of the year award[24]" (8: 25):

> I entered the competition and, unfortunately for me, a non-pharmacist won it. That was a setback for me because I just felt after ten years, you've got to get something, you know! And that's all I wanted - just a little trophy in a place, to say, 'you know, well done for your ten years!' It would have made me feel better. (8: 30)

Consequently, the feelings that she had not gained recognition, for either her research or her teaching, left her questioning her place in the university and contributed to her decision to leave: "The only way to express yourself as being powerful is by being either a good teacher and getting acknowledged therefore, or a researcher, when you publish. Now where do I fit in?" (8: 76).

At the time of the interview, she "was not practicing in other places of pharmacy" (8: 61) and, beyond the 400 practical hours of her internship in retail pharmacy, she had very little experience of other practice environments. Nevertheless, she had decided to:

> Take myself out of the university, move out of a comfort zone and become my own boss in a sense; to do part-time locum work, in other words, I can strengthen myself as a locum, thereby I can work in pharmacies. So I can get money for that, they don't pay too high, but not too little either, and I'm going to do extra courses, GMP25, and stuff like that, to improve myself. (8: 24)

Moreover, she added that she was "looking forward to this kind of life" (8: 24).

5.9.1 Interpreting Hypatia's story

5.9.1.1 Hypatia's self-perceived professional identity

After 12 years in pharmacy education, Hypatia had resigned and was soon to leave the university. The many frustrations which led to her resignation had undoubtedly coloured her opinion of pharmacy education as well as her role as a pharmacy educator, and perhaps contributed to many of the statements she made regarding the department. However, she described herself in the following terms:

[24] A national award made annually by the Academy of Pharmaceutical Sciences
[25] GMP is an abbreviation for Good Manufacturing Practice

> I'm not conventional. I don't necessarily teach conventionally, and I don't like to be held down by rules. I am very free-spirited and I'm a pretty good example of 'what you see is what you get', and I try not to be false. (8: 104)

She acknowledged that "some of the statements I made may be very bluntly said" (8: 104), but she believed that they were honest. Her story is very useful in helping to understand why some practitioners, not having found true professional fulfilment, would choose to exit a community of practice. In Wenger's (1998) terms, Hypatia could be considered to have been on an "outbound trajectory".

One of the factors which had led to Hypatia's resignation was a perceived lack of recognition for either her teaching or research roles within the university. As a consequence of this lack of external recognition, Hypatia expressed the feeling that "I don't see myself as either" (8: 30) a teacher or a researcher. Fascinated by knowledge, Hypatia "wants to be involved in research" (8: 22) and she wanted to be a researcher. However, she expressed the feeling that she did not have research experience "strong enough to go on by myself in research; so I need support, like anyone does. I'm not making myself inferior; I'm just saying everybody needs support." (8: 34). And the support she required was not available within the university where she was working. In terms of her research, Hypatia would still be in what Rowley and McCulloch, cited by Akerlind (2010, Kindle Location 1478), term the "apprenticeship" stage of the development of research expertise. This stage includes researchers who are typically in the postdoctoral period. Their scope of research activity is largely limited to that of their postgraduate studies, and they have a limited history of research publications and are still becoming acquainted with the wider academic community. In this stage, researchers require skilful mentoring to assist them in making the transition to the next stage, as members of the research community. It was a lack of mentoring or support that Hypatia recognised as having frustrated her and hindered her development as a researcher.

When asked to state her occupation, Hypatia wrote 'pharmacist'. However, when asked if this was how she viewed herself, Hypatia responded with:

> No, I actually thought 'senior lecturer'. I actually thought, 'you're probably thinking why I don't write senior lecturer?'. I could have written that. I do write it sometimes, although, at core, what I am is a pharmacist. I got a degree as a pharmacist; not a degree as a senior lecturer. That's kind of an appointment. Do I see myself as a pharmacist? No! I see myself more as an educator in pharmacy. Because if you say the word 'pharmacy' to me, the first thing I think about is retail pharmacy. (8: 53)

This would suggest that Hypatia had a strong identification with her core knowledge base which is in pharmacy, her BPharm qualification. However in her mind the practice of pharmacy was associated with retail or community pharmacy with which she had very little experience. She viewed her job description – senior lecturer - as a role which she was fulfilling, but not as a description of who she was. Her view of herself was of an educator, with the qualifier that it was "in pharmacy" (8: 53), highlighting that she viewed herself as being grounded in her knowledge base. However, Hypatia felt that, having taught on an integrated, problem-based teaching programme, she had not had the opportunity to develop herself as a specialist within any particular discipline of pharmacy, and that consequently she was "a jack of all trades and a master of none" (8: 82). She was of the opinion that this had hampered her development as an academic: "I don't think the world outside there is either ready to get lecturers that have problem-based learning experiences. So that complicates matters for your development" (8: 84).

A well-formed sense of professional identity is necessary for one's ability to adjust to the workplace and to make a meaningful contribution – one's sense of agency (Skorikov & Vonracek, 2011, p. 699) (see Section 3.2). In the context of this, it would appear that Hypatia's perception of herself as an academic is very confused and may have contributed to her disillusionment with academia. However, it is hard to know if this a consequence of her having made the decision to leave academia or the extent to which it contributed to her decision to leave.

Hypatia's sense of herself as a professional was based almost entirely on her experiences within academic environments. Beyond the 400 practice hours of her academic internship she had very little other experience of retail pharmacy. She viewed her exit from the university as an opportunity to develop herself in other aspects of pharmacy: "I'm going to do extra courses, GMP[26] and stuff like that, to better myself" (8: 24).

She had also never really felt integrated within the wider university community, and considered that to be a consequence of the workload demands of the department she worked in. However, having handed in her resignation, and motivated by the desire to develop herself personally, Hypatia had been attending courses which the university offered and had found much stimulation and support for her personal growth within the wider university.

> Isolated in our department, I feel sometimes - yes for most of my career I felt isolated because we've worked harder than other departments; we had to

[26] Good Manufacturing Practice

> set up a curriculum. I felt isolated and it's only in the last year, maybe even less that I've reached out. Actually, now that I've given in my resignation, I haven't attended so many courses, workshops, etcetera, that I have in a very, very long time. It's very strange but I'm really taking the maximum that I can get out of my environment now and so it is very stimulating for me. (8: 69)

Reybold (2005, p. 108) suggests that primary events in academic career development, particularly a perceived lack of support and feelings of isolation within the academic community and an inability to expand one's research profile "may be the genesis of later disillusionment". Both of these aspects are certainly evident in Hypatia's story, and have almost certainly contributed to her disillusionment and ultimately, her resignation.

5.9.1.2 Hypatia the lecturer

In her role as an educator, Hypatia viewed herself very specifically as a lecturer as opposed to a teacher: "I call myself a teacher because you used the term but actually it is a lecturer" (8: 80). She apparently saw the distinction between being a lecturer and a teacher in the degree of student interaction that happened in the classroom. Hypatia had an expressed preference for low engagement with students and thus considered herself a lecturer:

> I am not necessarily such a people's person. I am more of an individual. If you give me a task, I go and sit in my room behind my computer, and I do the work. Should I interact with people I like to be in a position of authority. In other words, a lecturer was a good position for me to be in, because I was the one who would give the lecture. (8: 21)

In fact, she went so far as to suggest that true engagement with students was an irritation to her:

> As a teacher I like aspects of teaching; I like working out a lecture, sitting behind a computer. I like undertaking new projects and seeing them through. I like editing - that is behind a computer. I like standing in front and giving a lecture to students but I find fine interaction with students irritates me. (8: 34)

Her specific correction of herself in the use of the pronoun "my", when relating to students and her replacement of the word "my" with the definite article "the" was also an indication of how Hypatia positioned herself relative to students: "I try to instil that in my students. I shouldn't say *my* students; I try to instil that in *the* students" (8: 92). Hypatia's use of "the" in

place of “my” was indicative of a distancing of herself from the students, thus indicating an attitude of detachment (Monrouxe, 2009). At another point in the interview Hypatia listed the aspects of academic life that she would miss after she left the university, with the notable absence of students or student engagement from the list; “I'll probably always stay a teacher in my heart; I love books, I loved stationery, I love gadgets. I'm actually looking forward to entering this new phase of my life but I am also seeing myself giving lectures” (8: 104).

In the interview Hypatia continually used the words teacher and lecturer interchangeably but she notably went to great lengths to clarify how she viewed the difference between the multiple aspects of the roles of teacher and lecturer, in an effort to explain how she identified with aspects of each role.

Hypatia’s identity as a lecturer, as opposed to a teacher, is grounded in her passion for knowledge and specifically in her role as a lecturer in the transmission of knowledge. For this reason, I chose the pseudonym “Hypatia” for her which is of Greek origin and means “intellectually superior woman” (Meaning of names.com, 2012). Hypatia was also the name of the main character in a film entitled “Agora”[27] with whom she strongly identified herself:

> That lady that played that role, I like her a lot. She is an English-speaking lady - Rachel Weisz. And I could so identify with her in so many, so many ways because nobody could understand the value of knowledge. We live in a society where your worth is sometimes so falsely built on money; how strong are you financially. They are showing the world they are strong by driving an Audi TT roadster or a BMW or this or that. And you can't do that with knowledge. I understood her so well - I understood her so well and I felt so intense about the knowledge and the people that didn't have the knowledge. How much wonderful information, history wasn’t burnt down to the floor unnecessarily? I'm going to buy that DVD. (8: 76)

She felt that the students generally did not appreciate the value of knowledge and expressed her frustration with this:

> Many times in my career I've walked out of classes. I've refused to give classes because the students were unruly; they didn't keep quiet. I worked very, very long on a presentation - they didn't understand the lecture, for example, and many, many times I felt like - and excuse my expression - but

[27] The historical drama film Agora stars Rachel Weisz as the Greek mathematician and philosopher – Hypatia. In the film, Hypatia unsuccessfully struggles to protect the knowledge of classical antiquity in the Library of the Serapeum from destruction by the Christians. (Bradshaw, 2010)

> I've felt like I was throwing pearls … I don't think students appreciate what we do. I don't think they know what goes in there, how to show a sense of appreciation. But there are students that have the savvy and say thank you, and it's those moments that keep you at the university. (8: 80)

Furthermore, although teaching had been a large part of Hypatia's work allocation, she did not particularly enjoy teaching: "So all I have been doing, most of my work that I have been doing, is teaching. And that doesn't say that I necessarily want to teach, or that I see myself as a teacher" (8: 29). She believed that teaching was a "job given to me" (8: 29) and therefore she considered it a "responsibility toward my husband - to support my husband in his job" (8: 29). In addition, she felt that she had a responsibility to give students an "opportunity to learn" (8: 29) which she considered to be a "gift, which is as basic as eating food" (8: 29). Again, she used a film to illustrate the importance she placed on knowledge:

> Again, I go back to the movies, with the drama 'The Reader', in which Kate Winslet starred and for which she won an Oscar. The fact that she was illiterate and she couldn't read or write and nobody realised that. That was probably one of the saddest things, as a teacher, which I could imagine. Because in this sphere that I work, in my mind's trail, I measure myself as a teacher or lecturer according to academic performance; academia - in the intellectual things. (8: 29)

In addition, Hypatia believed that her earning power, or value, was directly related to her knowledge: "My 'money' lies in academic knowledge, and that's not something that people can see". (8: 30). However, her sense of satisfaction in academia came from her ability to "share" her knowledge with others and, paradoxically, she was of the opinion that this could not be valued in financial terms:

> Sharing, it's nice to share, it's nice to share information; intellectual stuff, not speak a lot of rubbish, to share with the students, to share with other staff, for me to share information with them, or when they give it to me. That's 'richdom', knowledge, and its things that money can't buy. (8: 49)

Hypatia used the metaphor of "actor" to describe how she perceived herself as a lecturer. She suggested that when she stands in front of a class "you've got to have a different kind of

persona" (8: 49) in comparison with "an oral exam situation"[28] (8: 49) in which you are in a one-on-one relationship with a student, where you "can be a lot softer" (8: 49):

> So you've got to have those two kinds of faces. I don't like being near to students because I'm not - I'm old enough to be their mother to start off with. And second of all, I don't see that as professional. So you play different roles by the different presentations and different teaching you do. (8: 49)

She also used the image of a glowing ball of light to describe how she perceived herself, relative to her academic work:

> And it's like a ball with this fire inside and, as this ball turns, it's got little holes in, and there's this big source of orange, yellow light emitting through those little holes. What I'm trying to say to you is, when you are teaching, sometimes those little rays that comes through that spiked ball are who you really are. So although you can't - so even though you can't - separate yourself from not being who you really are, you have to have a level of distance. (8: 49)

Although I have already suggested that Hypatia achieved satisfaction from sharing her knowledge with others, this image she offered of herself as a lecturer, particularly the "spiked" nature of the ball and the little rays through which light is emitted, would suggest that she had a need to protect both herself, and her knowledge base in the process of imparting her knowledge to students.

5.9.1.3 Motivated by the 'public aspects' of academic work

The extent to which Hypatia felt undervalued as an academic was illustrated in various aspects of her story; for example, in her expressed disappointment in not winning the Teacher of the Year Award, "that was a setback for me, because I just felt, after 10 years, you've got to get something, you know" (8: 30); in her feeling that her contribution to her department was not sufficiently acknowledged; in her lack of research publications and even in the hope that she would possibly be remembered by the students for what she taught them - "they will remember me for that - and they *will* remember that. Maybe I'll be lucky that they can say, one day, 'Yes Dr [Hypatia] always taught us, take it with a lot of water …'" (8: 92).

[28] An "oral exam situation" refers to the use of individual student oral evaluations as a form of examination

Hypatia's emphasis on recognition and rewards suggested that her focus was on the "extrinsically and activity driven aspects of academic work", what Akerlind and McAlpine (2010, Kindle Location 3632) termed the "public" aspects of academic work. This is in contrast to the "personal face" of academic work, which "represents more intrinsically and purpose-driven aspects" (Akerlind & McAlpine, 2010, Kindle Location 3632). However, It is the "personal face" which underpins "academic purpose, meaning and identity" and is often the motivating force behind engagement in academic work and in the development of "personal understanding of academic practice over time" (Akerlind & McAlpine, 2010, Kindle Location 3632). It is possible, therefore, that Hypatia's focus on the public aspects of academic work and the failure to obtain the desired external recognition and rewards which she sought, have consequently left her without a sufficiently satisfying sense of purpose, meaning and identity: "The only way to express yourself as being powerful is by being either a good teacher and getting acknowledged therefore, or a researcher, when you publish. Now where do I fit in?" (8: 76), and may have contributed to her resignation.

Akerlind and McAlpine (2010, Kindle Location 3632) further contend that there is too much emphasis placed on the public aspects of academic practice, particularly in the socialisation of new academics. Consequently, this places too great an emphasis on or "over-privileges this aspect of academic work" and neglects the personal aspects of being an academic. However, they did not propose a shift in the other direction, but rather a rebalancing of the two emphases in the mentoring of new academics. It is possible that the focus on research outputs within the university domain, and also the lack of strong mentoring into the academic role, may have contributed to Hypatia's singular emphasis and reliance on the public aspects of academic work for her sense of purpose and identity.

5.9.2 Hypatia's perceptions of pharmacy and pharmacy education

Hypatia defined pharmaceutical care as "pharmaceutical assistance in specialised areas where you cater for the patient or the patient gets the best out of that intervention" (8: 92). She also viewed pharmaceutical care as including all the screening and monitoring tests that pharmacists offer: "If you say pharmaceutical care to me, I immediately think of cholesterol, blood glucose, those kinds of things" (8: 92). Furthermore, she added that "pharmaceutical care aspects" were included in her teaching modules.

From the perspective of a patient, Hypatia perceived that pharmacists whom she had encountered were not specifically providing pharmaceutical care: "Some pharmacists that I've come across on a personal level, that don't know me as a pharmacist, don't necessarily give any pharmaceutical care or advice" (8: 92). She suggested that the typical interaction

with a patient with regard to their medication involved the following: “Here are your tablets. That’s it. Go!” (8: 92), rather than a more pharmaceutical care based approach which might for example have been something like, “This is an antibiotic; it’s metronidazole to help you with your infection. Don't take any alcohol with it!’” (8: 92). In this statement she was equating pharmaceutical care with the provision of information to a patient for the purposes of empowering the patient to take their medication more effectively.

When she reflected on the manner in which she perceived the practice of pharmacy had evolved, Hypatia suggested that:

> In the olden days, you had your pharmacist who made your medicine and gave it to the patient. … that distance between making the medicines and standing behind the counter and issuing it to a patient, I think in today's terms has widened, like a triangle; where, as time goes by, the role that you can play, to eventually provide your patient with the best pharmaceutical care, has widened a lot. (9: 96)

She was of the belief that clinical pharmacy might have a role to play in bridging the “distance” and thereby ultimately enhancing patient care. However, notwithstanding the emphasis which the pharmacy department in which she was working placed on clinical pharmacy, she was not fully supportive of the concept:

> My personal opinion of clinical pharmacy, maybe it's because I don't know so much in the field, but I would rather prefer to be a doctor than a pharmacist playing around as a clinical pharmacist. That is a very personal statement I’m making, but that's how I feel. But, like I say, I don't think I've got enough knowledge maybe about what clinical pharmacy entails. (8: 96).

When asked about the role of pharmacy educators in shaping the future of pharmacy, she was of the firm opinion that pharmacy educators have a vital role to play:

> Very, very, very definitely, yes! It's been said that there is a shortage of pharmacists in South Africa, so filling that shortage comes with a lot of challenges. Most definitely, how you teach can affect the quality of your students that are going to pass. When they are placed in the outside world they will always carry the name of the university with them and people are going to judge them according to the university which they attended. They are not going to ask them, ‘Did you get a distinction in pharmaceutical chemistry?’ It's how well you are going to do your job. So yes, I do think that

we as educators can play, are playing, a very important role in pharmacy. (8: 100)

5.9.3 Who is Hypatia?

Hypatia has a passion for knowledge and consequently found her identity as a pharmacist in her knowledge base - her academic qualification. Although her “job” as a lecturer gave her an opportunity to share knowledge with others, she has a low tolerance for student interaction and therefore finds some aspects of lecturing difficult. Furthermore, the teaching load within her academic department, coupled with a perceived lack of mentoring and support, meant that her true desire to do research and be a researcher has been frustrated.

Motivated by extrinsic rewards and recognition, Hypatia considered herself to be under-valued and unrewarded in her job and this contributed to her resignation from the university. Consequently, she was on an “outbound trajectory” (Wenger, 1998) from the academic community. Although at the time of this interview Hypatia’s experience of other areas of pharmacy practice is fairly limited, she is seeking to develop herself in further aspects of pharmacy in order to make herself more employable within other practice domains.

5.10 Credibility of the stories

In order to verify the trustworthiness and more specifically the credibility of the stories and my interpretations of them, a process of “respondent validation” or “member checking”, as described by Johnson and Waterfield (2004, p. 125) was employed (Guba, 1981). The transcript of each of the interviews, together with the story and my interpretation of the story, were emailed to each participant. They were asked to read through them and respond to four questions which I posed to them:

1. Do you think my re-telling of your story and the interpretation of it is fair and accurate?
2. Is there anything that I have included that you feel might make you easily identifiable and therefore vulnerable to exposure?
3. Are you satisfied with the pseudonym that I have used?
4. Are there any other comments that you might like to make with regards what I have written?

All participants responded to my request and completed the member checking process.

The response to my first question was positive, with comments such as: “You captured and analysed my story completely”; “Yes I believe it is”; “It tells the tale as I recall I tried to convey it”; “It is an accurate reflection of the interview and I completely agree with the interpretation”; “Yes to a great degree, what you wrote I agree with. This was an eye opening experience for me – to see how I was thinking then and what my expectations were compared to my current situation”; and simply “Yes” being received. Only one participant felt that I had perhaps not interpreted her story entirely accurately and responded with:

> The telling is fairly accurate, except the analysis of the research component. I have said as highlighted in the transcript that I love research; that I have a passion for research is what the transcript states, but analysis infers that I do not like research.

The interpretation was therefore adjusted accordingly and rechecked with the participant, until she was satisfied.

A further participant sent the following response:

> I had a weird reaction on reading the story, for a couple of days I just couldn't answer you as I really didn't like the person in that story - and felt quite shaken by all the things I've not achieved. OK, I've gotten over myself and

> realised that it is absolutely the truth and that in your analysis you have captured the essence of who I am.

This response captures the notion of identity as a socially constructed reality and furthermore that it is in narrative, or the telling of one's story, that identity is constructed (see Sections 3.1.2.4 and 3.2.3). As McCormack (2009, p. 143) suggests, stories can offer professionals the opportunity to "reveal both the individual and collective nature of experience" and to "see into themselves". This participant thus described how she had gained deeper insight into her identity, after a gradual thoughtful consideration of the story of herself and my accompanying interpretation, despite an initial troubled emotional reaction when she first read it.

In response to my second question, three of the participants asked for minor aspects of their stories to be obscured in order to protect their identity. A fourth participant responded in the following way:

> On the question of identifiability - I've thought about it a lot, but in reality there is no way that changing a detail here or there will fully obscure my identity ... and that's okay with me. I think I'm comfortable enough if inadvertently someone could say who the story is about.

Recognising that the pool of pharmacy educators in South Africa is relatively small, and participants are vulnerable, every effort was made to obscure unique identifying features and aspects of their stories, whilst still maintaining the integrity and essence of the story, particularly as it related to their professional identity.

All participants were happy with the pseudonyms; and responses to the third question included: "Thanks, I love it"; "Yes that seems me to the 'T'"; and "I love the new name and I am very honoured to have been entitled with this name. Thank you for making me feel something that for many a day, I feel that I am not worthy of".

Beyond comments such as "I had a good time reading my life-story"; "I think you have encapsulated everything we spoke about very well", and "everything looks fine to me", the participants provided no further comments with respect to their stories in response to the fourth question.

Thus, as far as the participants were concerned, these stories and my interpretation of them appear to be credible.

5.11 Interweaving the stories

Within the context of a constructivist-interpretive research paradigm, where the emphasis is on the world as a socially constructed reality that involves multiple perspectives, the values, perceptions, and beliefs of all the participants need to be considered (Schwandt, 1994). Each of these narrated stories needs to be valued for its contribution toward understanding the unique professional identities of pharmacy educators. Furthermore, in order not to lose the diversity and richness of each of the narrative accounts, no attempt will be made in this section to create generalisable theories, rather to interweave the stories into a meaningful synopsis which describes the professional identities of these pharmacy educators, while still capturing something of the uniqueness of each of the participants.

5.11.1 Self-perceived professional identities of participants

Reybold (2008, p. 147) suggests that, in general, identity development is a "delicate balance" between "separation and connection", which is always in tension. For professional practitioners who have become academics, this particularly involves an on-going process of "separating from practice in one manner to connect to it in another", in what Reybold has termed "a balancing act" (p. 145). This was true for each of these eight participants who, to varying degrees, held in balance the tension between their underpinning vocational or practitioner identities as pharmacists, and their academic identities as researchers, lecturers, teachers, or academic disciplinary experts.

5.11.1.1 Identity continuum

The professional identities of each of these eight participants were a balance between at least two facets – a vocational or practitioner facet – pharmacy – and an academic facet. The extent to which they identified with, and held both or either of these facets in balance, largely determined their professional identity.

For some of the participants, such as Tia, Abbot, and Idania, their identification as a pharmacist was of primary importance to their professional identity – "I am a pharmacist and I'm something else secondary" (1: 40); and, "I am a pharmacist first and foremost" (5: 17). Although they acknowledged that their identities embraced an academic component, it was secondary to their understanding of themselves as pharmacists. Within the academic domain, Kiron, Abbot and Idania all tended to place more emphasis on their identities as lecturers or teachers, although their roles as researchers were also generally acknowledged. In contrast Tia identified herself more as a researcher than a teacher.

While others such as Vinetra and Hypatia hesitated to identify themselves as either pharmacists or academics, it is certain that their identification with the pharmacy profession underpinned their academic professional *personae.* Vinetra's professional identity was predominantly that of a teacher and mentor; however, she was "very passionate about pharmacy" (2:76) and sharing that passion with students and nurturing their professional development was central to her role as a teacher. Hypatia, on the other hand, stated "at core what I am, is a pharmacist"; however she went further to say, "do I see myself as a pharmacist … no. I see myself more as an educator, in pharmacy" (8: 53).

Kiron, Zeth and Zita were all very clear that their primary professional identity was academic in nature. Kiron viewed himself as a "lecturer, I am a lecturer" (4: 14) and furthermore went on to suggest that that "I'm there to teach; it's just that I'm teaching in pharmacy" (4: 14). His identity as a lecturer or teacher is, however, strongly supported by his practitioner identity as a pharmacist, since he was of the belief that "pharmacy defines who I am" (4: 14).

Zeth identified himself with the specific academic discipline within which he practiced, labelling himself "a pharmacologist" (6: 88). In addition, within the context of being a pharmacologist, he identified himself as being a researcher. Despite his strong identification with academia, Zeth did not deny his identity as a pharmacist; in fact, to the contrary, he stated "I'm still proud of the fact that I'm a pharmacist. I am a pharmacist" (6:88), however, he added "but when it comes to what I really do and that, then I'm a pharmacologist" (6: 88).

Still a relatively young academic, who could be considered to still be in the apprenticeship phase of her academic career, Zita labelled herself a lecturer "because my pay check says lecturer" (3: 33). However, her academic interest is primarily research and it is highly possible that when she completes her doctorate she will, with time, come to identify herself as researcher. Although she does not call herself a pharmacist, she recognised the value of being a pharmacist, to her academic role.

The professional identities of these pharmacy educators can be considered to lie somewhere on a continuum between their identity as pharmacist (their disciplinary or practitioner identity) and their academic identity. This continuum is illustrated in Figure 5.1 where the practitioner (pharmacist) and academic identities are represented as two intersecting spheres and professional identity as a continuum through and beyond these spheres.

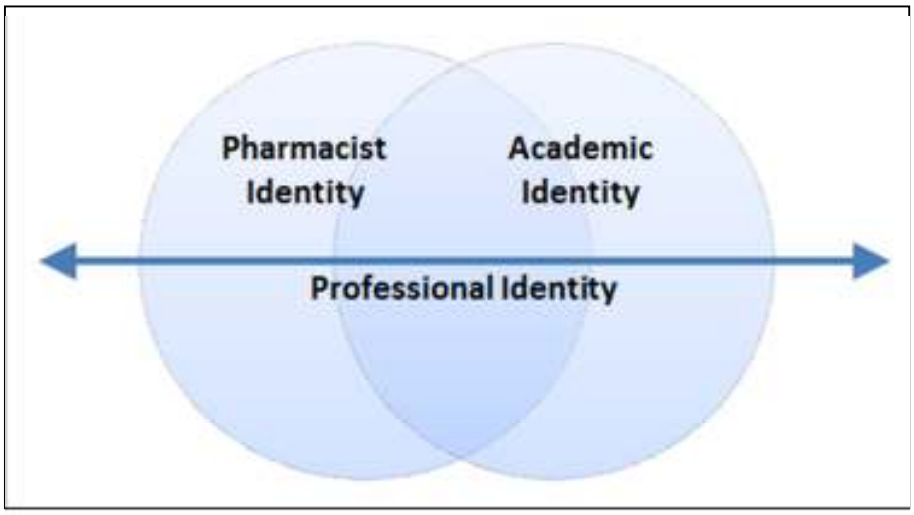

Figure 5.1: Continuum of pharmacy educator professional identity

It needs to be noted that, since there is both a disciplinary or practitioner aspect of pharmacist, and an academic aspect, to all of their identities, for all of these eight participants, their professional identity would lie on the continuum, but within the intersection of the two spheres. Furthermore, these two spheres or domains can be considered to be communities of practice, and thus for each of these eight pharmacy educators their professional identity is a "nexus" of membership of at least two communities of practice - a pharmacy community and an academic community (Wenger, 1998, p. 158).

5.11.1.2 Tension in balancing facets of identity

Wenger (2000, p. 242) contends that the experience of multi-membership and the work required to "combine, confront or reconcile various aspects of our identities" across community boundaries, provides a stimulus for personal growth. It also provides a basis for developing an experiential understanding of the notion of "being a person, at once one and multiple" (Wenger, 2000, p. 242). This reconciling identity work can also be understood as the tension that exists in trying to balance multiple facets of identity, such as the practitioner or pharmacist facet and the academic facet (Reybold, 2008).

The balancing or reconciling tension was, to varying degrees, evident in each of the participants' stories. Although it tended to be less obvious for those on either end of the professional identity continuum, it was more apparent in Vinetra's and Hypatia's narratives. After more than 30 years in academia, Vinetra still struggled with labelling herself professionally. Although she stated that she sometimes called herself a pharmacist, the nature of the tension she bore in naming her professional identity was very evident in her subsequent retort, "that's a lie - because I'm registered as a pharmacist, but I don't … I'm not

a pharmacist" (2: 18). Furthermore, within the telling of her story she explored and dismissed the possible use of other terms such as "educator", "academic" and "professor". Despite her telling people "I teach" (2:18), there was even hesitancy in identifying herself as a teacher.

Throughout Hypatia's story there was a constant tension in identifying herself professionally. Within the same response she both stated that "at core what I am, is a pharmacist" (8: 53) and immediately countered it with an explanation of why she did not view herself as pharmacist. Although she used the terms "teach" and "teacher", she indicated that that this was in response to my having used the terms in a question in the interview and she suggested that if anything, she was a lecturer. However, during the interview, her reliance on extrinsic rewards for her sense of identity became apparent, and with the expression of feelings that she had neither been adequately acknowledged as either a lecturer or a researcher, Hypatia actually asked, "Now where do I fit in?" The inability to resolve the tension of her professional identity had possibly contributed to Hypatia's resignation from academia.

For those with a solid pharmacy or academic core identity, this tension, although present, appeared to be much less pronounced. For Tia and Idania, who were both active participants in multiple pharmacy-related communities, and therefore practicing pharmacy beyond the university environment, their core identity as pharmacy practitioners was constantly being reinforced and strengthened. The tensions for these educators were more focused on their academic identity and the relationship between their identity as researcher or teacher. This was particularly evident in Idania's story. Despite having a passion for both research and teaching, throughout her academic career, her energy had predominantly been focussed on her undergraduate teaching. However, having recently obtained her doctorate, her research profile was increasing and consequently there was a sense in her story of the dynamic nature of her identity.

Abbot, on the other hand, who was also on the practitioner end of the professional identity continuum, was, at the time of the interview, not practicing beyond the university environment. Although he had come into academia with the specific intention of teaching, and teaching was his expressed priority, "I want to do what I want to do, which is to teach students" (5: 31), he understood the importance of research and furthermore felt the pressure to develop his research profile. Consequently, for him the tension in balancing his professional identity was also in balancing the academic aspects of teaching and research, which he expressed in terms of it being "a struggle in my mind" (5: 15)

Zeth and Zita both had strong core academic identities, associated predominantly with their focus on research and appeared to have very little tension in balancing their identities. They accepted that while their focus was on research, teaching was an integral aspect of being an academic, and appeared to take their teaching responsibilities seriously. Similarly Kiron, although his primary identity as an academic was focussed on teaching, had come into academia from a successful career in research and development and appeared to have very little difficulty in balancing the various aspects of his professional identity. Supported by a well formed sense of himself as a pharmacist, which was constantly been strengthened through on-going practice outside of the university, he was able to balance his research commitments with his primary focus of teaching.

5.11.1.3 Identity – "a nexus of multi-membership"

Analogous to Reybold's notion of "separation and connection" (Reybold, 2008) is Archer's concept of "disrupted processes" of "becoming" and "unbecoming" (Archer, 2008, p. 387). Both of these ideas are evident in Wenger's trajectories through communities of practice. It is apparent that the professional identity of each of these educators involved a level of participation in at least two broad communities of practice – the pharmacy community and the academic community. However, within each of these two broad communities, multiple other communities of practice were represented.

As Wenger (1998) suggests, communities of practice are primarily about learning, and participation in a community affords occasions for both personal and professional growth. For some participants, such as Abbot, Idania, Kiron and Zeth, who came to academia from well-established careers in other pharmacy domains, the manner in which their professional development and identity had been formed by their trajectories, through multiple communities, was clearly evident and typified by these statements from Abbot and Zeth respectively:

> It's true where ever you are, the interaction with the place or the people, or the kind of environment, if you work in a hospital that's going to change your perception of some things, if you work in industry that will push you in another way. (5: 27)

> Going through those phases of being in a hospital pharmacy, also going into industry for instance, the corporate environment, corporate pharmacy … has also made a huge contribution to how I see things today, and how I view myself as a rounded off professional. (6: 60)

Career changes that require an accompanying change in practice community have the potential to impact on all aspects of professional life, including knowledge, expertise, expectations, beliefs, motivations and identity, and may even be responsible for a state of "transitional shock" (Kember, 2011, p. 319). Although some of the four participants who came to academia from well-established careers, such as Zeth and Idania, indicated that they had difficulties with some of the new responsibilities required of them, specifically teaching, a sense of "transitional shock" was not particularly evident in their stories. It is possible that their transition from one practice community to another was fairly smooth since, for all of them, their new primary university community was within a pharmacy school or department and could be considered to be an extension of the broader pharmacy community. Furthermore, for each of them their appointment was based on their practice expertise, and depended on them not necessarily relinquishing their professional identity as pharmacists. Idania and Kiron, in particular, continued to sustain their pharmacist identity after their career moves, by continuing to practice in contexts outside of the university environment. As suggested in Section 5.8.1.2, this enabled Idania to keep her teaching relevant and also helped bridge the gap for her students between academia and practice. Kiron's experience of balancing practice with teaching and research was one of mutual benefit, where all dimensions of his professional role were strengthened and consequently his professional identity and his strong identification with the concept of professionalism, was reinforced and sustained (Section 5.5.1.2).

Some of the participants, for example Vinetra, Idania, Kiron and Zeth, participated in several other pharmacy communities, including organisations like the Pharmaceutical Society, the Academy of Pharmaceutical Sciences, the Medicines Control Council, the South African Pharmacy Council and the Pharmacology Society. This participation, however, was effectively in their capacity as academics, and could be viewed as fulfilling the community service aspect of their academic role (see Section 3.3.1.3). In all instances professional involvement was encouraged by the respective universities, although the participants did suggest that university support never extended to funding of their involvement. As was noted in Section 3.3.1.3, universities are increasingly responding to the societal challenge to increase their civic engagement and this was evident in each of the stories. Furthermore, in order to support and encourage community service, many universities now include community engagement as one of their academic staff promotion criteria. An example of this was provided in Vinetra's story:

> They actually weigh the community outreach the same. This university I think has moved probably earlier than some of the others to looking at the value of

> community outreach, and involvement in your profession and that kind of thing. So it's held in pretty high regard; I mean I would never have gotten promotion on research obligations; okay, I basically got it on teaching and community outreach, so that shows that they do consider it. (2: 54)

The reasons suggested by the participants for their participation in pharmacy communities of practice beyond the university were various. It provided a means of enriching and keeping teaching relevant:

> I'm actually using the locums to teach my students what current practice is and what is currently required, and trying to combine that with sticking to the law and the legal aspects, using them to enhance my teaching, telling them about experiences and all of that. (4: 12)

In addition, it was for some, such as Zeth, a way of informing and keeping research relevant: "that's the kind of question we brought [into our research], just purely by being out there, talking with the other areas of pharmacy, and then filtering that back into your own research questions" (6: 64). Involvement beyond the university environment was also seen as providing a positive role models for students: "when the students see your involvement, I think it's important in terms of the role modelling" (2: 38). From her concern about the incongruities she perceived between what was practiced and what she was teaching her students, Idania viewed her own practice as a means to bridge the gap between practice and academia: "And that's why I can always say to them, I don't sit in an ivory tower and tell you what to do, I get my hands dirty, so I can tell them this is how it's done" (7: 30).

On a more personal level, some of the participants including Tia, felt that their membership of other communities of practice contributed to their personal growth as professionals - "I realised that something needs to change professionally, I need to grow as a professional, so that's why I joined PSSA" (1: 171). Multiple memberships were also viewed as a means of reinforcing one's professional identity as a pharmacist – "I have never been a member of PSSA. I just started this year; I just decided that now it's time to grow into my profession and if I'm not part of a body of pharmacists, then what am I?" (1: 171). Furthermore, it provided opportunities for contributing to the profession

> These societies, they definitely have a role to play from my point of view, and it's often possibly neglected, in that it is not often seen as a forum where all the academics can get together, in all the areas of pharmacy, to interact and discuss things about the profession. (6: 64)

Although participants were active in a variety of pharmacy related communities of practice, it needs to be noted that outside of the pharmacy department or school, their participation in the wider academic community of practice within the university, was fairly limited. However, Abbot, possibly the most active of the participants within the broader university community, stated that his primary focus in this activity was "raising pharmacy's voice, from a professional point of view" (5: 33).

Notably, although some such as Tia, Zeth and Idania expressed early difficulties with teaching, none of them had any formal qualification in education. Furthermore, although some, for example Tia and Kiron had attended university courses on teaching and learning issues, none of the participants appeared to be active members of any education-centred communities of practice, beyond those in which they actually worked and taught.

The multifaceted, contextual and dynamic nature of the professional identities described in this and the previous two sections are therefore consistent with the assumptions underlying contemporary conceptions of identity described by Rodgers and Scott (2008) and used as a framework for the review of the literature around identity, professional identity and academic identity in Chapter 3 of this thesis.

5.11.1.4 Key determinants of professional identity

Emerging from the deeper analysis of the narratives, six key determinants were recognised as underpinning the participants' self-perception of their identity. Furthermore, each of these six key determinants can be characterised by a question (Table 5.2). The emphasis the participants placed on one or more of these determinants appeared to give evidence of some definitive pointers as to how they identified themselves professionally. For example, if a participant placed high value on the "expected role" determinant, what their job description suggests is required of them, how they answer the question "What am I paid to do?", would be integral to how they perceived their professional identity.

The first three determinants: "expected role", "knowledge base" and "practice" are more technical in nature, whereas the latter three "professional status", "passions" and "satisfiers" can be considered to relate to the emotional dimensions of professional identity.

The "expected role" can be described in terms of a job title, such as lecturer or senior lecturer, or by a more detailed job description, but essentially it is the role for which an individual believes they are paid and subsequently what is expected of them. Zita was an example of someone who based her professional identity on what it is that she is paid to do:

> I think that's basically what I been paid for so that's what I write. Yes, even though I am a researcher that's not like my primary profession. Or pharmacist as well, you know if I write pharmacist, that's not really right because my pay-check says lecturer. (3: 33)

The expected role is also consistent with the institutional identity described by Gee (2000), where identity is a position that is endorsed by authorities within an institution. The importance that an individual places on their "endorsed identity" can therefore determine how they themselves perceive their identity.

Table 5.2: Key determinants underpinning professional identity

KEY DETERMINANT	CHARACTERISING QUESTIONS
1. Expected Role (job description)	What am I paid to do?
2. Knowledge base (academic qualifications)	What am I qualified to do?
3. Practice	What is my practice, what do I do?
4. Professionalism	What supports my professional status?
5. Passions	What am I passionate about; what drives me?
6. Satisfiers	What gives me satisfaction?

One of the recognised distinguishing features of a profession is an underlying distinctive knowledge base (Thompson, 2000). Consequently, the process of becoming a professional usually commences with studies toward a formal qualification, which is a necessary criterion for entry into the profession. What became evident in some of the narratives was that this knowledge base can form the basis for professional identity. For example, although Hypatia did not see herself as a pharmacist, she stated "at core what I am, is a pharmacist; I got a degree as a pharmacist. Not a degree as a senior lecturer" (8: 53). This suggests that when considering her professional identity, her knowledge base, as represented by her degree, was a major factor. Similarly, Tia's strong core identity as a pharmacist could only be adequately explained in terms of the value she placed on her pharmacy qualification: "we

studied for years and we pharmacists are proud of the profession of being a pharmacist" (1: 88) (Section 5.2.1.3).

The importance an individual places on the nature of their work or practice can be a further key determinant underlying their identity. The notion that "who we are" is constructed out of "what we do" – practice - is the basis for the "structural" approach to understanding professional identity (Oliver, 2007, p. 37). Vinetra, for example, perceived herself primarily as a teacher. However, she never specifically called herself a teacher, but chose to reply to people when they asked her occupation "I teach" (2: 18). Similarly for Kiron, his identity as a lecturer - "I am a lecturer" (4: 14), was grounded in his practice: "I'm there to teach people" (4: 14). Conversely, some of the participants described their professional identity in terms of "who they were not" based on what they did not practice. For example, based on her lack of practice experience, Vinetra suggested that although she was registered as a pharmacist, she was "not a pharmacist" (2: 18), because "I can't go out there and practice pharmacy in a patient care setting" (2: 18).

Professional status was recognised as a further key determinant of professional identity. The value that some participants placed on this factor was particularly evident in both Kiron and Abbot's stories. For Kiron, being a professional "is a way of life, it's a way of thinking, it's a way of being" (4: 14) and was fundamental and definitive to his professional identity as both a lecturer and a pharmacist. On the other hand, moving from a successful career in the pharmaceutical industry into academia, Abbot held fast to his identity as a pharmacist - the location of his sense of self as a professional.

The extent to which passion is a determining factor in professional identity was apparent in Zeth's story. Zeth's passions were pharmacology and research and he had no hesitations in identifying himself decisively as both a pharmacologist and a researcher. Zeth identified his passion for pharmacology while he was still a student and decided then that was what "I wanted to make my career on" (6: 22). Subsequently he has not only made it his career but it has become central to "who he is" – his professional identity. Similarly, passion has also been a dominant theme in the development of Idania's professional identity: "I loved the teaching, I loved the research, and I loved being with my students and things like that. So I started to develop into an academic" (7: 19). Similarly for Vinetra, it was her passion expressed in her "love" for teaching, which appeared to provide the basis for her professional identity.

Fulfilling one's occupation-related passions can bring deep satisfaction, which can serve to positively reinforce one's sense of self, relative to one's work. Consequently, satisfiers can

also be considered to be a key determinant underpinning professional identity. In her Conceptual Framework for Academic Job Satisfaction, Hagerdorn (2000, p. 321) argues that job satisfaction in academia can be considered to be an outcome of two interrelating constructs, namely: mediators and triggers. Mediators refer to the contextual factors through which job satisfaction can be understood and includes motivators and hygiene factors – the intrinsic and extrinsic rewards associated with work, demographics and environmental conditions. Triggers are important work or non-work events that influence one's point of reference, for example being promoted, changing job, or starting a family.

Within this framework, the satisfaction or sense of fulfilment that Vinetra experienced from her teaching, "I really found fulfilment in teaching" (2: 14) would have been considered a positive motivator related directly to her work, and can be seen as having contributed positively to her identity as a teacher. Motivators or rewards can be either intrinsic, such as Vinetra's sense of fulfilment found in her teaching, or they can be extrinsic in nature and associated with recognition of work or achievement by a source other than oneself.

As explained in Section 5.9.1.3, intrinsic rewards represent the "personal face" of academic work, whilst extrinsic rewards are associated with the "public face" (Akerlind & McAlpine, 2010, Kindle Location 3632). Further examples of intrinsic rewards from participants' stories include: Tia's personal satisfaction derived from contributing to and witnessing the professional development of students (Section 5.2.2); the joy and fulfilment Vinetra experienced in mentoring younger academics (Section 5.3.1.2); the satisfaction Zita experienced from hearing positive stories of the success of graduates (Section 5.4); Kiron's sense of accomplishment in empowering students to be better than himself (Section 5.5); the sense of reward Abbot expressed in teaching students to be effective lifelong learners (Section 5.6.2); Zeth's desire to make a meaningful contribution to the "upliftment of mankind" through his research (Section 5.7); the manner in which Idania cautioned her students about becoming money-driven at the expense of patient care (Section 5.8.2); and the sense of satisfaction Hypatia experienced in being able to share her knowledge with others (Section 5.9.1.2).

Hypatia's story represents a situation where emphasis has been placed on the key determinant – "satisfiers", and yet failure to be afforded the extrinsic rewards sought, together with environmental conditions (distance from the university and the need to travel in a lift club) have resulted in dis-satisfaction, and consequently impacted on her professional identity; "The only way to express yourself as being powerful is by being either a good teacher and getting acknowledged therefore, or a researcher, when you publish. Now where do I fit in?" (8: 76).

The importance of the environmental aspects of Hagerdorn's framework in the context of job satisfaction and the development of professional identity should not be overlooked. What was particularly noteworthy in several of the narratives was the role that mentoring had played in contributing to participants' sense of satisfaction and development of professional identity. The importance of positive role models was highlighted in Zita's story. Although Zita could still be classified as an "apprentice", her apparent clarity of professional identity and her relatively smooth integration into all aspects of academic life, have been enabled through careful and close mentoring by her doctoral supervisor (see Section 5.4.1.2). By contrast, Tia's voiced lack of mentoring and support in her integration into and sense of belonging within academic communities of practice appeared to be at the root of her hesitancy to adopt an academic identity (see Section 5.2.1.3).

It would seem that the greater the emphasis an individual places on one or more key determinants, the greater the emotional and material investment they are likely to be willing to make, to nurture that aspect of their identity. For example, if one's emphasis is on knowledge base as a key determinant of professional identity, one would be more willing to make the investment or sacrifices involved in acquiring a doctorate than someone perhaps whose emphasis is on their practice. A person with an emphasis on practice is likely to find the pressure in higher education to acquire a doctorate at variance with their sense of self and their professional identity. This is illustrated in the contrast between Tia and Idania's stories. Tia's emphasis in her perception of herself as a professional was on her knowledge base, and therefore explains how she viewed acquiring a doctorate as central to who she was: "the PhD is a minimum, that's how I view it and then that's what is driving me, and getting that basically in terms of academia, that's it! Now you have an academic title, you are Doctor" (1: 56) and her practice – teaching - was simply a "means to the PhD". In contrast, Idania, who I called the "reluctant doctor" (see Section 5.8.1.3), placed great emphasis on the practice and passion key determinants of her identity, which then congruently explained why she did not view the acquisition of a doctorate as having changed her perception of herself as a professional:

> The fact that I've just got the "Dr" in front of my name; was I a totally different person? … I'm not that type of a person. I don't worry about it, to me it doesn't matter, I don't need it. It's just a matter of furthering your studies. (7: 62)

On the other hand, Idania had placed great emphasis on her practice – her teaching - at the expense of her personal development, evidenced in her response to a letter from the Deputy

Vice-Chancellor with regards her lack of research outputs: “I’m not publishing because I’m spending more time in my undergraduate teaching” (7:63).

I further propose that the extent to which all the above key determinants are aligned with and in support of aspects of professional identity on which an individual places the definitive emphasis, would determine the extent to which the individual has an integrated sense of self as a professional and an accompanying sense of agency as a consequence of their professional identity. This was particularly evident in Zeth’s narrative, where driven by his “passion” for pharmacology, he had reached a point in time at which his expected role, knowledge base and practice were all aligned with his passion, and he was doing work that was both deeply satisfying and served to support his sense of self as a professional and his clear understanding of himself as a pharmacologist.

5.11.2 Perceptions of pharmacy practice, pharmaceutical care and pharmacy education

In education there is often a distinguishable difference between what students are taught and what they learn. As Hafferty (1998) proposes, what is taught happens at the level of the formal curriculum. However, there is also an informal or hidden curriculum, which happens at the level of interpersonal relationships that impacts on what is actually learnt. Furthermore, Hafferty and Hafler (2011) suggest that the balance between the formal and informal aspects of a professional educational programme impacts on the type of professional that is produced. (see discussion in Section 2.4.5)

In order to more fully understand the potential influence through the informal curriculum of pharmacy educators on the socialisation of students into the profession, the attitudes, beliefs and behaviours of participants regarding the philosophy and practice of pharmaceutical care and pharmaceutical education were also explored in the interviews.

Hammer and colleagues (2003, p. 17) argue that if schools of pharmacy hold to a mission of developing practitioners of pharmaceutical care, “then professional development *must* be the priority for the school”. Furthermore, they suggest that all educators need to embrace this priority. Consistent with this notion, all of the participants in this phase of the study were aware that their role in pharmacy education encompassed developing future professionals. However, the emphasis they placed on this aspect of their role varied. For Vinetra, it was of prime importance: “I think I'm far more interested in teaching, not as in imparting content and knowledge but in terms of developing a professional *persona*” (2:26). Whereas Tia, although

acknowledging that she was “part of a bigger team that develops pharmacists” (1: 152) saw her role specifically as teaching pharmaceutics.

Similarly, all of the participants subscribed to the fundamental aspects of pharmaceutical care, particularly the concept of patient focus; however, the extent to which it informed their teaching varied. On the one end of the spectrum, Tia did not view pharmaceutical care as having any impact on her teaching, stating that she had never included any aspects of it into her teaching: “I’ve never included pharmaceutical care. I’ve never, not directly … I mean there are opportunities where I could make mention of it, but no, I must admit, I haven’t.” (1: 138). Whilst on the other end of the spectrum, Kiron believed that not only should pharmaceutical care be incorporated in all aspects of teaching, it should be modelled to students through the manner in which one teaches: “you can't teach students about pharmaceutical care and try and instil that in them, and you don't practice it toward your class; you have to care for your students, what they do, how they do it” (4: 41). As I highlighted in Kiron’s story, his notion of modelling care to students is analogous with Popovich’s concept of educational care, which Popovich (1992) suggests is necessary to develop caring students (see Sections 2.4.7 and 5.5.3). Vinetra’s concern that the term pharmaceutical care had lost its impact and value, and that whilst “everybody’s talking pharmaceutical care, I don’t necessarily think that people are internalising what it means” (2: 30), was significant. Furthermore, she was of the opinion that although people spoke about pharmaceutical care, it had not really impacted on practice: “I don’t think I see that happening in practice. I hear a lot of pharmaceutical care speak but it’s not necessarily happening” (2:30). This view was supported by Hypatia who, from a patient’s perspective, had not really encountered pharmaceutical care: “some pharmacists that I’ve come across on a personal level, that don’t know me as a pharmacist, don’t necessarily give any pharmaceutical care” (8: 92).

So, although pharmaceutical care has been taught in pharmacy schools and has been embraced and upheld by national pharmaceutical organisations for about twenty years, some of the very people that have been teaching it, are not seeing it impacting significantly on practice. Perhaps, as Vinetra has suggested, the term “pharmaceutical care” needs to be revisited. I would, however, go further to suggest that the whole concept requires re-examination. It is possible that, as Zeth suggested, pharmacy educators have “trained very competent academics as pharmacists” (6: 100) who “have not been able to convert that knowledge into clinically relevant and usable information which they can contribute back to the patient” (6: 100). Although Idania, with insider knowledge of the practice environment and an attitude toward education that says “whatever you preach, you must practice” (7: 24) and

was “scared to go and tell my students something that I'm not doing” (7: 24), believed in and taught the concept of pharmaceutical care. Notwithstanding the fact that there are pharmacy educators such as Idania, in the context of the needs based approach to pharmaceutical education being promoted by the International Pharmacy Education Taskforce (Anderson *et al.*, 2010), perhaps the relevance and practical feasibility of pharmaceutical care to the South African context needs to be re-considered.

Pharmaceutical care was not the only aspect of practice that concerned participants; there was a general feeling amongst them that there were incongruities between the manner in which pharmacy was taught and the way in which it was commonly practiced: “we've got a young student going out, we've got your idealistic professors here, and you've got the guys paying their salary, and that is the dilemma” (2: 36). Their general concern for the impact this was having on the students was typified in this comment from Tia, “it’s a shock for them, and it can be depressing” (1: 108). The nature of their concerns varied across many aspects of practice.

Tia specifically expressed concern about the manner in which she perceived pharmacy support personnel, such as pharmacist assistants, were being allowed by pharmacists, to act outside of their scope of practice. She believed that this diminished the value of the profession and had an adverse effect on students’ opinions of pharmacy. In addition, she felt that change was necessary, “there’s a switch that needs to come, or is already in progress, where we need to redefine ourselves as pharmacists” (1: 88). She did, however, still hold the hope that by making students aware of the incongruities and preparing them to be change agents, the “situation is not completely dead” (1:104) and “there’s a lot that can be done” (1: 104). This hope was shared by Vinetra, although she was particularly concerned over the “negativity” (2: 36) that appears to be pervasive in the profession, and specifically the way this affected the students: “students are brow beaten by people who are negative” (2: 36). Furthermore, she thought that the profession’s inability to change was related to its lack of self-belief in its capacity to add value to healthcare and to society. She, however, believed that if pharmacy educators continued to educate students capable of changing practice, a “tipping point” (2: 36) would be reached, at which practice will change. Abbot’s particular concerns were the impact of shortages of staff and other resources, especially within the public sector, on the manner in which pharmacy was practiced. Furthermore, he expressed concerns over the potential impact of the corporatisation of pharmacy, believing that it would lead to a loss of professionalism.

In the context of these expressed concerns over the way in which this sample of educators perceived pharmacy is practiced and the incongruities that exist between practice and

education, it is important that pharmacy educators maintain an awareness of the practice environment (Hagemeier, 2010). This was highlighted, for example, in Kiron and Idania's stories; through their locum work they had insider knowledge and a heightened awareness of the practice environment, which impacted on their teaching and their approach to preparing graduates for practice. Vinetra, on the other hand, despite not practicing in a patient care environment, maintained her awareness through involvement in pharmacy organisations and on-going contact with practitioners:

> And so I think also the involvement at branch level of the pharmaceutical society with being involved with portfolios at the council, and being part of the research study there, I think I see that making up for the deficit I recognise within myself. So I am a little bit involved ... I'm not at the coalface but at least I can bring something, you know, to this place. (2: 40)

With respect to the role of education in driving changes in practice, there was a mixed response from the participants. Although Zeth thought that in the past education had driven practice, he believed that following little success in this regard, education needed to be more responsive to the practice environment, "they should respond … maybe in the olden days, they used to drive things that they think should be happening out there and maybe things have not worked out that great" (6: 100). Zita was of the opinion that in certain sectors, such as the retail sector, education needed to be responsive to changes; however, she felt that in the industrial sector, education should be actively driving change. Perhaps there is a necessary tension between the two, and this was encapsulated in Tia's response. Tia believed that education should both drive change and respond to change in practice, consequently she felt that it was necessary to prepare students for pharmacy as it is currently practiced, but also for how it might be practiced in the future: "in essence, they are the ones that are going to create the future, but they are graduating into what is happening currently" (1: 112).

Hagemeier (2010) argues that pharmacy educators tend to prepare students with the skills necessary for ideal practice settings and not for the real issues that they will confront in the practice environment, and that this has the potential to impact of their job satisfaction and sense of fulfilment. However, it would appear that in the preparation of pharmacy students for practice, there needs to be a balance between both preparing them for ideal and possible future practice settings, in addition to preparing them for the realities of current practice settings. Perhaps the key to achieving this balance lies in what Tia describes as "flexibility" (1: 112):

> So maybe we can teach them for now – for what they are going to graduate into, but also it's still a flexibility that we need to teach them. To say this is what is going to happen to you, this is what is currently happening, but if you don't make a change and you are not flexible enough – if you realise what is happening and don't change it or start the process, then it's never going to change, and it's never going to happen. So in essence they are the ones that are going to create the future, but they are graduating into what is happening currently. So keep what we teach them currently, but have a component where we teach to change. (1: 112)

5.12 First phase summary

What I have attempted to do in this section - describe the professional identities of eight pharmacy educators - can be likened to trying to "collapse a video clip into a snapshot" (Sfard & Prusak, 2005, p. 16). However, the use of narrative, and the resulting collection of stories, provided a valuable means for reflecting on and constructing the professional identities of the participants based on their own words.

In the interweaving of the narratives, it became very apparent that the professional identities of each of the participants involved at least two aspects – an academic aspect, and a vocational or pharmacist aspect. The degree of tension and the extent to which participants identified with each of these aspects of identity, and held them in balance, largely determined their self-perceived professional identity. Thus the professional identities of the pharmacy educators were, by their very nature, multifaceted.

The identity of many of the educators had been formed through participation in multiple pharmacy-related communities of practice and continued to be formed through on-going participation, albeit at a peripheral level. The stories revealed many reasons for this on-going participation, including its value to the academic work of teaching and research, continuing professional and personal growth, and the opportunity to make a contribution to the profession.

Six key determinants were identified as underpinning professional identity and the emphasis which participants placed on one or more of these determinants appeared to correlate with how they identified themselves professionally. Furthermore, I proposed that the alignment of all other key determinants with those on which an educator had placed the greatest emphasis was significant in terms of the educator's integrated sense of self as a professional and their sense of agency as a consequence of their professional identity.

The participants all acknowledged that their role in education involved developing the next generation of pharmacy professionals. Although they all aligned themselves with the concept of pharmaceutical care the extent to which this impacted on their teaching varied. Furthermore, there were definite concerns expressed about the extent to which the concept of pharmaceutical care had penetrated practice, and also whether it remained relevant and feasible to practice. There was also concern expressed about the manner in which pharmacy is practiced and the incongruities between practice and education. The tension between practice and education relative to change was also highlighted, with the suggestion that by preparing students to be flexible, there is the possibility of preparing them to be change agents.

Many of the issues raised by the participants in this first phase of the research were further explored in the second and third phases of the study and will be reported on and discussed in the next sections of this chapter.

CHAPTER 6

DEEPENING AND WIDENING INSIGHTS INTO PROFESSIONAL IDENTITY

6.1 Introduction

In the first phase of the study narrative inquiry was used to gain comprehensive and deep individual insights into the self-perceived professional identities of eight pharmacy educators, and to explore how their participation across various communities of practice contributed to the formation of their professional identity. Furthermore, the attitudes, beliefs, and practices of the pharmacy educators with regards pharmaceutical care and pharmacy education were explored and described (Chapter 5).

This chapter will report on the second and third phases of the study. In the second phase a focus group approach was employed to explore, within a broader interactive context, some of the factors identified by participants in the first phase as contributing to development of professional identity. Opinions about pharmaceutical care and pharmaceutical education were also explored in the focus groups. The third phase of the study made use of a purpose-designed questionnaire, developed from the insights gained in the first and second phases, to extend the study to include a wider range of pharmacy educators in South Africa.

6.2 Phase two: Focus groups

In the second phase of the study focus groups were used to clarify further and expand the understandings gained from the narratives in the first phase of the study. Thus two focus groups were held at the Academy of Pharmaceutical Sciences annual conference in September 2011. The first group had seven participants (FGP1 - FGP7), whilst the second group had only had 3 participants (FGP8 - FGP10). Three participants is a small number of participants for a focus group if the interaction described in Section 4.3.2 is to be acheived. However the small size of the second focus group was all that was possible when three further potential participants did not arrive at the allocated meeting time and the conference

programme did not allow for rescheduling of the focus group, so the decision was made to continue with the small size group regardless.

Three key, open-ended questions were used to stimulate conversation and focus discussion (Appendix J). However, as described in Section 4.3.2.3, as the facilitator of the focus groups I remained flexible and willing to "go" with the group. Consequently the specific questions asked and the flow of discussion varied slightly between the two groups. Specifically noticeable is that in this phase of the study, analysis of the focus group transcripts included a more deductive approach, with the key issues identified in the first phase providing a framework for the analysis. The responses and discussion from both groups with regard to professional identity will, therefore, be reported together under the key themes identified in the first phase of the study; namely: balancing identities; tension in reconciling identities; identities – a nexus of multi-membership; and key determinants of professionals' identity. Furthermore, the perceptions of participants with respect to pharmacy practice, pharmaceutical care and pharmacy education will also be reported and discussed.

6.2.1 Objective identity of participants

In the context of identity theory, objective identity is identity in terms of official records and includes the demographic description of a person (Jameson, 2007). In this section I describe the objective identities of the focus group participants, based on the details drawn from the pre-focus group questionnaires and during the focus groups. A summary of these details is provided in Table 6.1.

Except for the Faculty of Pharmacy at Rhodes University, all schools or departments of pharmacy were represented in the focus groups. Amongst the participants, there was a fairly even representation of the four teaching disciplines, and also of the various age categories. However, only one of the participants was male. Although there was a fairly even distribution of male and female pharmacy educators attending the conference, only one male agreed to participate in the focus groups.

Years of registration with the South African Pharmacy Council as a pharmacist, and years of experience in higher education varied from less than five years to between 21 and 30 years. Four of the participants had been registered as pharmacists longer than they had been working in higher education, and had experience of other sectors of pharmacy before coming into higher education. A further four of the participants had no real experience of other pharmacy sectors prior to working in higher education. Two of the participants had been working in higher education longer than they had been registered as pharmacists; one of

these had been lecturing in a discipline outside of pharmacy, while the other, although teaching pharmacy, had not initially been registered as a pharmacist. Six of the participants were doing consultancy or locum work in other pharmacy sectors outside of the university environment.

Table 6.1: Demographics of the focus group participants

IDENTIFIER	GENDER	AGE CATEGORY	YEARS OF REGISTRATION	YEARS IN HIGHER EDUCATION	OTHER PHARMACY WORK	TEACHING DISCIPLINE
FGP1	Female	20s	<5	<5	Public sector	Pharmacy Practice
FGP2	Female	50s	21-30	21-30	-	Pharmaceutical Chemistry
FGP3	Female	20s	6-10	<5	Hospital, Industry	Pharmaceutics
FGP4	Female	30s	6-10	<5	-	Pharmaceutical Chemistry
FGP5	Female	40s	<5	11-20	-	Pharmaceutical Chemistry
FGP6	Male	30s	6-10	6-10	Retail	Pharmaceutics
FGP7	Female	40s	6-10	21-30	-	Pharmaceutics
FGP8	Female	20s	<5	<5	Retail	Pharmacy Practice
FGP9	Female	40s	21-30	11-20	Hospital, Industry, Retail	Pharmacology
FGP10	Female	50s	21-30	11-20	Hospital	Pharmacology

6.2.2 Identity continuum

In keeping with the outcomes from the first phase of the study, the results from the focus groups suggest that the primary professional identities of the focus group participants were on the continuum between academic and pharmacist. Four of the participants identified themselves primarily as pharmacists:

> I'm a pharmacist through and through. I practice a lot outside of the university. I locum quite a bit so I guess I still consider myself as a pharmacist. (FGP3 – 1:115)

Four participants primarily identified themselves as academics; three of these as lecturers and one as a researcher:

> If someone asks my occupation I always write lecturer. Sometimes I forget that I'm a pharmacist because I'm not practising and so you tend to forget and so it's odd when people call you a pharmacist. I never think to put 'pharmacist'. (FGP1 – 1:110)

> I do not see myself as a pharmacist at all, I see myself as a researcher. I feel reluctant if people call me a pharmacist and want me to answer any questions relating to pharmacy because I was in a pharmacy such a long time ago. I do not want to answer any questions relating to pharmacy. (FGP5 – 1:114)

Two of the participants identified themselves toward the middle of the continuum and used both academic and pharmacist facets to describe themselves:

> I normally write 'pharmacist' and then slash 'academic'. (FGP2 – 1:107)

> I would normally write 'academic pharmacist'. It's always a difficult one to answer but sometimes I would go with 'pharmaceutical scientist'. (FGP6 – 1:109)

The distribution of these identities on the continuum between pharmacist and academic is illustrated in Figure 6.1

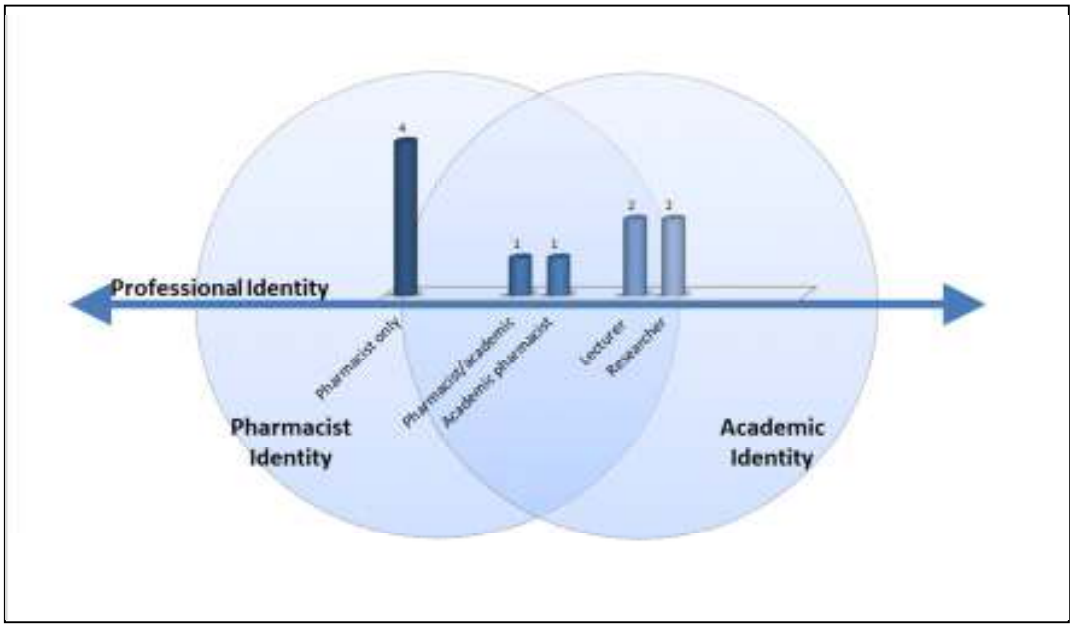

Figure 6.1: Distribution of focus group participant identities on the continuum between pharmacist and academic identity

As was suggested in the review of the literature (Section 3.3.4), academics teaching on a vocational programme often have a lack of clarity about the basis of their professional identity (Holroyd, 2000). As Holroyd argues, despite the expectation that their identity would be based on their "sense of unity with their peers in the academy", in reality it is often located within the profession for which they are preparing their students (Holroyd, 2000, p. 41). This certainly seems to have been true for four of the participants, who self-described or labelled themselves as pharmacists. One of the participants continued to hold her identity as a pharmacist alongside her academic identity. A further participant (FGP6), by identifying himself as either an "academic pharmacist" or a "pharmaceutical scientist", appeared to have integrated the two facets of his professional identity. However, the extent to which research was integral to his identity still remained a dilemma for him. This participant's apparent dilemma, together with some of the comments from other participants, suggests that the professional identity continuum, particularly on the academic spectrum, can be further categorised into lecturer and researcher identities.

6.2.3 Tension in balancing facets of identity

For all participants, even those on the two ends of the continuum, there was both a pharmacist and an academic facet to their identities. Therefore, in Figure 6.1 the professional identities of all the participants are shown as lying in the intersection of the two spheres, and their described identities were, in fact, a balance between these two facets. Furthermore, for many there were similar tensions in reconciling both aspects of their identity to those which were described for the participants in phase one of the study. This tension was typified in the following comment:

> I think it's almost three-pronged, especially being pharmacy academics, you are teaching an applied science so there's the teaching part of it; the application where you are a pharmacist; and then there is the research part of it … and it sometimes just becomes so muddled. I think it is a very personal thing as well because each of us sitting here has our own personal preferences. Some is toward research, some is certainly toward practice. Mine happens to be toward teaching, that's where my passions lie. I suppose that's why when I get asked the question 'what are you?' I automatically say 'teacher'. I think it's complicated for pharmacy academics especially. (FGP1 – 1:118)

As this participant suggested, in teaching on a professional programme there is an applied aspect to much of the teaching which, to a large extent, depends on one's identity as a professional, while on the academic side there is a constant tension between teaching and research. She suggested that it was personal preference or passion which often determined ones identification as a professional. She highlighted the contribution of one of the key determinants – passion – to identity as suggested in Section 5.11.1.4.

The tension is further complicated by contextual issues external to oneself. In the first of the comments that follow, the need to identify oneself as a pharmacist becomes a contextual issue and it is about promoting the visibility of the professional aspect of pharmacy programmes within the broader university environment:

> I think why I write 'pharmacist' first and then 'academic' - since I've become head of department I have got to look at the bigger picture. I keep my focus on the BPharm and the people we are educating to become pharmacists and because I'm in a faculty where we are in a faculty of science, not health sciences. I think I have over the years become more focused on bringing forward the fact that we are pharmacists. So I think that's why I do that now, probably for the very reason that I was feeling that we were not given that identity that we needed within the huge science faculty. (FGP2 – 1:117)

In Section 2.2 a profession was described as a well delineated occupation that requires using a body of specialist knowledge; furthermore, it is responsible to society for the services it provides. In an effort to ensure that her students are educated in a manner consistent with becoming a professional, within the context of a faculty of science, this participant viewed it necessary to promote pharmacy as a programme specifically developing healthcare professionals. Furthermore, her identification with the pharmacy profession and of herself as a pharmacist was viewed as promoting this cause. This would appear to relate to professionalism as key determinant of identity, suggested in the first phase of the study.

In the following quote the participant suggests that because her context involved teaching pharmacology to a variety of different healthcare students and professionals, her primary identity was that of a lecturer. However, she also highlighted the notion that there was no single generic concept of who a pharmacist was; that even within the pharmacist facet of the continuum there were different pharmacist identities. Within the context of a pharmacy department dominated by pharmaceutics research, the identity of a pharmacist was specifically associated with pharmaceutics and research:

> You are asking these really difficult questions. I definitely see myself as a lecturer first, not because I don't actively engage in the practice of pharmacy, but that I got a very wide reach with respect to interests - from pharmacology, involved in the manufacture industry, and community pharmacy (obviously I get phone calls from my students all the time, asking drug information questions) and also within the faculty - because the perception of me as a pharmacist who teaches pharmacology to a lot of different students clearly puts me there. Whereas, in our faculty, the perception of a pharmacist is somebody who is involved in pharmaceutics research that is highly funded. For me to be teaching in a more pharmacotherapeutic modality labels me as a different kind of pharmacist. (FGP9 – 2:60)

However, the tension for this participant was further sensed in the following two comments where she acknowledged that others - students and staff - perceived her as a pharmacist, and it was her identity as a pharmacist that enabled her to make a unique contribution within her faculty.

> I still see myself, yes, perhaps as an educator in all of those environments, but interesting that their perception is that I'm a pharmacist and that is why I am able to bring all of that information to them. (FGP9 - 2:99)

> I can give you the addendum for me which makes me think, it is that we have the big department of pharmacy; but in the department of pharmacology, which is really a science department that lectures to the rest of the university, I am the only pharmacist. That makes me quite special and I feel that specialness quite often, when they need help with specifically profession related kind of issues, because I am the only one. It confirms it definitely for me. (FGP9 – 2:102)

The manner in which she viewed and labelled herself as a lecturer or educator suggests that it was her self-proclaimed emphasis on the key determinant “practice” that underpinned her professional identity. However, by viewing and labelling herself primarily as a lecturer or an educator, the aspect of her identity – pharmacist - which made her contribution unique and added to her sense of “specialness”, then became to some extent overlooked, or even denied.

The participant who labelled himself an academic pharmacist (FGP6) explained how the label assisted him in integrating the pharmacist and academic facets of his identity whilst also reconciling the teacher and researcher aspects of who he was:

> I think from my side I did a Master's, that was my goal and as part of that I was asked to teach and from then the so-called teaching bug bit and I think the fulfilling part of our jobs is teaching. I enjoy that aspect but the reason why I often state 'academic pharmacist' and not 'lecturer' is because then people often just misinterpret it as being a glorified teacher - and I think there is a lot more to us than just teaching. We do all kinds of other things and a lot of us practice outside the university, keeping our foot in the door so to speak. It is a confused role and that's why I always avoid the word 'teacher' or 'lecturer', I think it's too exclusive. (FGP6 – 1:124)

He described how having come into academia in order to do a postgraduate degree, with a research focus, the opportunity to teach presented itself. In the practice of teaching, he discovered his passion and found fulfilment. However, to exclusively label himself a teacher or a lecturer, would have denied other important aspects of his professional and academic identities. All of the participants held dual and sometimes multiple identities and the labels that they offered to describe themselves professionally can be interpreted as largely reflecting a conscious or unconscious split in their identities. As Richards (2009, p. 3) proposed "every time we speak we reveal – whether deliberately or accidentally – something of ourselves and who we take ourselves to be" and furthermore "sometimes a single word is enough to represent a specific identity, with all its social and interactional associations" (p. 4). Therefore, by consciously using the term 'academic pharmacist' this participant (FGP6) integrated multiple aspects of his identity and was perhaps enabled to know himself as a "whole person with integrated identities" (Jameson, 2007, p. 211).

There are many reasons proposed in the literature for the reluctance of academics in higher education, teaching on vocational programmes which prepare students for a profession to which they themselves belong, to relinquish their identity associated with the profession in lieu of adopting an academic identity (see Section 3.3.4). One of the reasons often cited is that although many educators on vocational programmes have the relevant professional qualifications, and may be acknowledged experts in their particular disciplines, however, their teaching and lecturing skills have generally been acquired and developed experientially, and are not grounded in a solid, scientific, research-led knowledge base; they have learnt to teach "on the job" (McShane, 2005; Viskovic & Robson, 2001). As a consequence, feelings of under-preparedness for teaching, can leave them reluctant to fully identity themselves with their new roles early on in their academic careers, and cause them to cling to their former professional identity. This sense of under-preparedness for teaching was evident in many of the participants' responses:

> I was terrified but I don't know if anyone can stop that feeling. (FGP2 – 1:143)
>
> I was thrown in the deep end, told to go and teach – I had no preparation, I hadn't lectured and the worst was drawing up a practical when I'd never drawn up a practical and I learnt totally by trial and error. About five years after I started, no, maybe about three, I went on a lecturers-induction course, and then I was going, 'Oh' and then they talked about assessment methods and everything else. It was really completely the wrong way round. I mean, I was so unprepared when I arrived. (FGP10 - 2:77)
>
> I was appointed under contract, so my induction course was, I think, two years after I started and I sometimes feel that the powers that be make this assumption that, because we know the content, we will be able to teach it and that's ridiculous. My first assessment course that I did was four years after I started and the things I learnt from it were incredible. People make this assumption that, because you've been taught the work, that you will be able to teach it to someone else. I think teaching is a skill in itself; it's not just the content and whether or not we are covering the right work. It's whether we are presenting it to the students in such a way that they are able to learn from it. Nobody even walked into my lectures to see if I was teaching correctly. I also feel that on the teaching side of things we are just not given enough support or enough information on teaching practices. Just because we are an academic, it is assumed we will be able to teach. (FGP6 – 1:146)

The under-preparedness for teaching was further complicated by the pressures of trying to balance postgraduate studies or research with teaching:

> I didn't come in to actually teach, I was around the department a lot and I'd resigned from industry and I was working on my Master's - I had completed my community service and I'd worked in retail, and then industry, and I'd decided that I just wanted to get it done. I'd registered for this degree for so long and I needed time and then Prof said: 'But you're here so often why don't you just do it, it's not that much work.' Boy was he wrong! It added a year to my Master's. I really do like the teaching I like being able to teach but it's a very difficult environment. You feel torn a lot of the time between doing what you want to do and, I'll be quite frank, my supervisor said to me 95% of your time is going to be research and 5% of your time has got to be undergrads. If I look at my week, I've got five hours of class time and two afternoon practicals, so that's 11 hours

> out of a 40 hour week. That pushes the 95 / 5% right out of the way from the beginning. It's very difficult you can't get that. So it's hard. (FGP3 – 1:129)
>
> I liked practising pharmacy but I also always felt that there was more I could do and that fulfilment I got at the university. It becomes more complicated because, as institutions of knowledge, universities encourage you to do research and to do teaching. And now there is this paradigm where the focus is more on researching because that is what the universities recognise and that is what brings in the funds. You get frustrated as a teacher because you can be in a lecture room for eight hours a day but then when the university puts pressures on you to do research and other things, you do it but your role becomes muddled between 'what I want to do' and 'what the university expects'. (FGP1 – 1:120)

This supports the notion that an academic identity is complex and involves at least two aspects, teaching and research, which need to be held in balance. Based on their research, examining the experiences of new university lecturers in various healthcare disciplines, Smith and Boyd (2012) suggested that one of the greatest difficulties was the tension experienced from the underlying pressure to complete a doctorate and engage in research. The tension in balancing research and teaching and the impact of this on professional identity is further demonstrated in the following comments:

> One of the most frustrating comments that I've heard recently from somebody, in a very high position, was 'give the academics freedom to do research and the more research they do, the more competent they become to do research, the better teachers they will become.' That, to me, was the most ridiculous statement I had ever heard. (FGP6 - 1:146)
>
> I find that most good researchers, not all of them, most of the time don't make very good teachers. They find it difficult to bring it down to an undergraduate level. (FG3: 148)
>
> It comes back to the tension I was speaking about. A lot of the researchers see the undergraduates as being in the way of the research. Some of them do; I mean there's one guy in my department who every year incorporates something from his research into the undergrad programme, and it was obvious and we got good comments back, but not everybody does that. It takes a lot of time and while you are busy doing that, you can't also be busy writing papers. (FGP2 - 1:149)

These comments would suggest that for these participants, there was a tension between research and teaching and particularly in the notion that the ability to teach can be equated with one's research capabilities.

Smith and Boyd (2012), suggested that it is the tensions, such as these described above, and the academic workplace experiences of newly appointed lecturers on vocational programmes that leave them reluctant to relinquish their clinician-related identity and credibility, and slow to adopt academic identities as teachers and researchers within their professional fields. In addition, Smith and Boyd (2012) proposed that sustained support in the development of teaching and research skills could be a critical factor in the building of an academic identity. In general, however, for many of the focus group participants in this study, career support, guidance, and mentoring within the university environment were lacking:

> I must say I never felt like I had a mentor, I must be honest with you. I've never really thought about it before … I have basically learnt by making mistakes … I didn't ever feel that there was someone I could look up to and know that that was really where I wanted to go. There are obviously people that are role models but no one ever sat down with me and asked what my career path was and how they could help. I don't want to give the impression that no one helped and obviously along the line there were some people but pharmacy helps you learn to make your own decisions and to make your own mistakes. (FGP2 – 1:141)

> For me, the career path was not as clear when I got in. … The other thing is that in terms of my position in the department, I was thrust into a head of subject position very early on - nearly the day that I arrived - and I felt that at my current university there wasn't anywhere else to go or anywhere to develop from. I didn't have anyone about me to develop from so I didn't have that clear vision of what I wanted to do or where I wanted to go. (FGP6 - 1:135)

> I think as a young academic coming into a university type institution, it depends a lot on who your senior is to develop you and to guide you. For example: my senior, as I came in, was someone who… this particular academic was the type of person who said to me, 'You know what? You do what you are best at and you try to the best of your ability to make a difference in people's lives through doing the best that you can with the God-given gifts and talents that you have'. To me that was teaching and it was affirmed by the responses you get from students. Then, another maybe higher-level person, comes in and takes away from what the first person says by saying: 'in the following year you've got to do

> research for a PhD and you've got to do all the following, because this is your career path'. Then you find yourself becoming resistant because that was never part of my plan. It's not what I want to do. Almost like you can't fit a square into a circle and I think that's important - in knowing your people and in knowing who you are and where your abilities lie … and servicing humanity, students, whatever, by doing what you're good at. When you try doing things you don't want to do, it's not going to work. (FGP1 – 1:136)

> I would have preferred some more mentoring from the senior personnel in the department since I was newly out of community service and got given the second year class and module to teach and they said, "Here's it, please carry on." I would have preferred some form of supervision and saying, "Okay, you're doing the right thing; you're on the right track, carry on". (FGP8 – 2: 73)

All four of these comments highlight both the lack of and the necessity for clear guidance and mentoring on the academic path. In light of these comments, it is also not surprising that Smith and Boyd (2012) suggest that confronted with negotiating their own path through a multitude of often interwoven trajectories of identity, lecturers often hold fast to their existing identity trajectory as clinicians or practitioners and as mentors of new practitioners, and avoid focusing on developing academic identities as educators or as researchers within their professional field. In addition, the penultimate quote above also supports the notion that individuals have a greater affinity or preference for one aspect of academic work or practice over another and that this preference or affinity can determine how they identify themselves within the multiple demands of academic work.

6.2.4 Identity – "a nexus of multi-membership"

Many of the participants were actively working in various pharmacy domains outside of the university, and one of the participants even suggested that this was the norm for many of her colleagues:

> I'd say that we've got a large portion of our staff who consult or locum or work for the Pharmacy Council as inspectors. I'd say 80% of the staff still works in like, weekends and their own time. (FGP3 – 1:157)

There was noticeable support from focus group participants for the idea proposed by first phase participants that active engagement in other communities of practice informed both teaching and research, and furthermore that it provided a means for participants to make a contribution to the profession. Additionally, as both the following participant comments

suggest, this engagement in other communities of practice can also be considered integral to educators maintaining their sense of “calling” to their original vocation or profession and also their continued identification with the profession and as professionals.

> A lot of my locuming directs both my teaching and my research. Often you can identify problems, even from a pharmaceutics perspective, that are happening in industry in order to be able to drive your teaching or your research ideas. It's having practical, realistic examples - not these examples that are ideal in an idealistic world and you'd be able to relate better to students because they are often also working in these environments and are able to identify with us. Even for me, I've tried to get as much work experience outside of teaching, to a point where I was doing 11-3 shifts - 11 at night until three in the morning and also teaching at the same time. I think it's important for us to still practice what we were called to do. For most of us, pharmacy is a calling to help people and that's what we initially set out to do and most of us changed direction. I think all of us have that in us. (FGP6 - 1:158)

> In terms of because I locum, I relate very closely with the profession. I see it as a very good link because I really enjoy the locuming because I can bring it back to the lectures but I feel I also take something into the practice environment with my lecturing. The link to me is very important because it means I can make the subject come to life rather than just be in a textbook. The links are very strong - I didn't locum for a while and I felt very isolated from my profession and a feeling of ‘out of touch’, which is one of the driving reasons why I’ve gone back to locuming but I now feel that I'm lecturing pharmacists, but I also know what the pharmacy does. I've felt much better since I've started locuming again … I think my identity still goes back to being a pharmacist and that's why I felt isolated when I moved into this lecturing environment because I wasn't ‘hands on’ in the profession. The link now with the locuming and getting into practice, is definitely confirmed that the pharmacy profession is still where, I think I see myself more as a pharmacist than as a lecturer. I'm still very connected to the practice and it's probably because I spent quite a bit of time there first before lecturing. (FGP10 – 2:93)

The second quote is from a participant (FGP10) who came into higher education from a well-established career as a pharmacist and who also continued to locum in order to maintain her link with the profession and her sense of professionalism. The first quote, however, is from a participant (FGP6) who came to academia from community service, and consequently would

not have had a pre-established pharmacy career or identity. His work in retail pharmacies and industry afforded him the opportunity to connect with his original calling to be a pharmacist and to develop his professional identity as a pharmacist.

The following comment from another participant (FGP9 - 2:95) suggests that her participation in other communities of practice had also afforded her opportunities for involvement in the formation of the professional identities of other pharmacists:

> I don't actually locum on a regular basis but sometimes get an emergency phone call that they are really stuck; I will go in. I have a range of other activities that connect me with the practice, as it were, and one of the first things that I do is that I consult to quite a lot of the pharmaceutical companies in Johannesburg and it's part of their training too. So I will come in and train yes, some of their pharmacists, but also representatives with respect to their substances to have a more qualified approach to what the competition are doing. And I find it really interesting to interact with the pharmacists in the industry because they wear this hat of, “Am I going the medical side route or am I going marketing side route?” And as a pharmacist you can do both. They mostly, when I see them for training, haven't decided. It's quite interesting to see them forming those kinds of identities and how the information is actually applicable to both. I find that fun. The second group that I have quite a lot to do with is hospital pharmacist because there is this whole new antibiotic stewardship idea and it's that I've had quite a lot to do with setting up the training and actually doing some of the training for the clinical pharmacists in the hospitals. And that has been fascinating because that is developing a whole new professional identity with respect to themselves as well as the medical team. I find that very refreshing. Although I do have a little bit of retail ‘behind the counter’ experience, and I trade on that quite heavily sometimes in terms of teaching experience, I feel that it is wider than that and also, we have that whole online writing community with the journal and interaction with people as pharmacists who write. I also find that quite interesting and a discussion of what you should and shouldn't put in and what's important. I think there are a lot of practice communities that one can be involved in and I must say that I feel connected with all of them.

Because of her lecturing involvement beyond the pharmacy department, this participant called herself a lecturer as opposed to a pharmacist. It is, however, interesting to note that integral to her lecturing or training was the concept of development of professional identity. She was very aware of how, in imparting knowledge to practitioners in various communities

of practice, she was also enabling the development of professional identities. Furthermore, her own sense of connection with all of these communities of practice, including a web-based or online community, suggested that her own identity was a nexus of multi-membership.

6.2.5 Key determinants of professional identity

In the first phase of this study, six key determinants were identified as underpinning professional identity (see Section 5.11.1.4). The value which participants placed on one or more of these was to a large extent foundational to how they identified themselves. In this phase of the study, the manner in which passion and professionalism could be considered to be key determinants of professional identity has previously been highlighted in Section 6.2.3.

The notion of practice as a key determinant of professional identity was supported by comments such as:

> Sometimes I forget that I'm a pharmacist because I'm not practising, and so you tend to forget and so it's odd when people call you a pharmacist. (FGP1 – 1:110)

> I do not see myself as a pharmacist at all; I see myself as a researcher. I feel reluctant if people call me a pharmacist and want me to answer any questions relating to pharmacy because I was in a pharmacy such a long time ago. I do not want to answer any questions relating to pharmacy. (FGP5 – 1:114)

The first participant (FGP1) specifically called herself a lecturer and, although a registered pharmacist, she did not think of herself as a pharmacist, primarily because she did not see herself practicing as one. Similarly, in the second comment, the participant (FGP5) did not view herself as a practicing pharmacist, and in addition, she was afraid of having to respond to practice-based questions, and therefore really shied away from being labelled a pharmacist.

In contrast, a participant such as FGP3, identified herself primarily as a pharmacist, based on her extensive practice as a pharmacist outside of the university environment: “I'm a pharmacist through and through. I practice a lot outside of the university. I locum quite a bit so I guess I still consider myself as a pharmacist” (FGP3 – 1:115).

Similarly, for participant FGP10, her move to academia, had left her feeling “isolated” and perhaps with professional identity issues. However, her recent return to locum work in the practice environment had facilitated her reconnection with her sense of self as a pharmacist:

> I felt isolated when I moved into this lecturing environment because I wasn't 'hands on' in the profession and the link now with the locuming and getting into practice, is definitely confirmed that the pharmacy profession is still where, I think I see myself more as a pharmacist then as a lecturer. I'm still very connected to the practice and it's probably because I spent quite a bit of time there first before lecturing. (FGP10 – 2:100)

However, this same participant also placed emphasis on the key determinant – professionalism. In response to a question relating to her image of herself as a pharmacist/lecturer, she stated - "I would say a professional" (FG10: 55). This suggests that her status as a professional was of importance to her and, furthermore, that she found her sense of professionalism in her practice as a pharmacist.

In terms of the key determinant – knowledge base – the lack of a pedagogical knowledge base may have meant that participants were less reluctant to identify themselves as lecturers or teachers. The feelings of under-preparedness for teaching, identified by many participants, have already been highlighted in Section 6.2.3. However, it is interesting to note how the contribution and value of a pedagogical knowledge base to professional identity was suggested in the following comment from one of the participants, who subsequent to her appointment as a lecturer, had acquired an academic qualification in education, and viewed herself as an educator:

> I think that the involvement of all those communities, for me, is still very much at the level of information exchange as opposed to real deep education because all of those environments are looking to me to provide a curriculum or to bring in new knowledge and information and the challenge from my side - especially having become a little bit more aware of educative practice and pedagogy styles and all those kind of things - is how am I going to do this thing so that they are actually making those developmental strides and I am just guiding them towards where they could be. I still see myself, yes, perhaps as an educator, in all of those environments; but interesting that their perception is that I'm a pharmacist and that is why I am able to bring all of that information to them. (FGP9 – 2:99)

In the focus groups, there was also evidence of support for "satisfiers" as a key determinant underpinning identity. For example: participant FGP1, who identified herself primarily as a lecturer, stated that:

> I liked practising pharmacy but I also always felt that there was more I could do - and that fulfilment I got at the university (FGP1 – 1:120).

This would suggest that her identity was underpinned by the things that satisfied her, or were her sources of fulfilment. Similarly, for participant FGP5, her identity as an academic was supported by the idea that the university environment was where she found her sense of fulfilment:

> I think mine was also research but I did a PhD and then I went into industry for a little bit and like you were saying it wasn't fulfilling. It sort of felt like “Oh now I'm sitting in my little lab and I’m doing my little research” and it was a question as to how far the research was going to get, and, if I have to at the end of my life say “What did I do with it?” I would be unhappy. So it felt to me that at least if I have postgraduate students or undergraduate students, you’re impacting on somebody else's life. I want to do research because that's what I like but then it felt more meaningful to also teach. I, personally, do not like working in a pharmacy. (FGP5 – 1:123)

Although their “expected role” created tension for many of the focus group participants there was no real evidence to suggest that it constructively underpinned their perceptions of their professional identities. The tension that the “expected role” created was evident in the following comment from a participant who specifically identified herself as a researcher:

> After I got my PhD, I got a position as a researcher. But, after a year, it was expected of me to teach and I taught for 10 years. And I had to teach a part of everybody's course. So I teach for the whole year. For 10 years I've taught and I didn't have time to do my research. I had master’s students but I never had time to take off and to write articles. Last year, I had a year in which I only taught for a month as well as this year. So I've had two years, but it isn't enough. Next year I have to start teaching again. (FGP4 – 1:152)

Although she was appointed as a researcher, and identified herself as such, part of her expected role was that she would also teach. Teaching, however, appeared to have consumed the larger part of her time and had negatively impacted on her development as a researcher, and perhaps also on her sense of self as a professional.

The emphasis that participants placed on their under-preparedness for teaching, and the subsequent impact that this may have had on their willingness to adopt an academic identity, was described in Section 6.2.3. This suggests that “skills” might be a further key determinant

of professional identity. However, this lack of preparedness for teaching can also be related to formal pedagogical knowledge as well as the guided practice of teaching skills with feelings of not being adequately qualified to teach, as evidenced in the following interaction between three of the participants:

> We're trying to stuff so much information into their heads in that four-year period whereas we should be teaching them to be lifelong learners; to be critical thinkers and not focus so much on the content because that they will pick up if they need to anyway, if we have taught them to be critical thinkers. (FGP6 – 1:174)
>
> But to achieve that we've got to change teaching methodology, and you've got to get out of that didactic “this is what I did” and “here's the text book which is what you have to know”. (FGP3 – 1:175)
>
> Nobody has taught us how to do that and that’s my point exactly. (FGP6 – 1:176)
>
> It is incredibly hard. (FGP3 – 1:177)

The impact of courses or training in aspects of pedagogy, on their confidence to teach was also emphasised by participants:

> My first assessment course that I did was four years after I started and the things I learnt from it were incredible. People make this assumption that because you've been taught the work that you will be able to teach it to someone else. I think teaching is a skill itself; it's not just the content and whether or not whether we are covering the right work. It's whether we are presenting it to the students in such a way that they are able to learn from it. (FGP6 - 1:146)
>
> We had a five-day teaching course when I started. There were five days given monthly and it was quite helpful. It wasn't run by the Department; it was run by our teaching and learning division. It did help; there were pointers raised and stuff. It wasn't enough. (FGP3 - 1:145)
>
> Through formal instruction, I’d say. I’d been feeling very uneasy for a while about the way we’d been assessing our honours students because they had to write a final year project and the projects were very varied, although they weren’t pharmacology, there was an element of clinical pharmacology in some

> and laboratory pharmacology in other. Everyone would have to mark all of them and the marks were very far-ranging. So the first thing I said to the Head of Department was, “We need to get together and discuss why we’ve marked how we’ve marked”, not knowing that was a formal way of doing anything – just so that everyone’s on the same page and looking for the same thing and then I began to realise that people really weren’t looking for the same thing and why were they not? Because we’re such a big university they send out a weekly newsletter of things that are happening in the university, and it can be pages long sometimes, and they advertised in the department of education a little seminar on assessment and I thought, “Okay, let me go there and find what they’re going to tell me about structuring multiple choice questions correctly so that it’s fair and about how to make a rubric for an essay”. I went along to the seminar, all ready to learn about education, and the woman walked in and said, “What is truth? What is a fact? What is knowing?” I was sitting there, completely boggled, and I didn’t know what she was talking about and I couldn’t believe that this was an assessment seminar and then I got into it and I understood what she was getting at and then I looked at how we were teaching and what we were doing and I thought, “There isn’t an all-positivist way of approaching teaching as our department is doing and what can I do to start changing how we do this thing?” That’s where we are now. It’s been a very interesting ride, I have to say, but it was definitely a formal effort that kind of made me think whether we were really doing it right. You know what’s really interesting, is that after years now, finally my colleagues are actually beginning to relate. I definitely didn’t start that way and I wonder now if an education person had got hold of me then and said, “What do you think you’re doing?”, how much more down the line we would be. (FGP9 - 2:74)

Since it is apparent that formal education in pedagogy and teaching methodology contributed to some of the participants feeling more adequately prepared for teaching, I decided rather than including skills as a seventh key determinant, “knowledge base” should be expanded to include “skills base” since both of them can be served by or are related to academic qualifications.

6.2.6 Perceptions of pharmacy practice, pharmaceutical care and pharmacy education

Building on the understandings about the attitudes, beliefs and behaviours of pharmacy educators, gained in the first phase of the study regarding the philosophy and practice of pharmaceutical care, and pharmaceutical education (Section 5.11.2), these were further explored within the focus groups. Although many of the participants held to the philosophy of pharmaceutical care, and considered it be relevant and even integral to their teaching, there were some who expressed frustration with the lack of impact it appeared to have on practice. One participant described pharmaceutical care as the "ultimate" (FGP7 – 1:189) and another participant, in explaining her understanding of the potential for pharmaceutical care to impact on practice, also expressed her affinity for the concept in very strong terms:

> I think pharmaceutical care … takes us from being the distributors of product and the dispensers of product to being the empowering force behind the product as an instrument to better the patient's quality of life. I think the idea is phenomenal and is so much-needed when you look at disease burdens and you look at mortality rates and things that can be fixed if patients are educated on their drugs, and if someone is going to take the responsibility to be the empowering force behind the medicine. (FGP1 - 1:188)

This same participant, however, based on the outcomes of her unpublished research, expressed concerns that pharmaceutical care in practice is "unfortunately not a reality yet" (FGP1 – 1:188). She also expressed doubts that students would in the future, take responsibility for practicing pharmaceutical care, and she attributed this belief to her perception of a lack of professional confidence amongst students:

> Our students do not have enough professional confidence and professional identity to say "I am a pharmacist", "I am a drug expert", "I want to solve that problem based on this". They are not strong enough in their confidence. We were going to try and mirror a medical school model that does the same thing; and it works so well in the medical school so why can it not work as well in the pharmacy school? I find that medicine students are just so much more confident and in control of their profession, and wanting to do it, and wanting to get involved compared to pharmacy students. I think pharmaceutical care is a great concept but is it relevant? Not yet. I think it's up to us to put measures in place

> to make it relevant for our community because it is certainly needed if you look at the drug problems. (FGP1- 1:188)

The same participant also thought that pressures in the workplace did not promote or facilitate pharmaceutical care practice:

> The reason why pharmacists find it so hard to give pharmaceutical care based services is because, if you go to corporate and retail groups, a lot of them have timing systems. You get two minutes to speak to the patient and you can't do pharmaceutical care service in that time. (FGP1 – 1:191)

Furthermore, she expressed concern over the confusion created for students by the disparity between what they were taught and what they experienced in the workplace:

> Our students get so dismayed. What are we doing? My partner and I are teaching pharmaceutical care and we're giving them all the modules and we are doing case studies, and we're doing role play, and then in practice the boss is telling them you've got two minutes to attend to this patient. Our students are getting confused. (FGP1 – 1:191)

This opinion was supported by the practice-based experiences of one of the participants who suggested the reason she had left a hospital-based job was because the environment did not permit the provision of pharmaceutical care:

> I honestly agree with you and I left my hospital job because I just couldn't change - I was going to be changed. In terms of skills, we don't have those skills. I was going to be changed because they did not have enough pharmacists. So, instead of me doing my counselling, I had to make it snappy, in three minutes, because we don't have the resources. In a way, no matter how many years of teaching that we give to our students, if we do not have the capacity, it's going to be one minute counselling; which is no counselling. In all honesty, I don't know what's going to become of pharmacy if we are not doing what we are supposed to be doing for these patients - giving them the information that they need. Hopefully with skills, with more capacity, with more resources, we will be able to do what we are supposed to do. (FGP7 – 1:198)

However, another participant was of the belief that changes in the practice environment would both force the necessity for pharmacists to start practicing pharmaceutical care, and provide the support to allow them to do it:

> I think with the changes in the legislation, firstly, the technical assistant and the pharmacy technician is going to force pharmacists into practising what we are trying to teach. The consumer protection act; I don't know if pharmacists have realised how far reaching the implications of that are, but I think that also means we're going to have to have counselling. I think us, as universities are probably teaching pharmaceutical care, but it hasn't been enforced yet. And I think with the changes that are happening in the legislation and with the new pharmacy mid-level workers are going to change the role of the pharmacist and they're going to have to fall back on the pharmaceutical care. (FGP2 – 1:190)

The suggestion that changes in pharmacy practice would be forced by legislative changes was also expressed by a participant in the second focus group:

> I think what we are trying to teach our students, now, is that the scope of practice over pharmacist is actually exploding. Because with the government's relaxation on prescribing regulations which will come for everyone because they are just going to open up and say "Okay, out and about there; the pharmacist is actually the best qualified to handle that pharmaceutical care." Which it will be because there won't be any doctors involved or nurses involved. And students, I think, have to clearly understand that that is the responsibility that they are taking on and they are not going to be able to hide behind their counters and count - that they need to be able to engage in all of those practices which we are giving them because legally they will be entitled to, and morally, if they are going to work in this country as health care providers, that is what they owe their patients. I don't know if I would call it pharmaceutical care, but definitely it is an extended type of practice that we are going to see pharmacist doing things that they have never done before, legally. (FGR9 - 2:111)

The participant was focussing on proposed legislative changes to prescribing laws and suggested that these would force pharmacists into extended roles beyond what they were currently practicing. She did, however, query whether this could be termed pharmaceutical care. A further participant expressed concern over the confusion that she saw existing over

the use of the term “pharmaceutical care, and questioned whether it would not be better to use the term “medicines management”:

> The concept of pharmaceutical care I firmly believe in, but it has almost grown into a term that people feel they can't attain, so now everyone is talking medicine management which seems to be more tangible. Time will tell if people feel that they are better at medicine management than pharmaceutical care, but if I look at the pharmaceutical care, you've actually got to say, “What is it?” And there are so many opinions about what it is and everyone has got a different idea of what it is, so to me it has always been a term that everyone has got a different perception of what it is about and I think because of that, it depends who you talk to you as to what they interpret pharmaceutical care to be. (FGP10 – 2:110)

Medicines management was discussed in Section 2.3.1.2, where it was suggested that it is underpinned by the concept of pharmaceutical care, and, as this participant suggested, may be a means of implementing the pharmaceutical care philosophy in practice. This participant’s voice added further weight to the suggestion offered in Section 5.11.2 that the term “pharmaceutical care” needs to be revisited and its relevance and practical feasibility in the South African context needs to be reconsidered.

Thus, many of the opinions expressed in the focus groups with respect to pharmaceutical care were consistent with those of many of the participants in the first phase of the study as previously discussed in the context of existing literature in Section 5.11.2. One participant did, however, suggest that educators could do more to teach pharmaceutical care in a more integrated manner:

> Can I just say from a teaching perspective, I often find that as a pharmaceutics guy, that we've taught in silos for so many years and that as pharmaceutics and pharmacy practice teachers; we've always just said “While pharmaceutical care is a burden, we in pharmaceutics are just going to make sure that they know how to make drugs.” And pharmaceutical care is the job of pharmacy practice. I often find that that sort of aspect, the pharmaceutical care in the patient, we in pharmaceutics lose out on because we are so focused on the delivery system and I think we need to look at more integrated approaches to our teaching and to not being in the silos. I think at our university we are moving towards that; slowly, but we're moving towards that.

> All of us need to do that because we are trying to create a holistic pharmacist, not little individuals. (FGP 6 – 1:193)

The literature suggests that in the past pharmaceutical education has involved "limited integration between disciplines" (Stewart *et al.*, 2011, p. 1) and students have been taught in "silos" (Hughes, 2011, p. 7; Stewart *et al.*, 2011). As a consequence, students have been left to make interdisciplinary connections on their own, and have often struggled to apply the more pharmaceutical science concepts, such as those taught in pharmaceutics, to practice and to patient care (see Section 2.4.5.3). In the comment above this participant (FGP 6) has recognised the extent to which "silo" type teaching was perhaps impacting negatively on the ability of pharmacy graduates to integrate their knowledge in such a way that they were able to provide pharmaceutical care. Although this could be construed as a call for further changes to the curriculum in order to teach for change, and to teach for pharmaceutical care, perhaps the key to overcoming this kind of "silo" education lies in changing the "silo" thinking of pharmacy educators. It also lies in educators focussing on the end product – graduating a "holistic pharmacist" rather than simply focussing on teaching their own discipline, for example: pharmaceutics. I would go as far as suggesting that it might also be a consequence of educators not modelling a "holistic pharmacist" approach, but rather approaching their disciplines in individualistic ways.

Although I did try to explore with the second focus group the notion of modelling pharmaceutical care through the practice of educational care as described by Kiron in his story (see Sections 2.4.7 and 5.5.2), by asking the question:

> Would you think that there is an allied term for us as pharmacy educators of 'educational care'? If we see ourselves as pharmacists, as an educator, do we have a way of practicing pharmaceutical care in the education environment? If we unpack that, the core concepts of pharmaceutical are taking responsibility for outcomes and patient focus. Do you think that there is a kind of allied concept for us as pharmacy educators of educational care? (Facilitator - 2:114)

The participants did not like the term 'educational care', and apparently grappled to understand what it was that I was asking:

> I don't like that term because, to me, it sounds like I am looking at learning-disabled students. It's the term that is bothering me rather than what you are implying. (FGP10 - 2: 115)

> I am just trying to draw a parallel, because it's still bothering me what you said. We have physiotherapists who teach physiotherapists and OTs[29] and nurses and doctors, although a lot of people who teach our medics are not doctors, and that bothers the medics. I don't really know if, as pharmacists, we teach pharmacists, if that's any different and if we need to specify that that's what it is, because I mean, I think in terms of identity, it's fine to say "I am a pharmacist and I'm a lecturer and I don't always lecture pharmacy students, but I'm still lecturing and that is my *persona* and that is how I'm perceived." (FGP9 – 2:120)

However, despite this, and regardless of whether or not the term "educational care" is used or not, there was acknowledgment by one of the participants that pharmacy educators in the classroom do serve as professional role models for students:

> I think students do perhaps build their own *persona* by modelling on people that they see. And if they see you in a classroom, is that different from them seeing you on the weekend behind a counter or in the hospital doing ward round? I think that, yes, they do model on the professional parts of your behaviour, but what I'm saying is I don't think you need to label it; because as an educator you are student centred and you want them to take responsibility of it themselves, so that's like the education part - and you saying, in terms of the pharmaceutical care, you want them to be there for their patients, so I don't really see a conflict of having to bridge the two. (FGP9 – 2: 122)

In both focus groups the question with regard to the role of educators in educating students for current or future practice, evoked much discussion. There was, however, general consensus amongst participants that it had to be a two-pronged approach; that education should be both preparing students for current practice and, in addition, educators should be bringing about future changes in practice by educating students for future practice. A few of the participants also based their understanding of the need to educate students capable of changing practice on their own perception that current practice was not ideal:

> I would like to say that I'm trying to give them a vision of what practice could be like because it is not ideal and I'm always going on about what could happen, because I've experienced it overseas. So I think I'm trying to show where they

[29] OTs is an abbreviation for occupational therapists

> could be rather than what they will do now, and almost broaden minds in terms of potential that could occur if they would just allow it to occur. (FGP10 – 2:104)
>
> We have to know what current practices are in order to identify where the problems are; in order to define what best practice should be. Unfortunately, it sometimes feels like a hopeless effort because the young pharmacists will get into a pharmacy and eventually just fall into the bad ways of doing things. We as academics need to be defining what and how pharmacy should be. (FGP6 – 1:165)

These comments support the idea that students should be given an understanding of the short-comings of current practice, but also have a thorough grasp of what future or 'best' practice could be. However, there was a feeling that this was difficult since the curriculum was already crowded and discussion in the focus groups around how this could be done, emphasised the teaching of generic skills and preparing students for lifelong learning.

> At what stage does it stop though? Because, you have a four-year curriculum; how much more can you fit in? Or, are you going to teach them skills such as evidence-based medicine and say 'This is how you evaluate future decisions and this is how you should look at it and this information and this, and these are good sources"? Is that not the way we should do it? We are not teaching a way of thinking because we can never get everything into a four-year curriculum. Is it rather better to teach the student the skills to analyse data and to make decisions, than to tell them what they should be thinking? (FGP3 – 1:169)
>
> We've got to get our curriculum updated where we can but there is a point where we can't go on putting in more and more. We've got to look at what the qualification is, and it is a generalist pharmacist. But you've got to look at the other things we've got to put in, including the critical cross field outcomes, to equip students with the skills to know where to get the information and how to keep themselves updated and to become lifelong learners. (FGP2 – 1:171).
>
> I'm struggling with that because I'm thinking that, in pharmacology, we have a curriculum and you have to be fairly selective because you cannot teach every single drug. That's been one of my fights - to try and cut down on the volume that we teach and rather focus on structures of how people learn information and where do you find that information. (FGP9 – 2:105).

This discussion in both focus groups was in keeping with the collective theme described in the literature review as being common to many curricula strategies and approaches; namely: finding the ideal equilibrium between the cognitive and affective domains within the curricula that will develop well-informed, competent professionals capable of providing pharmaceutical care (see Section 2.4.5.4). Furthermore, this notion was well summarised by a comment made by one of the participants who refocused the locus of the problem on the pharmacy educators. Consistent with Hughes (2011) (see Section 2.4.5.2), he suggested that in educating pharmacists for practice, pharmacy educators need to hold their role in perspective and recognise its place within the broader context of lifelong learning. Consequently, he suggested the focus in education should not simply be the imparting of knowledge, but the teaching of critical thinking skills:

> I think our biggest mistake perhaps, as educators, is thinking that the product we produce is going to be at the end of the day the pharmacist in practice. And we forget that probably more than 90% of what a pharmacist learns in his career is learnt outside of the classroom and outside of the University - after you graduate. We're trying to stuff so much information into their heads in that four-year period; whereas, we should be teaching them to be lifelong learners; to be critical thinkers, and not focus so much on the content because that they will pick that up if they need to anyway, if we have taught them to be critical thinkers. (FGP6 – 1:174)

It is perhaps the critical thinking skills suggested by this participant which are the key to teaching the “flexibility” which Tia suggested in the first phase was necessary for balancing the tension between preparing students for both current and future practice. Similarly, in the first phase Vinetra expressed the view that if we educate sufficient pharmacy students capable of changing practice, a “tipping point” would be reached and practice would change. As I noted in the literature review (see Sections 2.4.5.2 and 2.4.5.3) there have been many attempts to address these key personal competencies such as critical thinking, a capacity for lifelong learning and change advocacy, through both the formal and hidden curricula and that finding the optimal balance between the cognitive and affective domains within the curricula was a common challenge in pharmacy education.

6.2.7 Credibility of the analysis of the focus group transcripts

In an attempt to verify the trustworthiness, and more particularly the credibility of my interpretation of focus group transcripts as indicated in Section 4.4.2.3, a participant from each of the two focus groups was invited, via email, to review the transcripts and the reported analysis and to indicate the extent to which they agreed or disagreed with the themes and sub-themes which I had identified. The following feedback was received from a participant in the first group:

> I believe that you have captured the essence of what we were trying to say very well (much better than how we vocalised it). In fact, it made me re-visit my thoughts on my own professional identity again. I think it's an amazing study that every new "academic pharmacist" should read! (FGP6)

This comment not only verifies the credibility of the analysis but it also provides insight into how participation in the study provided opportunity for reflection on issues of professional identity. Furthermore, it suggests the idea that new pharmacy educators should be actively encouraged to give serious consideration to matters of professional identity.

Feedback was also received from one of the participants in the second focus group:

> I confirm that what has been reported is in fact a reasonable and accurate representation of what was discussed in the focus group. (FGP8)

Thus it would appear that my analysis of the transcripts of both focus groups has been accepted, by a participant in each group, to be credible.

6.2.8 Second phase summary

In this section (Section 6.2), the discussions in two focus groups with a total of ten participants, which formed the basis of the second phase of the study, were analysed and reported under the key themes identified in the first phase of the study.

The findings reported in this second phase confirmed the notion that the primary professional identities of pharmacy educators lie on a continuum of identities between academic and pharmacist identities. In addition, it became evident in this phase that the academic aspect of identity can be further sub-divided into lecturer and researcher identities. Thus pharmacy educators, who primarily identify themselves as academics, either identify themselves predominantly as lecturers or teachers on the one hand or as researchers on the other. By

using an all-encompassing term such as “academic pharmacist” to describe and identify oneself professionally, one of the participants suggested a manner in which the multi-faceted aspects of the professional identity of pharmacy educators could be integrated.

In the discussion of the tensions involved in balancing the various facets of pharmacy educators’ professional identities, the contextual nature of identity was emphasised, akin to what emerged in phase one of the study. Participants specifically highlighted the way in which the faculty context within which they found themselves, contributed to the manner in which they perceived their professional identities. In particular, the need to promote pharmacy within broader science and health science faculties saw participants emphasising the pharmacist aspects of their identities. The contribution which a sense of under-preparedness for teaching, and the need to balance the teaching and research aspects of their roles, with regard to the negotiation of professional identities, were as in the first phase of the study affirmed. Furthermore, the possible contribution of a lack of mentoring and career support on identity formation was noted.

In this phase of the study there was further support for the concept of identity formation being a consequence of membership of multiple communities of practice. In addition, the manner in which participation in multiple communities informs both teaching and research, highlighted by phase one participants, was endorsed by the focus group participants. Furthermore, this phase of the study brought to light the manner in which engagement with pharmacy communities of practice, beyond the university, can serve to both maintain and strengthen pharmacy educators’ sense of “calling” to pharmacy and their sense of themselves as professionals. One participant also noted the opportunities multi-membership provided for her to contribute to the formation of the professional identities of other pharmacists.

There was evidence in this phase of the study to support all but one of the key determinants of identity that were proposed in the first phase, except perhaps for the “expected role” determinant. In addition, it was proposed that the ‘knowledge base’ determinant be expanded to include ‘skills base’, as an aspect of academic qualifications.

In this phase, participants generally also subscribed to the concept of pharmaceutical care, although once more, its lack of penetration into practice was emphasised. The relevance and applicability of the concept to South African practice settings was also brought into question, and there was support for the notion that at very least, the use of the term “pharmaceutical care” needs to be revisited.

Focus group participants felt that the relationship of education with respect to the preparation of students for practice required a dual approach; and that in addition to being prepared for

present practice, students require a vision of ideal and best practice. Educators also need to be aware of their role within the wider context of lifelong learning, and teach students cross-field skills, such as critical thinking, necessary for self-sustaining continuous development and in preparation for adaptation to future practice scenarios.

The use of focus groups, which facilitated the collaborative interaction of a further group of ten pharmacy educators, assisted in deeper understanding of many of the ideas with regard to professional identity, pharmaceutical care and pharmacy education which were proposed by the analysis of the phase one narratives. In the third phase the applicability of many of these concepts to a wider spectrum of pharmacy educators was explored through the use of a questionnaire.

6.3 Phase three: Questionnaire survey with pharmacy educators

This section examines the responses to the questionnaire designed to explore, with a wider range of pharmacy educators in South Africa, the insights that emerged from the first two phases of the study regarding the self-perceived professional identities, attitudes, beliefs and practices related to pharmaceutical care and the role of pharmacy education. A copy of the questionnaire is provided in Appendix K. Demographic data were elicited in the first section of the questionnaire, while in section two the details and experiences of respondents with regard to their employment in higher education were requested. In subsequent sections of the questionnaire, questions were asked regarding respondents' perceptions of themselves as professionals; pharmaceutical care; and, their role in educating future pharmacists. In this phase of the study an inductive content analysis approach was employed to evaluate the completed questionnaires. Reporting of the insights gained will therefore approximately follow the layout of the questionnaire, although the key themes identified in phases one and two of the study will also be highlighted and further explored throughout.

It was difficult to obtain precise data about the size of the target population and to determine accurately the number of pharmacy educators that met the study inclusion criteria; namely registered pharmacists, who teach in an undergraduate pharmacy programme. Nonetheless, making use of university staff lists, obtained from the internet or directly from the universities, and the South African Pharmacy Council register of pharmacists, the population size was estimated to be 85. An electronic version and the details of the online version of the questionnaire (see Section 4.3.3.1) were distributed to potential respondents via the heads or deans of the schools, departments or faculties of pharmacy. In addition, an invitation to participate in the study was also issued by the Academy of Pharmaceutical Sciences via email communication to all its members. Thus it was difficult to determine the exact number of potential respondents. However, 32 responses were received giving an approximate response rate of 38%.

6.3.1 Objective identity of respondents

Using the demographic data from the first section of the questionnaire, the objective identities of the respondents are described in this section. A summary of the respondents' demographic details, together with a unique identifier used to report responses attributed to them, is provided in Table 6.2. It needs to be noted that since the pool of pharmacy educators in South Africa is relatively small, the demographic details provided for each respondent has been limited to protect their confidentiality.

Table 6.2: Unique identifiers of Phase 3 respondents with demographic details

UNIQUE IDENTIFIER	GENDER	YEARS OF REGISTRATION AS A PHARMACIST	YEARS IN HIGHER EDUCATION
R1:	Male	10	10
R2:	Female	12	6
R3:	Female	12	8
R4:	Female	32	26
R5:	Male	29	18
R6:	Male	32	2
R7:	Female	3	2
R8:	Female	13	11
R9:	Female	7	5
R10:	Female	6	6
R11:	Female	27	23
R12:	Male	24	13
R13:	Female	15	6
R14:	Female	18	16
R15:	Female	27	9
R16:	Female	23	10
R17:	Female	36	35
R18:	Female	13	4
R19:	Male	24	20
R20:	Female	3	2
R21:	Female	7	2
R22:	Male	16	1
R23:	Female	12	9
R24:	Male	22	27
R25:	Female	14	1
R26:	Female	30	23
R27:	Female	6	6
R28:	Male	36	12
R29:	Female	12	5
R30:	Female	5	5
R31:	Female	38	36
R32:	Female	12	8

Of the 32 respondents, 75% (24) were female and 25% (8) were male (see Table 6.3). This reflects the apparent greater representation of females within pharmacy education in South

Africa. An approximate estimate of the ratios of males to females in the eight schools of pharmacy revealed that the highest male representation at any of the schools was 38%, whilst the lowest was 10%. In 2010, 59% of the total pharmacy workforce comprised women and, in keeping with international trends, there has been an increasing shift in gender dominance from male to female over several years. It has been suggested that this trend throughout the profession may be related to both the shifting focus within the profession toward the provision of pharmaceutical care and greater opportunities for flexible and part-time work hours, thus making the profession increasingly attractive to women (International Pharmaceutical Federation, 2009; South African Pharmacy Council, 2011).

In terms of age, 9% (3) of the respondents were younger than 30 years, whilst 3% (1) was older than 60 years. The modal age category was 31 – 40 years, 41% (13). The age category distribution of respondents is shown in Table 6.3.

Table 6.3: Summary of the demographic details of the phase three respondents

GENDER		AGE					YEARS OF REGISTRATION				YEARS IN HIGHER EDUCATION			
		≤30	31-40	41-50	51-60	>60	≤10	11-20	21-30	31-40	≤10	11-20	21-30	31-40
Female	(24)	3	11	4	5	1	8	9	5	2	17	3	2	2
Male	(8)	-	2	2	4	-	1	1	2	4	2	4	2	-
Total	(32)	3	13	6	9	1	9	10	7	6	19	7	4	2

Having been registered with the South African Pharmacy Council for an accumulated 596 years between them, the respondents had a total of 174 years of pharmacy-related work experience completed prior to taking up employment in higher education. The majority of respondents, 75% (24), had ten or less years of practice experience prior to their appointment in higher education, whilst 19% (6) of the respondents had no practice experience as a pharmacist prior to higher education. The prior experience of respondents had been in a variety of practice settings, including both public and private hospitals, community pharmacy, the pharmaceutical industry, pharmaceutical wholesaling and the military. Furthermore, it encompassed experience in various aspects of pharmacy including: manufacturing, research and development, regulatory affairs, quality assurance, logistics, management, clinical pharmacy and oncology.

Twenty-five percent (8) of the respondents had obtained academic qualifications in areas other than pharmacy. These included a diploma in therapeutic aromatherapy, three BSc degrees, one respondent with an Honour's degree in psychology and an MA, and a further

three held degrees at Master's level – an MSc, an MBL[30] and an MBA. Five of these respondents also had work experience in non-pharmacy related domains.

6.3.2 Employment in higher education

The respondents had been in higher education for an accumulated 393 years. Although 59% (19) of respondents had been in higher education for 10 year or less, 6% (2) of the respondents had more than 30 years' experience (Table 6.3). The range of experience in higher education was vast, ranging from contract lecturer status to that of vice-rector. The highest level of pharmacy-related, academic qualification, 56% (18) of the respondents, was a doctorate while a further 31% (10) respondents, had a Master's degree (Table 6.4). Forty percent (4) of those with a Master's degree were registered for and working towards a doctorate.

Table 6.4: Highest pharmacy qualifications attained by respondents

ACADEMIC STATUS	BACHELORS	HONOURS	MASTERS	DOCTORATE
Number of Respondents (%)	3 (10%)	1 (3%)	10 (31%)	18 (56%)

Of those respondents with a doctorate (18), only four of them had obtained the doctorate prior to their appointment in higher education, while the majority of them (14) had obtained it after their appointment. While one respondent had taken only two years to complete a doctorate, many had taken approximately six years and one had taken as long as twelve years. Similarly, nine of the 14 respondents with a Master's degree had obtained it after their appointment in higher education. The majority of the respondents, 78% (25), had no academic qualifications in education. One respondent had a Master's in Health Professional Education, while two had postgraduate certificates in higher education and one had a diploma in tertiary education. Three of the respondents had a formal assessor's qualification.

Table 6.5: Highest educational qualifications attained by respondents

ACADEMIC STATUS	NONE	ASSESSORS QUALIFICATION	PGCHE[31]	DTE[32]	MASTERS
Number of Respondents (%)	25 (78%)	3 (10%)	2 (6%)	1 (3%)	1 (3%)

[30] MBL is an abbreviation for a Master's in Business Leadership
[31] Postgraduate Certificate in Higher Education
[32] Diploma in Tertiary Education

Within the higher education environment in South Africa, a doctorate is considered the highest qualification and is desirable in terms of establishing an academic or research career (see Section 3.3.1.1). In the context where only a third of all South African academics have a doctoral degree (Cherry, 2010), it is noteworthy that 58% of the respondents in this phase of the study had a pharmacy-related doctoral degree. A further four respondents were working toward a doctorate. This might suggest that although the majority of the respondents (75%) had less than ten years' experience in higher education, many had the desired qualification basis for developing their academic career. Furthermore, several authors have associated doctoral education and the acquiring of a doctorate with the development of academic identity (Backhouse, 2009; Dison, 2004; Green, 2005; Harrison, 2009), suggesting that the doctoral status of many of these respondents may have contributed to the formation of their academic identity.

However, although the contribution of a doctorate to the development of an academic career and identity is well documented, it is not generally recognised as the basis for the development of teaching skills (Backhouse, 2009). Although 56% of the respondents had a doctorate, only 22% (7) of them had any formal teaching qualifications. This was not unexpected since a lack of formal teaching qualifications and a lack of preparedness for teaching had already emerged and been noted in the first two phases of the study and, furthermore, a previous research study suggested that as little as 5% of academics teaching at three South African universities had any formal teaching qualification (Wadesango & Machingambi, 2011).

6.3.2.1 Attraction to higher education

In order to understand the nature of pharmacy educators better, it is helpful to consider the factors which attracted them into higher education. Based on the responses to the question, "What first attracted you to, or brought you into employment in the higher education environment?" (Q 2.2), these factors can be categorised into five broad categories: including the: nature of the work; work environment; opportunity for career development; human element; and, personal factors. Table 6.6 is a summary of the factors in these five categories.

The single factor that held the greatest attraction to accepting an appointment in higher education was the opportunity to do postgraduate studies, with respondents offering suggestions such as "obtaining a higher degree" (R19: Q2.2), "wanted to further my studies" (R29: Q2.2) and "desire to improve qualifications" (R14: Q2.2). It was also often linked to the ability to fund postgraduate studies: "opportunity to work while doing Master's" (R17: Q2.2),

which explains the inclusion of the financial factor under the category of "personal factors". Considering that 23 of the respondents had obtained either their doctorate or Master's degrees only after their first appointment in higher education, it would follow that postgraduate study may have held a substantial attraction to these respondents.

Table 6.6: Categorisation of factors attracting respondents to higher education

CATEGORY	FACTORS
Nature of the work	Research, teaching, combination of teaching and research, challenging, specific task
Work environment	Working hours, flexibility, academic freedom, dynamic nature, stimulation
Career development	Postgraduate studies, change, frustration with other work environments, invitation, natural or logical progression, professional development, conferences
Human element	People, students, networking
Personal factors	Family commitments, relationships, travel, financial, autonomy

Backhouse (2009) suggested that although internationally there has been a shift in doctoral studies towards course work, in the South African context the doctorate, although considered the primary preparation for an academic career, is for the most part, a research degree (See Section 3.3.1.1). This also needs to be viewed in the context of research having been the most commonly identified factor in the nature of the work category - suggesting that many of the respondents had actually entered higher education with a greater focus and desire to do research than other aspects of academic work such as teaching. However, although research and postgraduate study is often a reason for entering academia, it can provide individuals with the experience of teaching or lecturing, and sometimes even offers them the opportunity to discover or develop a passion for it: "Having lectured part-time during my Master's studies I was exposed to higher education and fell in love with it" (R1: Q2.2) and similarly, "During post-graduate training I was asked to do a few lectures and enjoyed it" (R23: Q2.2). A similar experience was described by Vinetra and Kiron in the first phase of the study, and by some of the focus group participants.

Another factor that was often cited by the respondents as attracting them to higher education was the working hours - "Working hours also seemed to be better, compared to community

pharmacy" (R14: Q2.2). Furthermore, the flexible nature of the working hours was particularly attractive: "The freedom to be able to still put in my hours, but I can do this in the evenings when the children are sleeping" (R2: Q2.2). In light of the increasing feminisation of the pharmacy profession, it is not surprising that with the perceived nature of the flexible work-hours, there appears to be a high representation of females in academic pharmacy (see Section 6.3.1).

The association of working hours with family commitments highlights the co-occurrence of many of the factors across categories. For many of the respondents, their attraction to higher education involved a combination of at least two or more of the categories. For example: for Respondent 2, the perceived nature of the work environment – the flexibility of the work hours – was not only combined with personal factors – needing to spend time with her children, but also with the human element which involved a passion for interacting with people:

> I applied for the job in academia, as I enjoy interacting with people. The interaction with students is a continual joy. The community pharmacy world requires many hours of being in the pharmacy, leaving home at 8 am and standing till 6 pm, as well as working weekends. With a family, these hours were no longer conducive. Academia has given me the freedom to be able to still put in my hours, but I can do this in the evenings when the children are sleeping. This was the main reason, but, since I have been in this position, many other interests have arisen, including our research area into patient care and pharmacy literacy. Being involved in research to benefit the patient in this way is a lot more difficult to achieve when working in the community pharmacy environment 55 hours a week. (R2: Q2.2)

In a similar fashion, another respondent combined several categories together: "The stimulation and freedom to explore my research interests, the academic freedom, the flexible working hours, networking on projects and conducting workshops, presenting at conferences" (R16: Q2.2). Both of these examples also emphasise the perceived potential of the academic lifestyle to permit participation in multiple communities of practice. In the first example the respondent's role as a mother is accommodated by the flexibility of the academic environment. In the second example, the environment is seen as facilitating networking, presenting workshops and attending conferences and implies possible participation in several communities of practice. As Wenger (2000, p. 242) suggested, communities of practice, such as the academic community, that are able to accommodate aspects of the multi-participation of their members in other communities, have a greater

probability of engaging the "whole identity" of members. Furthermore, Wenger uses the specific example of a community member's role as a parent, and suggested that if, within the work community this is accepted, and accommodated, the parent is more likely to put her heart into her work.

The emphasis on flexibility of working hours and the ability to manage one's own time, and pursue one's own interests, in both of the last examples could also be indicative of a desire for autonomy which many respondents perceived was possible in the academic work environment.

6.3.2.2 Priorities within higher education

In order to understand the changing emphasis on trajectories into the academic community, in questions 2.3 and 2.4 the perception of main responsibilities and the shift in priorities from respondents' first appointments in higher education through their academic careers was explored (Q2.3 and Q2.4).

For the majority of the respondents 75% (24), their primary responsibility and focus in their first appointment was teaching and teaching-related activities, such as course development. There was a sense from some of the responses that this teaching responsibility was at times overwhelming and often at the expense of other activities: "teaching, teaching, teaching!!!" (R13: Q2.3), "teaching was my main priority (it took up all my time), my departmental and research roles were small" (R27: Q2.3), "taught a full course subject - teaching load was very tough not enough time for research initially" (R9: Q2.3) and further:

> Teaching has been my main responsibility, and it still is. Research is promoted, but we have to make the time to be able to achieve this aspect of our job description. Most of our time is spent on the teaching side, and the practicals, administration and marking which goes with this role. (R2: Q2.3).

A further three respondents viewed teaching and research as having had a shared primary responsibility in their first appointment, "50% research and 50% teaching" (R19: Q2.3), "research and teaching main priorities" (R10: Q2.3) and "lecturing and research was my main priority" (R6: Q2.3). Three respondents cited research as having been their primary responsibility, "research was initially my only responsibility" (R5: Q2.3), "research was my main priority, part time lecturer and helping with practicals" (R24: Q2.3) and "research, community involvement" (R26: Q2.3). There were, however, three respondents whose primary appointment in higher education had been specifically research focussed. A further respondent suggested that her main responsibility in her first appointment had been

management. However, she moved to academia after 14 years in the pharmaceutical manufacturing industry and her first appointment was specifically to a management position.

Research was the secondary focus for 31% (10) of the respondents, “teaching was my main responsibility; research was secondary, small departmental role” (R16: Q2.3) and “lecturing in first place and then research in second place with little administrative responsibilities” (R31: Q2.3). Although, in a similar manner to the respondents in the last two quotes, 31% (10) of respondents viewed their departmental role, or administration responsibilities as having been the tertiary focus, for 15% (5) of respondents it was their secondary focus, “teaching was my main priority, departmental role was secondary and research was very small” (R30: Q2.3).

Although many of the respondents had accepted a post in academia with the primary intention of acquiring a postgraduate degree, it became obvious from the responses, that in their first appointment, research, including their own postgraduate research, was not a priority. Furthermore, a heavy focus on teaching meant that time was an issue: “teaching became primary and my research was secondary; time featured nowhere” (R29: Q2.3), and that time for research was especially hard fought for, “Research is promoted, but we have to make the time to be able to achieve this aspect of our job description” (R2: Q2.3) and “I used my holidays to collect data and did the write-up after hours as well as over holidays” (R14: Q2.3).

As one respondent explained, over a period of time in an academic appointment there is a natural progression and shift in priorities:

> After teaching courses had been developed and more time was available, a move into increasing levels of research was automatic. The longer one is in a job, the greater the level of involvement in departmental admin. As an associate professor, I co-ordinate year courses and teaching is still a priority, but my involvement in research has increased and I am on more Faculty and University committees; although this involvement is secondary to teaching and research. (R4: Q2.4)

These shifting priorities are often associated with promotion, particularly promotion to management positions, such as head of section, or head of department. This was demonstrated in the following response: “When I was appointed as Head of Department my departmental role and university role became primary, with both teaching and research being very secondary” (R6: Q2.3). I suggest, however, that this experience of a decreased teaching load was not typical because for many respondents, even though their

departmental and management roles increased with promotion, this was often accompanied by an increase in research responsibilities and there was very little change in their teaching priorities: “Teaching and learning are still very important, but gradually I've become more involved in administration: as head of division and as deputy dean. I've also become more involved in research, and supervision of post graduate research” (R3: Q2.4), “Yes, more focus has now been placed on research and postgraduate student supervision. Teaching, however, still plays a major role” (R1: Q2.4) and “The admin work as head of the department was over and above my normal lecture load” (R24: Q2.4). Furthermore, while the administration and departmental responsibilities of 13 respondents increased and ten respondents reported an increase in their research responsibilities, 13 respondents stated that teaching had remained a priority and only five respondents recognised a decrease in their teaching responsibilities. It is understandable; therefore, that eight of the respondents viewed their shift in priorities as having been accompanied by an increase in workload:

> As senior lecturer and course coordinator (BPharm), my departmental role with respect to the BPharm programme became my primary priority, although my teaching remained heavy. Research was a secondary priority. I managed to complete my PhD by working night in and night out. Currently my primary priority is teaching at post-graduate level, together with departmental responsibilities. Personal research is a secondary priority, due to teaching and admin workload. (R14: Q2.4)

6.3.2.3 Rewards and challenges of higher education

As Akerlind and McAlpine (2010) suggest, academic identity and the meaning an individual attributes to it is influenced by the manner in which one values, motivates and perceives both the rewards and challenges of academic work, and by the underlying positive and negative emotions associated with it. For this reason the questionnaire was used to explore with respondents both the positive aspects and the perceived difficulties of working in higher education. The positive factors and the difficulties identified can be categorised into five themes, namely factors relating to: working with students; teaching; research; the environment; and those of a personal nature (Table 6.7).

From the responses it would appear that many of the respondents’ sense of value is associated with the manner in which they perceive themselves as being able to contribute to the pharmacy profession, through the development of future professionals. Although research and the opportunity to do postgraduate studies were major factors that had attracted many of the respondents into higher education and the opportunities for personal

growth within higher education were considered as positive, the opportunity to nurture students and develop new professionals was the aspect of working in higher education that was most commonly identified as being rewarding.

Table 6.7: Rewards and challenges of higher education

CATEGORY	FACTORS	
	REWARDS	**CHALLENGES**
Human element	Student development Feedback from students Enthusiasm of students Postgraduate students Enthusiasm of colleagues	Student management Staff politics
Teaching	Interaction with students Opportunities for personal learning and growth through teaching Satisfaction	Teaching load Under-preparedness of students Large classes Lack of training Student management
Research	International networking Conferences Innovation Freedom to pursue personal research interests	Pressure of outputs Lack of resources – time and funding
Work environment	Dynamic nature Interesting challenges Stimulating Academic freedom Supportive colleagues Nurturing Flexible working hours	Structure and bureaucracy Restructuring and merger process Intuitional politics Management leadership style, expectations, lack of recognition Staff shortages Workload Tension – balancing academic elements
Personal factors	Personal satisfaction Personal growth Autonomy Opportunities for creativity Academic freedom Change agent Professional recognition Travel opportunities	Time Salary Demographics Lack of postgraduate qualification Lack of mentoring Lack of career path Lack of recognition

Respondents expressed a sense of fulfilment and felt rewarded for having been involved in the professional development of students; furthermore, many of them valued student feedback and appreciation:

> Fulfilment of seeing students achieve as a result of your input into their development. (R1: Q2.5)
>
> I always feel great when we get emailed, or approached at conferences, and thanked personally for what we taught our past students. It is lovely to nurture a student through their four years of studies, and see them grow and develop, and finally go out there as a leader". (R2: Q2.5)
>
> The fulfilment that I receive from watching the students mature into young professionals is an indescribable and beautiful feeling. Just to know that I may have contributed to that makes it worthwhile. (R30: Q2.5)

It is possible that some of the respondents began their own pharmacy studies with a perceived 'calling' to pharmacy, a healthcare profession and thus by nature a caring profession. Therefore, it is not unexpected that finding themselves in a university with teaching as their primary role, much of their satisfaction was found in contributing to the nurturing and developing of students into future pharmacists. This would certainly be an aspect of what Popovich (1991) described as "educational care" - a concept analogous with pharmaceutical care (see Section 2.4.7).

There was also a sense for some that by being in pharmacy education they were still albeit indirectly, contributing to societal healthcare needs: "The positive aspects of this job are knowing that one is addressing the need of producing a scarce skill, addressing the health care needs of our society" (R32: Q2.5). Beyond the perceived contribution to the pharmacy profession, many respondents found teaching satisfying and enjoyed their interactions with the students: "Being able to be exposed to the enthusiasm of young pharmacy students"; "enjoyment of teaching" (R9: Q2.5); and, "interaction with students, teaching them" (R20: Q2.5).

However, difficulties with teaching were also identified and included factors such as: "big classes" (R13: Q2.6); "increasing numbers of under-prepared students" (R17: Q2.6); "large student numbers" (R23: Q2.6).

A lack of formal training or qualification in education, highlighted in Section 6.3.2, was also identified by some as a challenge:

> Having to teach when I am not trained as a teacher ... In addition, teaching is

> not a passion of mine and it wasn't what attracted me in the first place. So doing justice to the content and subject (which I like) and doing it in a way that is stimulating for the students was, and continues to be, an area of improvement. (R27: Q2.5)

The lack of formal training in education was also linked to a "lack of mentorship programmes" (R16: Q2.5), which was not surprising since teaching skills are often learnt "on the job" and mentoring would be perceived as beneficial to the process (Kreber, 2010). The greatest issues with teaching, however, were issues of workload. As highlighted in the previous section, many respondents found the teaching load overwhelming and contributed to workload issues being one of the concerns most commonly expressed by respondents:

> The constant stress of never feeling that you are at the end of a job … The feeling that there is always SO MUCH [sic] to do. (R4: Q2.6)

> Being consumed by work - work can easily take over your life as there is always more to do. (R11: Q2.6)

> The workload is overwhelming, which leaves me feeling despondent at times. (R30: Q2.6)

The workload issue was at the source of several tensions for the respondents, including tensions between: work and personal life – "the difficulty of being able to go away and not do anything connected with work as it follows you around everywhere if you have postgrads" (R4: Q2.6); teaching and research – "the teaching workload does not allow for much time to develop as a researcher and I have come to recognise that this area should not be neglected. I wish that I had the time to encourage my research needs" (R30: Q2.6); teaching and personal development – "finding the balance between what needs to be done for the students and the department and for my career development" (R11: Q2.6). Furthermore workload issues were also viewed as impacting negatively on the ability to work effectively, "work load can sometimes be stifling and could impact on time to think creatively and strategically" (R31: Q2.6). These tensions illustrate the complexity of the academic role, which involves a combination of responsibilities and priorities and as suggested by one of the respondents, expectations:

> The lack of acknowledgement from university authorities of a job well done, as opposed to always being harangued about taking on more postgrads,

> increasing numbers of undergrads, improving pass rates, ensuring that students from disadvantaged backgrounds get the necessary support without the university actually helping one to provide it, is a problem. (R4: Q2.6)

The responses also suggested that time was given to teaching and administrative tasks rather than being protected for research, despite a perception that research was expected and academic success was measured by research outputs: “Staff shortages and work overload result in limited time for publications, which is unfortunate, as the success of an academic is determined by the number of publication he/she has” (R14: Q2.6).

Other factors which were cited as difficulties within the work environment and which may have impacted negatively on respondents’ personal sense of wellbeing included: bureaucratic and hierarchical structures - “bureaucracy and slow administrative process, changes cannot be made immediately. Autocratic style of leadership – too many hierarchical barriers” (R16: Q2.6); lack of recognition – “I am a pharmacist with a few years work experience, however, it has strangely been hard work to earn the “trust” from some of the academic staff” (R21: Q2.6); and poor salaries and opportunities for promotion – “Failure of management to recognise the scarcity of our skills and therefore failing to reward us appropriately in terms of salaries and promotion” (R1: Q2:6). It is understandable that issues such as these would have been difficult for healthcare professionals who ordinarily would have been accustomed to professional status and recognition, reasonable remuneration and promotion opportunities outside of the university environment, and who would have been expected to make autonomous and often quick decisions. It is also possible that such experiences of the workplace could impact negatively on pharmacy educators’ willingness to adopt academic identities and to relinquish practitioner-related identities and recognition (Smith & Boyd, 2012).

6.3.2.4 Utilisation of personal and professional strengths in the higher education environment

The centrality of authenticity or integrity to the development of academic and particularly teacher identities was discussed in Sections 2.4.7 and 3.3.1.2. Authenticity has been defined as a “sense of self” that involves “being genuine, showing consistency between values and actions” (Cranton & Carusetta, 2004, p. 7), while integrity can be thought of as that which an individual perceives as being integral to selfhood (Palmer, 1997). In order to explore the extent to which opportunities for authenticity and integrity existed for the respondents within the higher education environment, respondents were asked how their personal and

professional strengths had been utilised, since an individual's perception of their strengths provides an indication of their perception of what is integral to their sense of self. Furthermore, as Gibson, Dollarhide, and Moss (2010) propose, the development of professional identity is both intra- and interpersonal and involves both personal and professional attributes, both of which need to be understood in order to comprehend the process.

The personal strengths identified by respondents as being utilised within the higher education environment can be classified as attributes and skills. The category of skills most commonly alluded to were interpersonal skills:

> I have been able to develop my interpersonal communication skills with the students and other staff members. (R2: Q2.7)
>
> I interact well with other people and this has helped in dealing with students and colleagues. (R4: Q2.7)
>
> I enjoy being relational and feel that I have been able to engage with all staff regardless of the personality differences. (R18: Q2.7)
>
> I believe that I am approachable. I enjoy being able to relate to the students in a manner that hopefully enables them to feel comfortable about approaching me when they are struggling to grasp the contents of the work. In my opinion, I am diplomatic and am content to reach a compromise with staff and students. This is important when one is working in a team situation. (R30: Q2.7)

This last response also suggests some of the many attributes such as "approachable" and "diplomatic" that were mentioned, and can be considered to directly support interpersonal skills. Other similar attributes named include: "patience" (R6: Q2.7); "good listener and motivator" (R13: Q2.7); "respect, integrity, patience, listening skills, humility" (R16: Q2.7); and "affable" (R27: Q2.7).

Some of the other personal skills identified by respondents included the ability to: "meet deadlines" (R1: Q2.7); give attention to details – "logical perfectionist" (R10: Q2.7) and "meticulous" (R4: Q2.7); "simplify complex and/or abstract concepts" (R23: Q2.7); "work independently (R8: Q2.7); "hard working and organised" (R11: Q2.7). The value of all of these to both research and teaching aspects of work in higher education is understandable.

The professional attributes which respondents considered to be utilised in the higher education environment were largely related to their practice experience and included: “clinical skills” (R5: Q2.8); “knowledge of industry” (R6: Q2.8); “medicine distribution” (R7: Q2.8); “ability to teach more practically” (R30: Q2.8); “contacts” (R15: Q2.8); and “organisational skills” (R23: Q2.8). Attributes relating to professional knowledge were also identified and included: subject “knowledge” (R25: Q2.8); “knowledge of the profession” (R18: Q2.8); and lifelong learning skills – “continuous learning and improvement of knowledge” (R14: Q2.8). Professional standing was another area in which professional attributes were identified and included: expert status – “recognition by the MCC as an expert” (R24: Q2.8); and “involvement in professional bodies” (R19: Q2.8). Other professional attributes that were identified, which might be related to personal attributes, included: “strong ethical foundation” (R1: Q2.8); “ability to think analytically” (R31: Q2.8); and “research” skills (R26: Q2.8).

These professional attributes identified all related directly to both their past and on-going experiences as pharmacy practitioners and also their status and standing within the pharmacy profession. This would suggest that for many of the respondents, their professional identity as pharmacists was integral to their perceived selfhood and authenticity as pharmacy educators.

6.3.2.5 Perceived role within the wider university

Respondents perceived their roles within the wider university as ranging from minimal to active and fully engaged. Responses from those who perceived themselves as minimally involved included comments such as:

> I feel that I am at the bottom of the food chain in the broader university community as I do not have a PhD. (R2: Q3.3)
>
> I am a bit of an island that doesn’t play a role in the wider university (R13: Q3.3)
>
> Somewhat detached (R16: Q3.3)
>
> Minor – I feel like academics have a stronghold of administration over them and are unable to really reach their full potential because of the amount of red tape and committees that they have to get through to achieve anything. I can be a voice on some of those committees, but am not convinced that the idea’s or comments reach the higher authorities of the University. (R18: Q3.3)

> Very minor or negligible (R29: Q3.3)

However, it needs to be noted that all of these responses came from respondents who had been in the higher education environment less than ten years, and it is possible that with time their role within the wider university will both develop and become more evident to them. In Section 6.3.2.2 it was noted how with promotion, particularly promotion to management positions, such as head of section, or head of department, there was a shift in priorities for respondents, with departmental and wider university priorities becoming far more prominent. The comment from Respondent 2 also highlighted the emphasis that is apparently placed upon the doctorate within the university environment, and lack of status within the university that comes from not having it. A further respondent felt that within the wider university she was "not recognised as professional" (R8: Q3.3). This would suggest that for her, professionalism would be key determinant of her professional identity, and since she did not believe that her professional status was acknowledged within the university environment, it might have had consequences for her sense of self as a professional.

A further group of respondents viewed their role within the wider university as being directly related to their status as pharmacists, to the teaching of pharmacy students and to the promotion of the pharmacy discipline within the wider university:

> Hard-working member of pharmacy department, not going to lead the department, reliable, good support person. Contributes to a number of committees. (R4: Q3.3)

> As chairman and head of department of pharmacy and pharmacology, I make sure that pharmacy is not left out in any major decisions in the faculty and university. (R6: Q3.3)

> Specialist in pharmacy (R10: Q3.3)

> Compared to medicine, pharmacy unfortunately never gets the recognition they deserve. I see my main focus thus within the pharmacy department, aiming to strengthen the department. (R14: Q3.3)

> Contribute to the education of future pharmacists and facilitating personal growth for people. (R19: Q3.3)

> There is a great demand for health care professionals, so I believe that the Department of Pharmacy is an integral part of the university's course

> offerings. As a department, we can promote school learners to consider Pharmacy as a career choice and encourage awareness. (R30: Q3.3)

This suggests that these respondents have found their place within the wider university; that is university communities of practice, outside of the pharmacy department. However, their participation in these communities of practice is directly related to and dependent upon their identity as pharmacists and identification with the pharmacy profession.

There were also a group of respondents who had found their academic voice and consequently their place within the broader university:

> As an engaged member of academe, and as a public intellectual. (R5: Q3.3)

> As I begin to sit on more committees I believe that I am taken seriously and am contributing. (R9)

> As the faculty representative for community engagement. (R15: Q3.3)

> Contribute towards the expertise within HE (R22: Q3.3)

> One of leadership and management of academic activities, staff and other resources. (R31: Q3.3)

Furthermore, this indicates that they had adopted an academic identity, which had not only given them a sense of 'who' they were - "an engaged member of academe", but also a sense of agency, an understanding of their ability to "contribute" to the university community.

One of the responses however captured the tensions for pharmacy educators, that like those recognised in the first two phases of the study centred around balancing their academic identities with their identities as pharmacists:

> I serve on numerous committees that do not relate at all to the profession of pharmacy (such as ethics committees etc.). I therefore feel that I participate and contribute to these structures despite me not have any formal training in these fields. (R1: Q3.3)

This respondent stated that although he contributed to the wider university in various ways, these were not related to his pharmacy knowledge or his status as a pharmacist, and was perhaps suggesting that he was not adequately trained or qualified for the work of higher education. Without formal training in education, it is conceivable that one can feel inadequate in making high level decisions relating to educational issues.

6.3.3 Participation in multiple communities of practice

Beyond their participation within university-based communities of practice, respondents were involved in a diverse range of pharmacy-related activities or professional organisations outside of the university environment. This included involvement in various capacities in a varied range of national and local pharmacy, and pharmacy-related organisations, including the: South African Pharmacy Council; Pharmaceutical Society of South Africa; Academy of Pharmaceutical Sciences; South African Association of Hospital and Institutional Pharmacists; South African Society of Clinical Pharmacy; Medicines Control Council; Medicines Research Council; Department of Health: South African HIV Clinician's Society. Participation in and contribution to the various organisations varied, for example involvement with the South African Pharmacy Council included: facilitating training workshops for interns (R7: Q2.9); "assessment of intern portfolios" (R14: Q2.9); serving as an "elected member" (R31: Q2.9); serving as an "invited member" of a committee (R31: Q2.9); and, serving on a university audit team (R3). Some of the respondents were also involved in international communities of practice. However, this involvement was generally research related and included: "FIP[33]" (R4: Q2.9); "ISPOR[34]" (R8: Q2.9); "member of the Cochrane Collaboration[35]" (R16: Q2.9); "WHO[36]" (R19: Q2.9).

Participation in these various organisations influenced both teaching and research aspects of respondents' work in higher education:

> It keeps me abreast of the latest developments in research and education in South Africa. (R1: Q2.9)

> Involvement in professional organisations such as ISPOR keeps my teaching and research relevant (R8: Q2.9)

> Member of the Cochrane Collaboration - review assists in critical analyses of clinical trials - assists teaching a research module. (R16: Q2.9)

One respondent also suggested that it enhanced her "understanding of healthcare in South Africa" (R11: Q2.9), while a further respondent recognised the opportunities for "community engagement" (R15: Q2.9) that it provided. A respondent who was in various leadership and management positions within and outside of the university environment understood her

[33] International Pharmaceutical Federation
[34] International Society for Pharmacoeconomics and Outcomes Research
[35] An international not-for-profit organisation preparing, maintaining and promoting the accessibility of systematic reviews of the effects of health care
[36] World Health Organisation

multiple community participation as central to her ability to perform in these additional roles: “Influence of vital importance on execution of task as Head of Pharmacy education at SAPC (4 years) and Head of Pharmacy School as well as Dean of Health Sciences” (R31: Q2.9).

Many of the respondents, 41% (13), did locum work in community or hospital pharmacies, and although the most common reason offered for doing so was “keeps my teaching relevant” (R8: Q2.9), responses suggested that there were also a variety of other reasons for doing so:

> Helps me highlight real world problems within the profession to provide relevant case studies in my teaching. (R1: Q2.9)
>
> Both for my own pocket as well as for the chance to stay up to date. I try each year to work for a 2 week block as this gives time to meet up with the representatives, and see what new medicines are now registered. (R2: Q2.9)
>
> Enhances my knowledge and helps me link with practice. (R11: Q2.9)
>
> Sensitises me to the problems of the community and the pharmacists in practice. (R13: Q2.9)
>
> Helps with continued professional development and makes it easier for me to relate to and teach the students. (R21: Q2.9)
>
> It keeps me in touch with new products and delivery systems. (R27: Q2.9)
>
> The exposure one gets by continuously being exposed to patients ensures that one presents material that is relevant to current practice, one is able to also identify disease trends in our local communities (R32: Q2.9)

Respondents therefore suggested that locum work helped them access current knowledge of practice, the practice environment and products. Furthermore, it informed their teaching and kept them in touch with the pharmacy profession and the communities they served. This would suggest that they viewed their professional experience as pharmacists as influential and beneficial to their role as educators.

6.3.4 Perceived roles within the broader pharmacy profession

Many of the participants, 56% (18), viewed their role in the broader pharmacy profession as being directly related to their role as educators of future pharmacists. This is typified in the following comments:

> I perceive my role within the profession to be important in that I influence many more pharmacists than most other pharmacists would. It is an extremely important role that comes with a lot of responsibility to ensure that the professionals I develop are competent and become important role players in the profession. (R1: Q3.4)

> I believe that academics mould future pharmacists and are critical to the future of pharmacy. When I participate in activities outside of the university I begin to see value in what we do. (R9: Q3.4)

> To be responsible for producing graduates who are professional, knowledgeable about pharmacy-related matters and who have a strong sense of civic responsibility. (R15: Q3.4)

A small group of respondents, 16% (5), also saw contributing to the pharmacy research domain as their role, through their own research as well as the training of postgraduate students in research:

> Someone who's a leader in research (R8)

> As an academic my future role will be in post-graduate training and the development of post-graduate programmes. (R14)

> Through research I would like to make more of a contribution towards policy change that will expand the scope and significance of pharmacists in the community. (R23)

In summary both of these groups of respondents viewed their status within the profession and their contribution to the profession as being directly related to the teaching or the research aspects of being an academic. Furthermore, in line with their standing as academics, a further group of respondents viewed themselves as being a valuable source of knowledge to practicing pharmacists:

> Need to contribute to knowledge and enhancing knowledge in the pharmacy profession - supporting initiatives in practice where my experience can be useful. (R11)

> Lecturers are perceived as role-models to practicing professionals in terms of providing information. Thus, we are approached to tackle drug-related queries. However, there is a stereotypical view that academics are not practice-based and

> that their theoretical thinking limits problem solving abilities in the corporate or industrial sectors. This view may be overturned if more academics get involved in practicing in the aforementioned sectors. (R30)

This last comment reinforces and explains the need already expressed by some respondents, to keep their practice knowledge current and relevant as evidenced by the number of respondents who were doing locum work (see Section 6.3.3).

Some respondents even viewed themselves as being leaders within the profession or as ambassadors for the profession:

> As a leader and innovator, and as a public voice for the profession. (R5)

> I am an ambassador for pharmacy. (R13)

> Hopefully as a leader/worker towards a better and more empowered profession (R28)

> I am a pharmacist regardless of the sector I work in, thus anything that affects the profession affects me and what I do in public affects the image of the profession. It's my role then to promote pharmacy as a good profession and to exemplify how professional pharmacists should be. (R27)

In this last comment the respondent recognises that despite working in the academic field, she is a pharmacist. This would suggest that her primary professional identity is as a pharmacist and as such she has an on-going responsibility to maintain the professional image of pharmacy.

6.3.5 Self-perceived professional identity of respondents

In order to determine how pharmacy educators "self-label" themselves professionally, respondents were asked to stipulate what they normally write when they complete a form that asks for a respondent's occupation (Q3.1). Much like the self-perceived identities described in the first two phases of this study, the responses lay on a continuum between academic on the one side and pharmacist on the other and there were twelve different responses to this question

Twenty-three (72%) of the respondents included the term pharmacist or pharmacy in their descriptions of themselves, while 18 (56%) of the respondents included some reference to their academic identity, for example: lecturer, senior lecturer, or academic. The distribution of these self-labelled identities is represented on the continuum between pharmacist and

academic identities as suggested in the first phase of the study and described in Section 5.11.1.1 (Figure 6.2).

Ten (31%) of the respondents identified themselves as pharmacists only, while six (19%) of the respondents included only an academic descriptor (such as academic, lecturer, researcher) in their self-identification. Sixteen (50%) respondents included both a pharmacist and academic descriptor in their response, for example: “academic pharmacist” (R1); “lecturer and pharmacist” (R3); “professor and pharmacist” (R19); and “academic manager/pharmacist”.

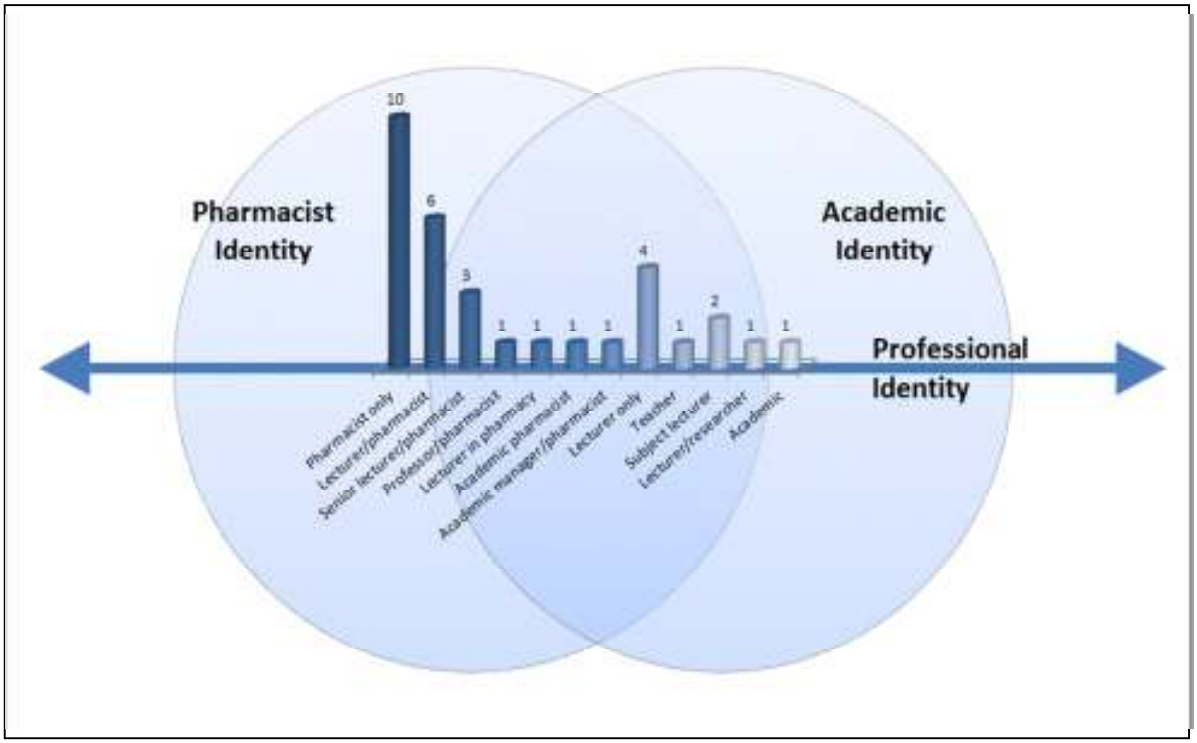

Figure 6.2: Distribution of Phase three respondents’ identities on the professional identity continuum

This supports the notion proposed in the first two phases of the study, that the professional identity of pharmacy educators lies on a continuum and that there are educators who view themselves predominantly as pharmacists, while there are others who view themselves primarily as academics.

In the context of postgraduate studies and, in particular doctoral studies being recognised as “leading to an academic career” (Backhouse, 2009, p. 102), and the fact that postgraduate study was the most commonly cited factor for attraction of the respondents into higher

education (Section 6.3.2.1), it is conceivable that respondents might have very readily identified themselves as academics. However, considering that the opportunity to contribute to the pharmacy profession through the nurturing of students into new professionals was the aspect of working in higher education that was most commonly identified as being positive (Section 6.3.2.3), it is also of little surprise that so many educators still retained "pharmacist" as an aspect of their identity. This is further supported by the fact that the professional attributes, that participants considered to be most utilised within the higher education environment, related directly to their experience as pharmacy practitioners and not as academics. Furthermore, the role of respondents within the wider university was also often associated with their identity as pharmacists (Section 6.3.2.5). Conversely, however, many of the respondents viewed their role within the broader pharmacy profession to be related to their academic role, particularly their role as educators (Section 6.3.4). This diametric description of identity also reinforces the notion of identity as both contextual and fluid.

In order to explore further the tensions which might have existed for respondents in balancing these two aspects of their professional identity, they were asked if they had noted any hesitations in labelling their identity, and to describe the nature of their struggle in this. Twenty-one of the respondents had no hesitations while approximately a third of the respondents (11), suggested that they did. The nature of the dilemma and the tension experienced is encapsulated in the following response:

> Yes. I often try to decide between pharmacist, lecturer or academic pharmacist. The first two don't accurately describe my true functions, while the third does encompass most of what I do. The dilemma is that I struggle to identify as an academic exclusively or a pharmacist exclusively. I also find it difficult to relate to other pharmacist colleagues that I trained with as their roles are significantly different from mine. (R1: Q3.2)

Many of the others, who shared the dilemma, also struggled to identify themselves exclusively as a pharmacist or an academic, and preferred to include a dimension of both aspects in their self-label. It is also of interest to note that a further five respondents who related that they did not hesitate in the naming of their occupation reported routinely including both aspects in their self-label.

One of the respondents related that how she identified herself is contextual and "depends on who is asking" (R4: Q3.2). A further participant described the desire to always want to include a pharmacist aspect in the label but "links occupation to place of employment" (R11:

Q3.2). Other respondents were also specifically concerned about retaining a pharmacist aspect to their identity as academics, because they primarily perceived themselves to be pharmacists, such as the following responses suggest:

> Yes, I often hesitate between responding `pharmacist` or `lecturer`, mostly because I think of myself as a pharmacist firstly and a lecturer secondly. Probably because I have spent more time working as a pharmacist than as a lecturer. (R15: Q3.2)

> I have hesitated between writing 'pharmacist' and 'lecturer'. I perceive myself to be a pharmacist who happens to lecture, however, if I mention that I lecture, then that's the occupation I am asked to write. I don't see why my occupation should be written differently to an industrial pharmacist, we are both pharmacists, just working in different sectors. (R27: Q3.2)

> Yes, Senior Lecturer. Reasons: short exposure to new appointment - I am mainly a pharmacist and I am appointed for my experience within this. (R22: Q3.2)

> Day-to-day activity is management in an academic environment while my profession will always be that of a pharmacist. (R31: Q3.2)

Although the reluctance of some, such as Respondent 22 (penultimate comment above), to relinquish their identity as pharmacist can be related to the short period of time spent in higher education (1 year in higher education and 16 years as a registered pharmacist), this is not always true. The last comment above was made by a respondent who has been registered as a pharmacist for 38 years, and 36 of those have been spent in higher education. Furthermore, she has served in various capacities including senior university management.

Thus, for many educators their identity as pharmacists is integral to their role and identity as academics; and their struggle to retain the pharmacist aspect of their identity in self-labelling leaves them with a dilemma in terms of what they call themselves professionally. It again leads me to question whether the use of a unifying term such as 'academic pharmacist' suggested by one of the participants in the focus groups would not assist pharmacy educators to better integrate all aspects of their identity.

As a further means of exploring the professional identity of the respondents, they were asked to describe how they viewed themselves as pharmacy educators in terms of a metaphor (Q3.5). The use of metaphors as a means to explore self-perceptions of professional identity was previously discussed in Section 4.3.1.3.1. Furthermore, Thomas and Beauchamp (2011) suggest that asking educators to describe their professional image of themselves in terms of a metaphor, can provide an opportunity for a personal and profound means of considering professional identities.

Many respondents (11) declined to answer this question, one of them suggesting that they were “not creative when it comes to language”. Fifteen respondents did offer metaphors, while a further four provided slogans or sayings. The metaphors provided by the respondents can be categorised into four different themes, namely those that relate to their role in relationship to: students; the educational process; the pharmacy profession; their personal experience. Some of the metaphors used to describe their relationship to students included:

> I'd like to think of myself as someone who 'moulds' young pharmacists. (R1: Q3.5)
>
> Pointing the way on a map. (R5: Q3.5)
>
> I am the light the students use to discover knowledge and to show them the way to lifelong learning. (R14: Q3.5)
>
> Cook book with great pictures – I provide the guidance and inspiration, but students still have to do it for themselves. (R17: Q3.5)
>
> I can liken my participation as an educator to baking. The students are the ingredients and the educator is the pastry chef. All the ingredients are equally important; however, the manner in which they are handled will differ. Some ingredients, like pastry, need to be carefully moulded and others, like, piping decorations that are artistically drawn onto a cake, require more time and work. On the other hand, simple ingredients, like nuts being sprinkled onto the top of a cake, are easy to handle and provide their own flavour without much work on the chef’s part. Regardless of the type of ingredient that is being encountered, an excellent pastry chef will be able to handle all of them with the appropriate level of input, so that the final result is an excellent representation of what has gone into making it. (R30: Q3.5)

In each of these metaphors the respondent is making a direct link between their identity as an educator and their role in relationship to their students. This might suggest that for the respondents their relationship with students is an integral part of their professional identity. In the first of these metaphors above, the person (R1) who viewed himself as "moulding" students, is possibly alluding to the process of socialising students into the profession. This notion is also particularly evident in the "cookbook" metaphor, in that the respondent (R17) specifically emphasised the pictorial aspect, suggesting that not only is the required knowledge provided but furthermore there are "great pictures" which provide an image of the desired outcome. In addition she described her role as providing "guidance and inspiration". This would suggest that integral to her professional identity as an educator was her concept of herself as a "role model" for the students. In the "baking" metaphor the respondent (R30) goes to great lengths to explain how she viewed each of the students – the "ingredients" as unique individuals requiring a distinctive and sensitive approach by her - the "chef" – to yield the final product. This metaphor suggests that integral to her concept of herself as professional is her ability to bring out the best in each of her students. In addition, she suggested that the process which she employed to do so, was itself an important aspect of producing the final product.

The second group of metaphors bore similarities to the first but appeared to refer more to the manner in which respondents related their identity to the general education process than to the students specifically. They included metaphors such as:

> I am a facilitator of learning. (R3: Q3.5)
>
> Change agent. (R16: Q3.5)
>
> Leader-learner. (R22: Q3.5)
>
> Used to see myself as a translator of developments in health care and the profession into what competence and thus education is required for pharmacists to render a useful and competitive service to the community. (R31: Q3.5)

In the second metaphor, "change agent", the respondent highlights the potential education has in bringing about change and, furthermore, the importance she placed on her ability to facilitate change. In the third metaphor, "leader-learner", the respondent (R16) is perhaps

drawing attention to the concept of education as a shared learning experience, in which he viewed himself as both leading in and learning from others. The metaphor of “translator” is possibly a reference to the way in which the respondent (R31) viewed her responsibility as an educator to meets the needs of society, through the “translation” of these needs into relevant and appropriate education solutions. This metaphor could also be viewed as falling within the third category, since it also describes the manner in which she viewed herself in relation to the profession.

There was only one other metaphor offered in the category that described self-perception in relation to the pharmacy profession:

> Often feel like we are on the outside looking in at the profession - academia is perceived as not part of the real world of pharmacy. Perhaps watching everyone play but we are sitting on the fence, hoping to be invited to join the game. (R11: Q3.5)

In this metaphor, by describing pharmacy educators as “sitting on the fence” the respondent (R11) is apparently describing the tension between balancing the two aspects of identity – namely the academic and the pharmacist aspect. It suggests that she still identified herself very closely with the pharmacy profession, and yet there is a sense as an academic that she was not actually practicing pharmacy; not quite in the “game”. This might explain why she and others “locum in hospital pharmacy” (R11: Q2.9), which she perceived to “help me link with practice” (R11: Q2.9).

The last set of metaphors offered, relate respondents perceptions of themselves to their experiences of higher education:

> Work Horse. (R6: Q3.5)

> A rollercoaster ride – many ups and downs - at times things move along speedily and at other times it’s like crawling to the top of the ramp. (R18)

> Reluctant hero. (R27: Q3.5)

> Another fish in a pond. The opportunities, possibilities and resources to students are endless. It is up to them to choose whether they would like me to fit in their professional development. (R29: Q3.5)

A work-horse is defined as “something, such as a machine, that performs dependably under heavy or prolonged use” or, more informally, as “a person who works tirelessly, especially at difficult or time-consuming tasks” (The Free Dictionary, 2012). By using the metaphor “work-horse”, the respondent (R6) is possibly alluding to his perception that the workload expected of pharmacy educators was sometime large and relentless, which was previously cited by several respondents as one of the challenges of the higher education environment (see Section 6.3.2.3).

In the second metaphor - “rollercoaster ride” – the respondent (R18) is making reference to the “highs and lows” of academic life. Her description of “crawling to the top of the ramp” evokes a similar image to the “work-horse” aspect of academia. However, she also recognised that there were high, fast moments.

The “reluctant hero” is a heroic archetype described in a novel by Joseph Conrad and typically refers to “an ordinary person thrust into extraordinary circumstances which require him [sic] to rise to heroism” (Wikipedia, 2012). The offering of this metaphor by respondent (R27), is possibly making reference to the elevated status which the pharmacy profession often affords pharmacy educators, and of which Vinetra spoke in the first phase of the study (see Section 5.3.1.1). Similarly to Vinetra, it could suggest that the respondent viewed herself as an “ordinary” person and was not comfortable with an elevated status. The last metaphor in this category “another fish in a pond” also suggests that the respondent (R29) did not view herself as anything special – she was simply another resource available to students in their professional development.

These metaphors further suggest that the professional identities of pharmacy educators are varied and often complex. In addition they provided particular insights into how some educators viewed themselves in relation to their students and their experience of the educational process.

6.3.6 Academic pharmacy as a speciality

The complex nature of pharmacy educators’ identities revealed in the first two phases of this study, and in particular the tension that exists in trying to balance professional identity as a pharmacist with academic identity, led to questioning whether the recognition of ‘academic pharmacy’ as a speciality by the South African Pharmacy Council would not be of benefit to pharmacy educators.

In a presentation to the South African Society of Clinical Pharmacists, Lorraine Osman, the Vice President of the South African Council, suggested that the goals of introduction of pharmacy specialities, included recognising that expertise or specialities in pharmacy exist, and, furthermore, that they would also serve to create a career framework and move the profession forward (Osman, 2011). In addition, she suggested that a speciality is based on: advanced knowledge in the field of specialisation; advanced practical experience in the field of specialisation; the requirement of a pharmacy-related postgraduate degree; and must be needs-driven (Osman, 2011). All of these conditions suggested by Osman as relating to specialities appear to also be relevant to academic pharmacy.

Respondents were therefore asked whether they thought academic pharmacy should be recognised as a speciality by the South African Pharmacy Council and to motivate their responses (Q3.6). The majority of respondents, 75% (24), believed that it should, 6% (2) were uncertain, and 19% (6) respondents believed that it was not necessary. Those who believed that it should be recognised as a speciality suggested various reasons for this including: the requirements for specialist knowledge and postgraduate qualification; the potential to create an attractive career path and the fact that it was needs-driven. These needs and factors are further illustrated in some of the following responses:

> Yes. However, simply having a postgraduate qualification should not entitle one to be a specialist academic pharmacist. Those wishing to specialise should obtain a higher qualification in their field (i.e. MSc or PhD) AND have a qualification in teaching and learning in higher education (such as a PGCHE or HDE). This would ensure that more academic pharmacists pursue these qualifications in order to improve their skill as teachers. Offering a specialisation would also encourage potential academics to take up a position as an academic pharmacist in order to address the huge skills shortage we currently have in academic pharmacy at the moment. (R1: Q3.6)

> Yes, absolutely. Some people still think of academia as `those who can - do, and those who can't - teach` Nothing could be further from the truth. Academic Pharmacy is challenging and exciting and we should attract people who WANT to be in academia. (R3: Q3.6)

> Yes, if you obtain a PhD it means you are a specialist - so why not register as such? (R8: Q3.6)

> Most certainly - the profession already respects academics. However universities and the SAPC should look at ways to attract and keep pharmacists in academia. (R9: Q3.6)
>
> Yes. Academic pharmacists are specialists in their area of teaching. They are also responsible for the training of specialist pharmacists. (R14: Q3.6)
>
> Yes. The Academic Pharmacist wears many different 'caps'. Not only must the Academic Pharmacist have a degree in pharmacy, they also have to have the skill and in-depth knowledge to teach as a lecturer. They have the responsibility to train all the future pharmacists! (R21: Q3.6)

As demonstrated by the first response above, (R1), some felt that registration as a specialist academic pharmacist should, in addition to a pharmacy-related postgraduate degree, also require a formal qualification in education. The requirement of a formal qualification in education would also add weight to the notion that academic pharmacy requires a level of specialised study in the field of practice. Since the practice of academic pharmacists is education, a formal qualification in education should be required. Furthermore, this respondent believed that such a requirement would encourage pharmacy educators to take the need to develop their educational skills more seriously. As was previously suggested (see Sections 6.3.2 and 6.3.2.3) a lack of formal training in education had left some of the respondents feeling under-prepared for teaching.

The second and fourth comments, (R3 and R90), relate to the continual shortage of pharmacists in academia and the difficulty in attracting and retaining them in academia. The sense from these and other responses is that by creating a clearly definable and attractive career path, more pharmacists might be willing to make the move into academia.

The last two responses, (R14 and R21), refer to the manner in which academic pharmacy meets a need within society. There is a constant need to graduate increasing numbers of pharmacists to meet society's needs for pharmaceutical services at all levels, and see that it is the task of pharmacy educators to meet this need.

The responses also provided further insights in the respondents' perceptions of themselves as professionals. A notion that was commonly suggested was that of academic pharmacists as specialists (28%). For some this was related to the requirement for a postgraduate

qualification, whilst others related it to specialist experience and knowledge in education. Yet others, as illustrated by the last response cited above, made reference to the multi-faceted nature of pharmacy educators – "wear many different caps" (R21). The perception of the elevated status of pharmacy educators within the profession was also alluded to – "the profession respects academics" (R9).

Some of the reasons against having academic pharmacy registered as a speciality included:

> No, why should we want this? We know who we are and what we do. (R4: Q3.6)

> No - I am of the personal opinion that the broader category of pharmacist is sufficient. Others will argue differently. It might have its uses, for instance, perhaps there is a scarce skill levy attached to it, but what I forsee happening is that we will have to pay for each speciality on the register, and we will then only be able to practice within that field, unless we pay twice or three times for example: academic, community, hospital to be able to work in all the fields. I know that the clinical pharmacists are pushing for this, but is it not something which should be a job application requirement rather than a statutory requirement? (R2: Q3.6)

> I don't consider academic pharmacy a practice that could be classified as a speciality- similar to clinical pharmacy etc. Academic pharmacy is according to my own experience well recognised - a specific committee for Heads of Schools[37] functions under the auspices of the SAPC and an academic internship can still be enrolled for. (R31: Q3.6)

The first comment (R4) suggests that there were respondents who believed that their own well-formed sense of their academic identity did not require any further recognition of it by others. In the second comment the respondent (R2) argued that unless there was anything to be gained from it financially, it had the potential to limit the scope of practices of pharmacy educators. The respondent who made the last comment (R31) was of the opinion that academic pharmacy was already well recognised and accommodated by the South African Pharmacy Council. She also raised the notion of the academic internship being a recognised form of preparation for an academic career. In South Africa one of the requirements for registration as a pharmacist, is the completion of one year of practical training under the

[37] A forum hosted by the South African Pharmacy Council in which heads of pharmacy faculties, schools and departments meet together on an annual basis.

supervision of a tutor. If registered with a university for fulltime study on a postgraduate degree programme, interns have the option of completing an academic internship (South African Pharmacy Council, 2011). With a view to recognising academic pharmacy as a speciality it might become a feasible option for the Council to expand the requirements for an academic internship to include formal training and experience in other aspects of academic work such as teaching or lecturing, beyond the requirement of completing a postgraduate research degree,

6.3.7 Perceptions of pharmaceutical care

In order to broaden the understanding of pharmacy educators' perceptions of pharmaceutical care already gained in the first two phases of the study, respondents to the questionnaire were also asked about their feelings or thoughts regarding the concept. All except one respondent, who declined to comment, supported the concept.

Reasons for supporting the concept are exemplified by the following comments:

> The concept of pharmaceutical care should be foremost in our minds when training pharmacists as it relates to the holistic management of patients which should be our goal. (R1: Q4.1)

> Pharmaceutical care should be an integral part of the daily duties of the pharmacist. Pharmaceutical care allows the pharmacist to use and integrate all his/her knowledge to improve outcomes for the patient. (R14: Q4.1)

> This is the primary role of the retail pharmacist - patient care must be at the forefront of the pharmacist's mind at all times. However as the custodian of medicine this begins at the start of drug research and development. To manufacture and distribution – a safe, effective product is as important as the correct product. (R18: Q4.1)

> The concept of pharmaceutical care is brilliant for the pharmacy profession. This concept enables practicing pharmacists to view the patient holistically. In my opinion, it provides the ideal foundation for individualised care. Additionally, it allows pharmacists to provide a more valuable service not only to the patient, but also to physicians and other health care professionals. (R30: Q4.1)

> I live and breathe pharmaceutical care, as I believe that if all pharmacists who encounter patients on a daily basis were driven and motivated by this

> philosophy, we would have more empowered patients which would hopefully translate into better adherence to medication as they would understand their disease states, and the role they have to adopt, in their medicine use. (R32: Q4.1)

All of these comments and other similar ones, suggest that the philosophy and practice of pharmaceutical care has the potential to provide "holistic" (R1) "individualised" (R30) care to patients with the possibility of improving their "adherence to medication" (R32) and "outcomes" (R14). Pharmaceutical care was also conceived as encompassing all aspects of pharmacy practice including the development and manufacture of "safe effective products" (R14). Furthermore it was viewed as "the ideal philosophy" (R8); "vitally important to the profession" (R6); "the main pillar of our ethical profession" (R28); and also as having "provided the profession globally with a good 'marketing tool' and united pharmacists behind a single concept of what pharmacists do" (R4).

However, many of the respondents, despite supporting the concept of pharmaceutical care, also expressed concerns regarding it. The concerns, mostly of three types, were specifically around: the term and definitions of the term; lack of implementation and penetration in practice; and its relevance to the South African context.

There was fairly broad similar support for the concerns expressed during both the first and second phases of the study around the use of the term, its definitions and meanings associated with it (see Sections 5.3.2 and 6.2.6), as evidenced by the following comments:

> There are all the conflicting `definitions` about what 'pharmaceutical care' is, involving the pharmacist taking responsibility for the patient outcomes. Working in our cultural environment where there are diverse attitudes to pharmacy and medicine, I do not think that a pharmacist should be `responsible` for the patient outcome. You should work with the patient, support them, encourage when needed, but at the end, it is the patient who is responsible for their life and the way they choose to take their medication. If you have done everything in your role to perform and provide the care that a reasonable pharmacist is expected to provide, then 'pharmaceutical care', in my view, has been provided. (R2: Q4.1)

> I believe in the concept - but I hate the name. (R3: Q4.1)

> Good to have a universal take on a philosophy of practice, but the original definition which included `taking responsibility for patient outcomes` was

> patently misguided. We cannot take responsibility for anything other than ensuring that patients are equipped to practice good medicine-taking behaviour, and of course motivate patients/consumers to adopt a healthy lifestyle. (R4: Q4.1)
>
> The role of the pharmacist is well defined through this definition, yet the profession appears confused - results in many interpretations of pharmaceutical care when implemented in practice. (R11: Q4.1)
>
> One of those terms that is very loosely used in the profession and therefore has lost its meaning. (R12: Q4.1)
>
> I think this concept is overused. As pharmacists we should all be patient-centred which implies that we should care about patients but patients should be encouraged to take responsibility for their health and that pharmacists should not take responsibility for patients' health. Our responsibilities include providing accurate information in a way that patients can understand it, checking for understanding, follow up and monitoring of patient outcomes and development of new medicines. (R15: Q4.1)

Although there was general support for the patient focus as central to pharmaceutical care, several of the respondents above specifically had difficulties with the notion of pharmacists taking “responsibility for outcomes”. They also felt that the term “pharmaceutical care” was overused and had lost its meaning. This supports the suggestion that was made in Section 5.11.2 that the concept of pharmaceutical care needs to be revisited.

Despite one of the respondents suggesting that:

> It should by now be an integral part of the practice of pharmacy – accepted as such by especially pharmacists trained over the last number of years as it forms part of the competency standards of the profession and should be reflected in the curriculum. (R31: Q4.1)

Several respondents believed that the concept had not been implemented nor had it penetrated the practice of pharmacy:

> Although, of course, how many actually DO it? (R4: Q4.1)
>
> Not performed enough (if at all) in SA. Could prevent a lot of mistakes (sometimes fatal). (R10: Q4.1)

> Pharmacists are not practicing it and it is the greatest strength we have. (R27: Q4.1)

Some went even further and asked whether it was actually implementable, bringing into question its applicability to the South African context, particularly the public sector

> The ideal philosophy. Practically not implementable in South Africa. (R8: Q4.1)

> Certainly needed, but not possible to implement in the public sector. (R16: Q4.1)

Two of the respondents also made suggestions as to why it had not penetrated practice:

> Great concept but poorly executed in practice due to various constraints and conflicting interests. (R23: Q4.1)

> Pharmaceutical Care is vitally important to the profession. We were supposed to train technicians, to take over the dispensing role, so Pharmacists could set free to consult properly with patients. This has not happened. (R6: Q4.1)

Although the first response suggests that the respondent (R23) believed that there were "various constraints" and "conflicting interests" as barriers to its implementation, they made no suggestion as to what these might be. The respondent (R6), who offered the second comment, proposed that because of a lack of support with the technical aspects of the dispensing process many pharmacists were bound to dispensing and not free to enter into the patient consultations integral to the provision of pharmaceutical care.

These responses uphold the notion suggested by the literature review that, despite wide acceptance of the concept of pharmaceutical care, uptake and implementation has been slow and the impact of the concept on practice is questionable (see Section 2.3.4). Several barriers to the implementation of pharmaceutical care worldwide and in South Africa have also been identified and, as the literature review proposed, include resource related and system constraints and pharmacist and educational concerns (see Section 2.3.5). This further supports the suggestion that not only should the term and definition of pharmaceutical care be revisited, its suitability for implementation in the South African context should also be reconsidered (see Section 5.11.2).

6.3.8 Education and pharmaceutical care

In the literature survey it was suggested that for the past 15 years pharmaceutical care has been the focus of pharmaceutical education (see Section 2.4.5) and, as Respondent 31 commented, since it "forms part of the competency standards of the profession" it "should be reflected in the curriculum" (R31: Q4.1). As Hagemeier (2010, p. 137) further argues, it is the pharmacy educators who have a critical role to play in the development of pharmaceutical care practitioners:

> If the profession desires to advance patient care, specifically in the community setting, pharmacy educators must nurture and develop student pharmacists into advocates who desire to enter academic and community pharmacy with the integrity and awareness necessary to stand firm in their primary responsibility to patients.

Therefore in order to further understand the impact of the pharmaceutical care concept on the teaching of pharmacy educators in South Africa, respondents were asked "Does the concept of pharmaceutical care relate to your teaching? If so, please motivate your answer" (Q4.2).

The majority of the respondents, 81% (26), believed that it did relate to their teaching, while 16% (5) thought it did not and one respondent declined to comment. Some of the respondents who were of the opinion that pharmaceutical care did relate believed that it was integral to the curriculum and underpinned all teaching, typified by the following responses:

> Yes, absolutely. It was the underpinning of the entire Pharmacy Practice curriculum I contributed to developing in the early 1990s. (R5: Q4.2)

> Pharmaceutical Care is in all our subjects. In biopharmaceutics and pharmacokinetics, it is the central theme as to why we need to have knowledge of the subject. (R6: Q4.2)

> All teaching in any of the core subjects has one aim and that is to provide the pharmaceutical care necessary. (R19: Q4.2)

Others described how they believed the concept related directly to their particular discipline or module:

> Yes. I teach clinical components of an undergraduate degree which pharmaceutical care forms a major component.. (R9: Q4.2)

> Yes. Hospital Program and Externship Program both require students to be taught and moulded into the best pharmacists who can provide optimal pharmaceutical care to all patients. (R21: Q4.2)

> Yes. I'm involved in clinical training and pharmacy students are continually reminded of their responsibility toward the patient in ensuring that therapeutic outcomes are achieved. Of course, this entails all the steps preceding the dispensing of medication as well as the monitoring and follow up that ensues. (R23: Q4.2)

> Yes, without proper knowledge of chemistry students/future pharmacists cannot deliver quality pharmaceutical care for customers (R24: Q4.2)

There were others who viewed it as a stand-alone concept or process which was taught as a separate module or topic which did not impact on other aspects of the curriculum:

> The process of pharmaceutical care is taught through practical examples and clinical training – don't feel that it relates to my teaching but rather that it is content / process that is taught. (R11: Q4.2)

> Yes. Undergraduate students do an eight week module in pharmaceutical care where they spend most of their time in the wards aimed at pharmaceutical care interventions. Many post-graduate projects are also focused on pharmaceutical care and clinical pharmacy. (R14: Q4.2)

The belief that pharmaceutical care is a stand-alone concept was the predominant reason why some of the respondents, despite having expressed support for the concept, did not view it as relating directly to their own teaching:

> Not really, as our curriculum is fairly separate in terms of how we present it. (R1: Q4.2)

A few of the respondents recognised their own role as pharmacists in modelling pharmaceutical care and applying the concept through their own care of students:

> I emphasise the role of advising and education of the patients by the pharmacist. Pharmacology doesn't really look at pharmaceutical care, but because of my role as a pharmacist, I sensitise the students for their advisory role. (R13: Q4.2)

> Yes, it is the guidelines by which we work to teach and care for our students too. They must also be responsible for their educational outcome, provided we have been there, supported and offered all the help and encouragement that is expected from an academic pharmacist. (R2: Q4.2)

> Yes. Practicing this and leading by example might motivate students and indirectly influence the care they give and will give to patients in future. (R29: Q4.2)

As has been discussed previously (see Sections 2.4.7 and 5.5.3), the idea of modelling care to students is consistent with Popovich's concept of educational care (analogous with pharmaceutical care) and is necessary for the development of students into caring practitioners (Popovich, 1992).

One of the respondents, who did extensive locum work in the retail and hospital sectors of a private hospital pharmacy, recognised the incongruities between what is sometimes taught and what is practiced and sought to empower students to find creative ways to overcome this:

> An adequate understanding of the principles governing pharmaceutical care is vital for both educators and students. I always try to provide practical examples during lectures, in order to facilitate discussions about existing pharmaceutical care practices. Currently, the implementation of consistent and good quality pharmaceutical care is infrequently observed in the practice environments. Thus, the provision of real-life examples will highlight shortcomings and encourage students and educators to provide productive solutions. (R30: Q4.2)

As Hagemeier (2010, p. 133) suggests: "The discontinuity between what is taught in pharmacy school and what is experienced in community practice" has existed for years.

However he argues that pharmacy educators have the potential to "transform product-focused community settings" through the "development of advocates for the profession" (p. 133). Respondent 30, as illustrated in her comment above was striving to do just that; by drawing the attention of her students to the inconsistencies which exist, she is preparing them, not only for the realities of practice, but to be agents of change.

The responses of the pharmacy educators to the question of the relationship of pharmaceutical care to their teaching practice were therefore varied. Despite 97% of them offering support for the concept (Section 6.3.7), there were some that did not view it as being integral to their discipline or modules, while others were of the belief that the concept was foundational to the whole curriculum. A few of the respondents recognised their personal responsibility as pharmacists and educators to model the concept in their own practice of teaching. These respondents, who sought to model care, apparently recognised that the formation of care is not only about the acquisition of knowledge and the development of skills. Based on their research to determine the factors which influence pharmacy students' caring ability Fjortoft and Zgarrick (2001, p. 338) concluded that the influence of pharmacy educators on students' levels of caring lay beyond what they teach or how they teach it, but rather it was dependent on "who we are as teachers". Furthermore as Intrator and Kunzman (2006, p. 17) proposed: "A teacher's capacity to teach well is linked to a set of ineffable, hard-to-codify qualities that often become characterised as heart, passion or connectedness".

6.3.9 Educating the next generation of pharmacists

In order to understand and describe the respondents' perceptions of their role in terms of educating pharmacy students and socialising them into the profession, two questions were asked of the respondents: "How do you perceive your role in terms of educating the next generation of pharmacists?" (Q5.1) and "As a pharmacy educator, do you think you have influence on the future practice of your students?" (Q5.2)

The responses to these two questions can be categorised into four themes: knowledge and skills; adapting to change; professional development; and teaching future educators. Some typical responses suggesting the first theme – knowledge and skills – included the following:

> My role as an educator is to educate! I would like to enhance awareness of the patient experience and try and get students to grasp the importance of communicating with patients about their medicines at a meaningful level. I also see my role as still being one of ensuring that future pharmacists have all those

> core attributes of accuracy, responsibility, `nit-pickiness`, good basic knowledge of our field, as the students coming in now have greater difficulty grasping the importance of KNOWING things as opposed to looking up things on Wikipedia and then giving vague unformulated responses. (R4: Q5.2)
>
> As I believe that teaching is a large component of my job and as the subjects I teach are very clinical, I believe that this will become very important as the profession changes. (R9: Q5.2)
>
> Teach them how to make the correct diagnosis based on symptoms, how to determine dosages, teach them how to decide which medication to dispense to certain patients. Teach them practical skills that will be necessary to be able to do. (R20: Q5.2)
>
> Our curriculum has been re-developed to bring a greater balance about regarding clinical exposure and training but maintaining the focus on a solid knowledge of the product. (R31: Q5.2)
>
> Yes, by making all options visible to students and equipping them with the necessary knowledge will definitely have an impact on the decision made by the student. A good equipped student will execute an informed decision. (R22: Q5.3)

These comments all suggest that the pharmacy educators still see teaching knowledge and skills as fundamental to their work of preparing future practitioners. The first comment also encompasses the emphasis that some of the respondents placed on generic skills such as the ability to work accurately. Several of the respondents also highlighted the need to teach students the skills necessary for lifelong learning, exemplified in the following comment:

> My role is to provide the students with some knowledge, and the ability to know how to obtain more knowledge when needed. They must leave my courses knowing the basics, knowing how to put those basics into practice, and being able to, in the future, continue with educating themselves beyond what the lecture hall had to offer. Our profession is dynamic, changing monthly in many cases with new additions of products, new ways to treat conditions, and new prevention methods. The students must keep up themselves; they must want to know that they are able to compete in the market place. I would like to think that I help them develop skills which will last them for years, even if the products

> change, or something new comes along, that they will be able to cope in the ebb and flow of pharmacy as a profession. (R2 Q5.2)

This comment also linked to the second theme – adapting to change. Several of the respondents felt that pharmacy educators have a responsibility to develop in students an attitude that empowers them to adapt to change:

> Yes, a positive attitude towards changing in policy in the country will be a key element in ensuring the success thereof. (R8: Q5.3)

And furthermore be themselves agents of change:

> Yes. We are sometimes accused of `being in an ivory tower` - but we are responsible for creating change agents, for creating pharmacists who will be able to solve problems, and who are prepared to challenge and change pharmacy. (R3: Q5.3)

Similar to the manner in which the respondents above viewed it important to teach for change, some of the respondents were of the opinion that pharmacy educators also need to be able to adapt to change if they are going to develop pharmacists for the future. The following are typical examples of comments of this nature:

> Our roles as pharmacy educators have changed significantly over the last ten years with the changes in the schooling system and the 'massification' of higher education in South Africa. We are faced with a very different type of student as in the past and this requires re-thinking the manner in which we train pharmacists. I believe that my role would be to re-assess the manner in which I teach in order to adapt to the unique needs of students entering the programme today. (R1: Q5.2)

> Review and adapt the curriculum to respond to changes in practice and to the needs of the community. (R14: Q5.2)

> ICT and mid-level workers are going to play an even bigger role; thus the compounding and signing on manufacturing which were the preserve of pharmacists is going to disappear. The next generation will need to solve higher level problems, have greater managerial capabilities and ICT skills at their fingertips. It's my responsibility to move them away from hands on work to thinking work. (R27: Q5.2)

These comments make reference to the various contexts of which educators need to be aware and also be willing to adopt the changes necessary to accommodate them. The first comment makes reference to the changes which have been happening in education in South Africa. These changes, to which the respondent (R1) refers, were previously discussed in Section 3.3.2.1, and include changes in the schooling system which have left many students apparently under-prepared for higher education (2008, p. 353). In addition, there is a constant drive to enrol greater numbers of students in higher education – massification (Department of Higher Education and Training, 2012). As the second response suggested (R14), pharmacy educators need to be aware of changes that happen both within the healthcare environment and the pharmacy profession and be willing to modify what they teach to respond to these changes. The third comment (R27) refers specifically to some of the factors which are driving change in pharmacy practice, including the impact of technology and the introduction of mid-level workers. The potential impact of the introduction of the mid-level worker category of pharmacy personnel has previously been highlighted by other participants in this study (see Sections 5.7.2 and 6.2.6), who in a similar manner to this respondent, suggested that a more cognitive approach to practice from pharmacists would be required.

The professional development or socialisation of students was a major theme identified by respondents. As the responses below suggest, many respondents viewed the professional growth and the development of appropriate professional attitudes within the students, to be of importance:

> Need to share knowledge but also experience to guide and support new pharmacists. Also need to share my passion and pride in my profession and to instil the core attributes of being a pharmacist. (R11. Q5.1)

> Facilitating their education and professional growth. (R19: Q5.1)

> My role is to ensure that we have a more socially conscientious pharmacist, who is self-assured and whose ethics and morals are above board (R32: Q5.1)

> I want pharmacy graduates to know exactly where their expertise lies and what contribution they can make in the healthcare and pharmaceutical industry team. There should be no confusion about their identity and worth. (R23: Q5.1)

In addition, many of the respondents had a heightened awareness of the manner in which they served as professional role models for the students:

> Yes. We seldom recognise how significant our actions are on the development of a student. What students see in their lecturers is often mimicked in their practice and it is therefore essential to maintain a high level of professionalism at all time. (R1: Q5.2)

> Yes! Students look to educators for guidance, and the way an educator operates is an example for students. If the lecturer is not professional or ethical, that is the message sent to the student. (R7: Q5.2)

> Yes. Expose students to practice at an early stage of learning and instil the desire to serve people; lead by example; inspire students to take responsibility, to make a difference and to see changes as challenges and not as threats. (R14: Q5.2)

> Our interests and passions will influence those we teach. (R19: Q2.5)

> Yes, absolutely! The students naturally come to their teachers or coordinators and ask for advice or assistance. The way that we deal with students can "mould" them into the kind of pharmacists that the university wants to have graduate. (R21: Q5.2)

> I think a lecturer is obliged to fulfil a role model for his/her students. (R28: Q5.2)

Some of these responses once again refer to the "ineffable" qualities, proposed by Intrator and Kunzman (2006, p. 17), such as heart, passion and connectedness, which are necessary for good teaching. One respondent suggested that she understood the importance of educators as role models because of the influence her own lecturers had on her professional development:

> I believe that educators have a major influence. The lecturers that taught me had a major influence in moulding me into the pharmacist I am today. (R9: Q5.2)

There were also several respondents who recognised that the professional socialisation of students was not simply the responsibility of pharmacy educators, but also lay with pharmacists in practice:

> I think I can heighten awareness of `a way of being`, but I think the `practice` skills and ways pharmacy is practiced are moulded mainly by practice experiences. (R4: Q5.2)

> Yes, how I conduct myself gives them a glimpse of what being professional is about. The hope is that it leaves an impact, especially if they see professional behaviour from all pharmacists with whom they interact. (R27: Q5.2)

> Yes, to an extent. Students practice what you train them to be but the pharmacist coaching in the field might enhance or inhibit this. (R29: Q5.2)

The idea that pharmacists in practice might "enhance or inhibit this" alludes to some of the incongruities that exist between what students are taught and what they experience in practice. These incongruities were also recognised by participants in the first two phases of the study (see Sections 5.11.2 and 6.2.6) and are again highlighted by respondents in this phase:

> I also think that the pharmacists in the workplace let us down by not continuing the lifelong learning and professional behaviours we instil in our students. (R18: Q5.2)

As a consequence, some of the respondents identified the need not only to teach students how to practice, but also how not to practice:

> Yes - through examples of how not to do things versus how to improve quality of care and make a difference in patient outcomes. (R11: Q5.2)

> Yes, I hope so. I emphasise the ethical role of the pharmacist and give them lots of examples of how `not to treat a patient`. (R13: Q5.2)

One of the respondents, acknowledging the incongruities that exist and the potential they have for creating disillusionment for students, drew attention to the need for a collaborative effort between educators and pharmacists in practice, in order to socialise students into the profession in a consistent manner:

> I feel that the practice of future pharmacists will be influenced by both educators and practicing pharmacists. I am of the opinion that collaboration between educators and practicing pharmacists needs to occur, so that students can become used to a certain level of professionalism and practices

> of pharmaceutical care that are consistent and predictable. Any kinks in the chain of educators and practicing pharmacists will discourage and confuse students. (R30: Q5.2)

The important role of educators as role models in the socialisation of students into the profession, identified by the respondents in this phase of the study, is not only consistent with that highlighted in the first two phases of the study, but also with the literature (see Section 2.4.6). The professional socialisation process begins for pharmacy students as soon as they start to interact with pharmacists (Hammer *et al.*, 2003). Therefore, for many students, this happens during their undergraduate studies, and the first pharmacists they truly interact with are their teachers or educators. Keshishian (2010, p. 1) describes this early interaction as "anticipatory socialisation", and suggests that it includes everything that the student learns that prepares them for becoming a professional. She further identifies two factors central to determining the outcome of this early socialisation process, namely: ''realism", which is the extent to which the view a student has of how life in the profession really is, is complete and accurate; and ''congruence" - the extent to which the student feels a personal alignment with the beliefs, behaviours and attitudes that they see manifest by the profession (Keshishian, 2010, p. 1). Thus, as some of the respondents indicated, pharmacy educators serve as professional role models for students, and it is therefore "who they are" and "how they behave" that is important. In other words, their professional identity is central to the impact they have on preparing students for the profession. Furthermore, they not only need to prepare students with the basic skills necessary for ideal practice settings, but they need to work collaboratively with pharmacists in practice to prepare them for the real issues that they will confront in the practice environment.

Some of the respondents also recognised the responsibility they have in perpetuating the profession through the role they play in not only educating future pharmacists for practice, but also training the next generation of pharmacy educators:

> Focusing on research and postgraduates now - maybe in educating new `teachers`. (R8: Q5.1)

> Coming to the end of my teaching career now, focusing on inspiring my younger colleagues to take on that role. (R17: Q5.1)

These two responses suggest that in their interaction with postgraduate pharmacy students and younger colleagues, these respondents acknowledged that they not only influence how students are currently taught, but also how they will be taught in the future.

6.3.10 Educating for change or in response to change?

In order to explore further pharmacy educators' perceptions of their role and that of pharmacy education in shaping future practice, two questions were asked with respect to education and changes in practices, namely: "Do you think that pharmacy education should drive changes in the practice of pharmacy?" (Q5.3); and, "To what extent and in what ways do you think that pharmacy educators should be responsive to changes in practice?" (Q5.4).

Many of the respondents provided positive responses to both of these questions, suggesting that they believed that it was also necessary, while remaining responsive to changes in practice, for pharmacy educators and education to be actively involved in driving change. There were some who believed that the role in driving change should be the more dominant one, while others argued that their responsibility lay predominantly in being aware of and responsive to changes.

From the responses, several approaches to the manner in which respondents believed education and educators should be driving change were identified; these include through: teaching and/or research; the development of change agents; involvement in professional and statutory bodies; personal attributes; and collaborative efforts with the profession

Some of the responses which proposed driving change through teaching and/or research included the following:

> Yes. It needs to be a two-pronged approach in terms of what we teach our students as best practice and the research we conduct in practice that would drive the teaching. In other words, as academic pharmacists, it is our responsibility to conduct research on practice related issues, make recommendation on changing current practices to move towards what would be considered best practice, and then using those guidelines in our teaching. Another way of driving changes to move towards best practices would also be to collaborate closely with external stakeholders within the profession and create partnerships for student experiential learning. (R1: Q5.3)

> Yes - curriculum changes, monitoring international trends and looking at changes in healthcare and where the pharmacist can play a role. Then offer postgrad or short courses to update. Pharmacists in practice are often not aware of the bigger picture and their pharmacy world is literally their small work environment and interaction with colleagues - academia need to have the vision (R11: Q5.3)

As both of these responses above suggest, in order to drive change through teaching it is necessary to keep the curriculum updated such that educators teach for best practice. As the following comments suggest, this is best done through monitoring world trends, comparing these to the local context and needs, and by consequently teaching best practice and new models of practice:

> We should be AHEAD of change, not responsive to it. We are the ones who should be at the cutting edge of innovative practices worldwide as we should be regularly scanning the literature and have an awareness of how practice is changing. If WE don't do this, then who will?? (R4: Q5.4)

> It has to, by continually drawing attention to the gaps between global best practice, as informed by theory, and the local reality. By developing and advocating for new models of practice. (R5: Q5.3)

> I think pharmacy education is pivotal to change in practice. The education entities are in a position to plan practice change in an unbiased way, as it is not directly influenced by professional political issues in the market place, and it can more easily maintain neutral standpoints on the professions needs. (R28: Q5.4)

As the last response above suggests (R28), the “the neutral standpoint” that is possible for educators make them ideally suited to drive change, free of commercial and political agendas.

The development of graduates capable of being change agents in the practice environment was one of the ways that it was suggested that education can drive change in practice:

> Yes – by creating pharmacists who can think and who are sufficiently motivated to critically assess practice and become involved in agitating for change (R17: Q5.3)

> Education at universities should always be on the forefront of technology and developments. In this sense we should prepare the pharmacists we educate to cope and initiate change in the profession. (R19: Q5.3)

> I think it can play a role: if we challenge students to analyse situations/information critically, this will hopefully encourage them to become

> agents of change when practising. Faculty members can also play a role in different organisations e.g. MCC, SAPC or PTCs[38]. (R15: Q5.3)

This last response (R15) further suggested that the involvement of pharmacy educators on professional bodies and statutory organisations such as the South African Pharmacy Council was another means of driving changes. This notion was supported by comments from other respondents:

> Yes, become involved in the different law making roles (R26: Q5.3)

> Yes – pharmacy educators should be on the fore front of international and national developments in the profession, health care and the role of the pharmacist. Pharmacy education should thus respond in an appropriate way - backed by own research and development. Participation on national level is of critical importance and the role of pharmacy educators in statutory and professional bodies' activities should not be under estimated. (R31: Q5.3)

In addition, other respondents also highlighted the potential of the personal characteristics and practice experience of educators to impact on changes in the profession:

> Yes, we must be innovative, pro-active and inspirational (R24: Q5.3)

> Pharmacy educationists are probably unknowingly doing just that. The lecturer's common sense and experience of practice (a must) should suffice education to change practice in order to fit the pharmaceutical care ethos (R28: Q5.3)

Some respondents were of the belief that through direct interaction with pharmacists in practice, it might also be possible to drive changes in practice:

> Yes, pharmacy educators may attempt to drive changes in pharmacy practice. This will be a titanic task, since it will require co-operation from practicing pharmacists and students. I imagine that it would also be a time-consuming process, but if successful, it will definitely be worth the effort. Educators could make appointments to visit retail pharmacies and give lectures on how practice can be improved upon. It is impractical to run these discussions during trading hours, so it may be better to conduct them thirty minutes before opening time or after closing time. (R30: Q5.3)

[38] Pharmacy therapeutics committees

> Yes. Pharmacy education and the health service need to meet every month to exchange experiences, share ideas and pilot programmes jointly. Breakdown the existing silos of individuals (academy and pharmacy service) by implementing joint appointments. Communities of practice should be established. (R16: Q5.3)

In summary, the notion expressed in these two responses above is apparently grounded on some of the understandings proposed in the earlier responses; that educators are on the "cutting edge of innovative practice worldwide" (R4); that they are "innovative, pro-active and inspirational" (R24); "not directly influenced by professional political issues" (R28); and, are themselves willing to be agents of change.

One of the respondents also suggested that driving change in practice clearly required a combination of approaches:

> It should; (a) by continuing to train pharmacy students according to best practice, (b) influencing changes through the SAPC and MCC i.e. have academic pharmacists who serve in influential committees, (c) promoting CPD; why not have a free update short course for pharmacists with more than 20 years' experience? (R27: Q5.3)

Other respondents were of the opinion that pharmacy education should be responsive to changes in practice. Although a few believed that responding to changes was more important than driving change, others believed that responding to change should be in addition to driving change:

> This is a difficult one, as I believe that the industry should drive what is needed now, as they are the closest to patients and the needs of the industry. We should, however, be able to have our input into this process so we can react very quickly to the future needs. (R6: Q5.3)

> I think the driving is done by pharmacists in practice (or the government's regulations). (R10: Q5.3)

> Changes are initiated from practice but the implementation thereof must be enforced from an academic point of view. (R22: Q5.3)

Several respondents suggested that central to being able to respond to change was an awareness of current issues in practice in order to keep education current and relevant:

> I would like to think that we are already responsive to the changes in practice. By teaching up to date material, knowing what is happening in practice and incorporating that into the teaching, we should be achieving this. But saying that, I am the only one in our Faculty who does any locums in practice, so I do not think that many of the other staff are even aware of what is happening in practice. They are probably aware of what is happening in their sector however, like the industry sector, which I am ignorant about. If you do not know what challenges are being faced by the students when they get into practice, you can't address these in the curriculum. I know our faculty has tried to have the different sectors feed into our new curriculum. Have they responded to the questions? I am not sure. But I think that the only way to stay knowledgeable about change is to be part of it. Then we can address it and make others aware of it. (R2: Q5.4)
>
> It is our responsibility as educators to actively respond to changes in practice. If we do not keep up-to-date, we will be failing our students because they will be unprepared for the working environment after graduating from the university. (R30: Q5.4)
>
> Pharmacy education has to be updated continually as the practice of pharmacy changes. It is imperative that the pharmacists we produce at higher education can fit in to practice as soon as they leave the institution. Keeping education current and interactive and appropriate for the modern generation of pharmacists as well as integrating students into the workplace from early on in their degree: sites where they are placed must be evaluated as “Best Practice Sites” to ensure the student are working in a legal and ethical environment. (R18: Q5.4)

As the first response (R2) above illustrates, many of the educators felt that one of the primary means of keeping their awareness and knowledge of practice updated was through regular locum work. This was also suggested in Section 6.3.3 when it became evident that 41% of the respondents did locum work, and many stated that their reason for doing so was that it kept their teaching relevant.

There were several respondents who succinctly stated that pharmacy education and educators should not only be leading or driving changes in the profession, but should also be responding to changes in practice and adjust the educational process accordingly.

Furthermore, many of these respondents highlighted the need to work closely together with the practicing professionals:

> I do not think education solely can drive practice changes in pharmacy - in an ideal world, these would go hand-in-hand with practice AND with research to provide evidence for outcomes related to changes in practice. Pharmacy education should, of course, reflect where we would like to be in practice, but this influence can be dimmed by the harsh reality of practice `out there` and the drivers that determine how the profession is practiced, for example, the corporates who demand numbers. (R4: Q5.3)

> Yes and no. We must be responsive on the one hand to the contextual needs of society but on the other hand, we should be proactive and, through our research, drive change in policies that will influence practice for the better. (R23: Q5.3)

> Partly, sometimes, it is people in the field that are best suited as they are faced with the different challenges. Practicality is not always feasible but if change is introduced positively from both sides it can benefit the profession. (R29: Q5.3)

> It cannot ignore the realities of practice, and must always be responsive to those realities, while still keeping an eye on the goal of more effective and efficient patient care. (R5: Q5.4)

> There should be a balance between being responsive and proactive. I would say 65% responsive and 35% proactive. (R23: Q5.4)

The responses to these two questions also need to be considered in the context of the respondents' perceived relationship with the wider pharmacy profession (Section 6.3.4). Many of the respondents (56%) viewed their role within the profession as being directly related to their responsibility to their academic status and their work of teaching pharmacy students. In addition, some of the respondents considered their ability to influence the profession directly as being a consequence of their academic status. This suggests that, generally, respondents recognised their responsibility both to influence change and respond to changes within the profession. Consequently, many of the responses to these two questions appear to be consistent with the concept that pharmacy educators are in a "unique position of influence" and, through their interaction with pharmacists and future pharmacists

and pharmacy leaders, are ideally situated to positively impact on the profession and the practice of pharmacy (Hagemeier, 2010, p. 134).

6.3.11 Third phase summary

In this third phase of the study the self-perceived professional identities, attitudes and beliefs related to pharmaceutical care and the role of pharmacy education were explored with 32 pharmacy educators. Many of the educators (87%) had a pharmacy-related postgraduate degree whilst only 22% had any formal qualification in education.

The factors that were identified as having attracted the educators into higher education were classified into five categories including: nature of the work; the work environment; career development; the human element; and personal factors. The single factor which had held the greatest attraction for educators was the opportunity to do postgraduate studies. Many of the educators had also viewed this as an opportunity to do research. However, once in higher education, the aspect of their work that demanded most of their attention, and was their greatest priority, was teaching or lecturing. With time and career progression, research and their departmental role or administrative responsibilities, made even more demands on their time. However, for many of the educators, the emphasis on teaching did not decrease proportionally. As a consequence, many of the educators cited their biggest frustrations with working in the higher education environment as workload and time. This is, however, a generalisation, and there were some individuals who had been appointed in higher education as researchers; and although some teaching had been required of them, research had remained their primary focus throughout their academic careers. One educator, with significant managerial experience in the pharmaceutical industry, had led to an appointment in higher education as an academic manager and thus her management and administrative role had always been her priority.

Rewards and challenges were identified with almost every aspect of work in higher education, including: the human element; teaching; research; the work environment; and personal factors. Despite many of the educators having been attracted into higher education for their own personal growth, that is to do postgraduate studies, it appeared that the opportunities afforded them, through teaching, to nurture students into the pharmacy profession was for many of them the most satisfying aspect of their work. This apparently provided them with a sense of being able to make a continued and valued contribution to the pharmacy profession, and suggested that their perception of themselves as pharmacists was important to their professional identity.

Many of the educators viewed their interpersonal skills, and the personal attributes which supported these, as being those most utilised within the university environment. The professional skills which were identified as being most utilised all related directly to their pharmacy practice experience and to their status within the pharmacy profession. Similarly, many of the educators, who had found their place within the wider university, suggested that it was directly related to their identity as pharmacists, and to their ability to promote the pharmacy profession within the university environment. There were some who had no sense of belonging within the wider university, while others had found their academic voice and identity through participation in the wider environment. Paradoxically, however, it was their role as educators within an academic identity, which 56% of the educators considered as the basis of their role and contribution within the broader pharmacy profession.

The educators in this study were active in a wide variety of local and national pharmacy organisations; and 41% of them did regular locum work. They viewed both the participation in pharmacy communities of practice and working in practice as a means to keep their teaching relevant.

Supporting the findings reported in the first two phases of the study, the professional identities of these educators lay on a continuum between pharmacist identities on one end and academic identities on the other. There were those who viewed themselves predominantly as pharmacists (31%), and those whose primary identity was academic in nature (19%), whilst half of the educators viewed their professional identities as being a combination between both pharmacist and academic. This would suggest that for many of the educators their professional identity was a balance of multiple identities, and for some there was a tension in knowing how to balance them, and in how to name their professional identity.

Metaphors were used to explore further the identity of the educators. For many who offered metaphors (15), these suggested that their identities as educators were related to their relationship with their students. Some metaphors suggested that the educator's identity was related to their role within the educational process, and one alluded to the tension in balancing the pharmacist and academic aspects of professional identity.

The majority of the educators (75%) believed that academic pharmacy should be recognised as a speciality by the South African Pharmacy Council. The reasons offered in motivation of this standpoint included: the requirements for specialist knowledge and postgraduate qualification; the potential to create an attractive career pathway; and the fact that academic pharmacy was needs-driven. Although there were dissenting voices (19%), a

recommendation that emerges from this phase of the study is that the South African Pharmacy Council be lobbied to consider recognition of academic pharmacy as a speciality; however, this recommendation would include a formal qualification in education as a registration criterion, as well as a pharmacy-related postgraduate degree. In addition, the call should be made for the Council to consider expanding the requirements for an academic internship to include formal training and experience in other aspects of academic work such as teaching or lecturing, beyond the requirement of completing a postgraduate research degree.

All except one of the educators supported the concept of pharmaceutical care. However, concerns around the term and its definitions, its lack of penetration into and implementation in practice, and its relevance to the South African context were also voiced. The majority of the respondents (81%) were also of the belief that pharmaceutical care related to their teaching. Some considered it to be integral to the curriculum and underpinning all teaching, while others viewed it as a stand-alone concept or process to be taught in specific disciplines or modules. Aligned with the concept of educational care, a few of the respondents recognised their own role in modelling pharmaceutical care, through the application of it to their care for students.

The beliefs of the educators about their role in raising the next generation of pharmacists were categorised into four themes: knowledge and skills; adapting to change; professional development; and teaching future educators. Many of the educators viewed the imparting of knowledge and skills to students as primary to their work of preparing future practitioners. However, the professional development of students and their socialisation into the profession was a major theme and many of the respondents were specifically aware that they served as role models for the students in this regard. This would suggest that they understood their professional identity as pharmacists as central to the impact they have on preparing students for the profession.

The responses of educators with regard to their role, and that of education in driving changes in practice as opposed to being responsive to changes, to a large extent supported the views offered within the second phase focus groups. Although some suggested that one aspect was more important than the other, many of the educators believed that education should be both driving change *and* responding to change. The ways that were identified as the means to drive change included: through teaching and/or research; the development of graduates capable of being change agents; through direct involvement in professional and statutory bodies; through educators' personal attributes; and through collaborative efforts with pharmacists in practice.

Although this summary has attempted to draw together some of the dominant themes identified during this phase of the study, because of the constructivist-interpretive approach to the study and, consequently, the predominantly qualitative nature of the questions, the diverse and sometimes unique positions and beliefs of educators, as highlighted throughout the section, cannot be disregarded. The attempt to widen the study participant base through the use of a questionnaire should not be viewed as an effort to draw generalisable conclusions, but rather to provide greater depth and understanding to some of the perceptions, belief and issues already identified in the first two phases of the study.

CHAPTER 7

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

In this chapter the findings of all three phases of the study are reviewed in the context of the existing literature, in relation to each other also and to the research questions presented in Chapter 1. I then provide my personal reflections on the research process and its implications for understanding of my professional identity. Thereafter study limitations and implications are discussed and recommendations are offered. Finally, suggested directions for future research are also highlighted.

7.1 Review of the results and the initial research questions within the context of the reviewed literature

Despite the concept of pharmaceutical care having been accepted and endorsed by national and international pharmaceutical organisations for more than twenty years, it has seemingly failed to penetrate and transform practice in the manner in which it was hoped (Austin *et al.*, 2006; Droege & Baldwin, 2005; Hughes *et al.*, 2010; Montgomery *et al.*, 2007; Williams, 2005) and pharmaceutical care remains "a dream deferred" (Hepler, 2010, p. 1319). Although many barriers to the implementation of pharmaceutical care were identified and reviewed in Section 2.3.5, it has been suggested that underpinning all of these barriers may be a "tenuous professional identity" which inhibits the pharmacy profession from accepting its responsibility for a pharmaceutical care approach to practice (Williams, 2005, p. 146). Furthermore, it has been proposed that pharmacy education and educators are integral to the development of professional identity and that shortcomings in pharmacy practice may be due to short-comings in pharmaceutical education (Hagemeier, 2010).

Notwithstanding attempts to address these short-comings through numerous pharmaceutical education reforms which have focussed on the curriculum, teaching methods and strategies (reviewed in Sections 2.4.5.2 and 2.4.5.3), practice has not been transformed significantly (Austin & Duncan-Hewitt, 2005). However, as far back as 2000, Smith (2000, p. 100) argued that attempted reforms had failed to address the role of pharmacy educators and particularly

the potential impact of their professional identity on their teaching and the educational process. Furthermore, he made a call for pharmacy educators to do the "heavy mental work" of self-reflection, particularly with respect to who they are as teachers. Although the literature suggests that the role of pharmacy educators, particularly with regards the socialisation of students into the profession, has been investigated (Beardsley *et al.*, 2008; Hagemeier, 2010), no reported studies specifically giving consideration to the professional identities of pharmacy educators were identified.

It is in this context and in the light of the four incidents described in Section 1.1 which contributed to my personal concerns regarding clarity of my own professional identity and effectiveness as a pharmacy educator that the current study sought to identify, describe and analyse the self-perceived professional identity of pharmacy educators.

Although the findings of each of the three phases of the study have been reported and discussed in Chapters 5 and 6, a synthesis of these findings in relation to the five research questions is provided below.

7.1.1 What are the self-perceived professional identities of pharmacy educators in South Africa?

There was a multiplicity of professional identities that existed for the participants and respondents. However, all of their identities appeared to be comprised of at least two facets – a vocational or pharmacy facet and an academic facet - and could be located on a continuum between pharmacist identity and academic identity (see Sections 5.11.1.1, 6.2.2 and 6.3.5). The manner in which pharmacy educators held these two facets in equilibrium largely determined where they were located on the professional identity continuum and the nature of their perception of their professional identities. Consequently, some of the educators identified themselves primarily as pharmacists; others saw themselves predominantly as academics, while some described their identities as being both pharmacist and academic in nature.

Within the academic side of the continuum various sub-aspects of identity were recognised and those whose identities lay on this end of the spectrum described themselves as researchers, lecturers, teachers or disciplinary specialists, rather than using a generic description such as academic. In total, 46 pharmacy educators participated in this study and only one of them used the generic term academic. A participant who identified himself using the term "academic pharmacist" explained how this term unified and integrated the various facets of his professional identity.

The literature reviewed suggested that both professional and academic identities were multi-faceted in nature (see Sections 3.1.2.3, 3.2.2 and 3.3.1) and for many of the participants and respondents there was a tension and vacillation involved in trying to reconcile the various facets of their identity. For many, particularly those toward the midpoint of the continuum the tension lay in balancing the pharmacist and academic facets. Similar tensions to these have been previously recognised by other authors as being frequently experienced by academics teaching on vocational programmes (Boyd & Smith, 2011; Holroyd, 2000; Shreeve, 2011) (see Section 3.3.4). There was often reluctance on the part of academics in these other studies to relinquish their vocational or clinician related identity in lieu of adopting or developing an academic identity. It was suggested that support structures and in particular academic mentoring was helpful in the development of teaching and research skills and the forming of academic identity. In all phases of this study the absence of mentoring in the academic environment was identified as a challenge and perhaps a missing component that may have led to a willingness of some participants and respondents to adopt an academic identity.

The tension in reconciling aspects of identity was further complicated for some of the participants by the struggle to balance the teacher or lecturer aspects of their identity with the researcher aspect. It became evident throughout the study, but particularly in the third phase, that many of the participants or respondents were attracted to academia by the desire to do postgraduate studies and to develop themselves as researchers. However for many of them, particularly early on in their academic careers, they experienced a contradictory situation where the teaching or lecturing load they were given was so large that its demand became their primary focus. This created tension for them and had consequences for their perceptions of themselves professionally, in particular for the integration of the research aspect of their practice into their identity. On the other hand, there were some participants and respondents who viewed themselves primarily as teachers or lecturers and struggled with the constant expectation and pressure to develop the researcher aspect of their identity. This supports the findings of other authors who have suggested that the complex relationship between teaching and research (and administration) has resulted in tension between what academics perceived as their professional identity and that which becomes prescribed by the university at which they were employed (Billot, 2010; Kreber, 2010; Winter, 2009).

It became clear during the third phase of the study that for many respondents their sense of agency and their self-perceived capacity to make a meaningful contribution within higher education and the wider pharmacy profession was related to issues of identity. However, many of the respondents viewed their identity as a pharmacist as being central to their

contribution and participation in higher education, while the converse was also true; many also viewed their contribution within the wider pharmacy profession as being directly related to their academic identity.

Jameson (2007, p. 211) suggests, that despite the multi-faceted nature of identity, most people strive to know themselves as a "whole person with integrated identities". Thus it is conceivable that the work of reconciling their identities would have been a concern for some of the participants. In addition, Shreeve (2011) argues that the inability to successfully manage and integrate the various aspects of the academic role is an issue of identity and that failure to reconcile the various aspects of identity can result in a lack of real engagement with the academy. This might in part explain why some of the respondents in the third phase of the study perceived their role within the wider university as being either minimal or related to their status as pharmacists and why many of the participants throughout the study described their identity primarily as pharmacist. It is in this context that I suggest that the use of an all-encompassing term such as "academic pharmacist" provides a means by which pharmacy educators can assimilate the multi-faceted aspects of their professional identity into an integrated sense of wholeness.

Shreeve (2011) further suggests that there are personal and social factors which need to be recognised in the negotiation of identity and that the academy needs to create opportunities within which academics can both express and position themselves. This supports the recommendation for the need for work on clarifying the career path of academic pharmacists and for mentoring and guidance in the development of an academic career and in the negotiation of professional identity within the academic environment.

7.1.2 What are the key factors which contribute to participants' self-perception of their professional identity?

Briggs (2007) proposed that issues of professional identity lie at the juncture between agency and structure and that an individual's professional identity is determined by their personal perceptions of self-image and self-efficacy in relation to their working context. In the first phase of this study six key determinants were identified as underpinning the participants' self-perception of their professional identity. These included three structural determinants: expected role; knowledge base; and practice and three determinants relating to the emotional dimensions of professional identity: professional status; passion; and satisfiers. Knowledge base was expanded in the second phase of the study to include skills base.

I proposed that the greater the value an individual places on one or more of the key determinants, the greater will be the extent to which they are likely to make the investments necessary to develop that aspect of their identity. In addition, the interplay between the key determinants and the degree to which they support the facets of professional identity on which an individual places the greatest importance, can determine the level to which the individual is able to integrate their sense of self as a professional. Furthermore, it can also determine the individual's accompanying sense of agency associated with their professional identity. The structural key determinants identified, to a large extent, describe the manner in which professional identity can be considered a product of work context, whilst the latter three are perhaps more related to the agency aspect of identity. This supports the notion proposed by Briggs (2007, p. 473) that professional identity is both a "product and an agent of the systems and structures within which the individual's working life is located".

Although not included as a direct key-determinant of professional identity, the third phase of the study revealed how the workplace was perceived to support or contribute to the other key determinants and ultimately the self-perception of professional identity. Challenges identified within the workplace which may have impacted negatively on respondents' willingness to adopt academic identities included: workload; bureaucratic and hierarchical structures; poor salaries and opportunities for promotion. These challenges would have been pivotal in what emerged as key determinants such as expected role, professional status and satisfiers.

7.1.3 How has membership across multiple communities of practice contributed to the development of professional identities?

In all three phases of the study it became evident that the professional identities of participants and respondents involved a degree of participation in at least two broad communities of practice – a pharmacy community and an academic community. Furthermore, within each of these two broad communities and particularly the pharmacy community, participation in multiple other communities was also evident.

Consistent with the notion that professional identity is dynamic (Reybold, 2008; Slay & Smith, 2010; Trede *et al.*, 2012) the in-depth narratives of Zeth and Abbot in the first phase of the study, clearly illustrated how professional identities are formed by trajectories through communities of practice. Wenger (1998) proposed that communities of practice are essentially about learning and that participation in a community can be a stimulus for both personal and professional growth. In several of the narratives, but particularly in those of Zeth of Abbot the personal and professional growth and accompanying negotiation of professional identity as they moved through various communities of practice were evident.

Wenger's (1998) idea that identity formation happens in the tension between a sense of belonging to a community (identification) and the capacity to contribute meaningfully within a community (negotiability) was also borne out by some of the narratives. In particular, Tia's peripheral participation within retail and industrial pharmacy communities never led to identification with those communities, since she believed that her capacity to contribute to them in any meaningful manner was negligible (see Section 5.2.1.2). By contrast Zeth's identification with his subject discipline and his ability to contribute meaningfully to its knowledge base developed within him a solid identity as a pharmacologist – a subject specialist (see Section 5.7.1.1).

The extent to which pharmacy educators participated in pharmacy-related communities of practice outside of the university environment was evident in all phases of the study, but in particular, during the third phase. Some of the third phase respondents actually indicated that the perception of the opportunities which the academic lifestyle afforded for participation in multiple communities of practice, had been one of the factors which had first attracted them into higher education.

Opportunities for legitimate participation in pharmacy-related communities of practice were of importance to the participants and respondents. The reasons cited for their multi-membership of communities of practice included: enriching and keeping teaching and research relevant; a means of providing positive role models for students; a means of contributing to the profession; opportunities for community engagement; enhanced understanding of the healthcare environment in which pharmacy is practiced; opportunities for involvement in the formation of the professional identities of other pharmacists; personal growth as a professional; and furthermore, reinforcing pharmacist identity - maintaining their sense of "calling" to the profession and also their identification with the profession and as professionals. This last reason highlights the recognition of the important contribution participation and agency in professional communities of practice makes to sustaining professional identity.

What was, however, made evident during the third phase of the study was that the respondents' sense of agency within the broader pharmacy profession was often associated with their academic identity. Some even expressed the view that their academic identity elevated them to a leadership status within the profession and that they were ambassadors for the profession. By contrast, participants and respondents' participation in the wider university community was sometimes very limited and when they did participate it was often for the purpose of "raising pharmacy's voice, from a professional point of view" (5: 33). Furthermore, very few of the participants or respondents participated in education related

communities of practice outside of their immediate university environment. This is consistent with the literature which suggests that many vocational educators do not become fully participating members of the wider pedagogical community (Smith & Boyd, 2012; Viskovic & Robson, 2001, p. 223).

7.1.4 What are the attitudes, beliefs and behaviours regarding the philosophy and practice of pharmacy, pharmaceutical care and pharmaceutical education?

Healey and Hays (2011) argue that "agreement with the guiding philosophy" of a profession is fundamental to one's professional identity and furthermore both defines one's beliefs and values and determines the manner in which one approaches one's role within the profession. Pharmaceutical care as a guiding philosophy was embraced and supported by almost all the participants and respondents in all phases of the study. Some of the educators viewed it as underpinning the whole curriculum and claimed to have been teaching it for many years, while others suggested that in terms of the curriculum it was a standalone concept which was and should be taught in specific modules or courses. However, some did not view it as impacting directly upon their teaching.

Some participants expressed concern with regards the term "pharmaceutical care" suggesting that it was overused and that it had lost its meaning. However several participants expressed concern that as pharmacy educators they have been teaching an idealistic model of pharmaceutical care which was neither feasible nor appropriate for the South African context. Although supportive of the patient focus of pharmaceutical care, they specifically struggled with the notion of pharmacists taking "responsibility for outcomes" and suggested that the definitions regarding pharmaceutical care were confusing. In the original definition of pharmaceutical care suggested by Hepler and Strand (1990, p. 535), the responsibility of the pharmacist for outcomes, within the context of a patient focus, was a central theme (see Section 2.3.1). Although in the past, in an effort to protect the "purity" of the concept authors, such as Kennie and colleagues (1998, p. 18) warned that the term should be used with caution and should not be applied to all care services that pharmacists offer. However more recently, other authors such Farris and colleagues (2005) have argued that in terms of practice, pharmaceutical care should be viewed as any activity or service which ensures the best pharmacotherapeutic outcomes for patients.

It is perhaps an attempt on behalf of pharmacy educators to teach the ideal or "pure" model of pharmaceutical care as described in Section 2.3.3, that has left some of them confused

about the term and the many ways in which it is defined. Furthermore, this is perhaps also at the source of many of the participants and respondents' sense of disillusionment with the extent to which they consider that it has not been implemented in practice. In addition, some have been left questioning its relevance and practical feasibility within the South African context (see Sections 5.11.2, 6.2.6 and 6.3.7). Based on these concerns, I suggested that the term and definition within the South African context needs to be revisited. I further offer that in keeping with the suggestion of Farris and colleagues (2005) that we cease trying to cling to an ideal or pure model of pharmaceutical care and that the term be expanded to encompass any pharmaceutical services or activities which, within a patient centred approach seek to ensure the best pharmacotherapeutic outcomes for patients and society.

The extent to which pharmaceutical care has not penetrated practice was not the only practice-related concern expressed by participants and respondents. There was a general disquiet amongst educators in all phases of the study, about the incongruities they saw between the way they were teaching pharmacy and the manner in which it was commonly practiced. They were particularly concerned about the confusion, frustration and disillusionments that this often created for students. This is however a concern that has been voiced by pharmacy educators throughout the world. As Austin and colleagues suggest (2006, p. 536) this "misalignment of expectations, attitudes, and behaviours" has serious implications for the socialisation of students into the profession and has the potential to leave students disappointed with their education and frustrated with pharmacy as a career choice. Some of the educators in this study supported the idea proposed by Hagemeier (2010) that pharmacy educators should not only be preparing students with the basic skills necessary for ideal practice, but should also be preparing them for the real issues which they are likely to be confronted with in the practice environment.

Although some of the participants and respondents believed that pharmacy educators should focus teaching on preparing students for current practice, there were others who believed that it was the responsibility of pharmacy education to drive changes in practice, by teaching for future practice. Many did however propose that it required a dual approach, similar to that advocated by Hagemeier (2010), that pharmacy educators have a responsibility for preparing students to be aware of the realities of current practice and yet with a vision and knowledge of how practice could be changed and furthermore, also reinforce the capability of changing practice. As Hagemeier (2010) further suggests through their interaction with students who are the pharmacists and pharmacy leaders of the future, pharmacy educators are in a unique position to positively impact on the profession.

7.1.5 What is the perceived mutual impact of professional identity and participation in multiple communities of practice, on teaching and more particularly the beliefs, attitudes and behaviours modelled to students?

Consistent with the notion proposed by Hammer and colleagues (2003, p. 17) that if the mission of pharmacy education is the preparation of competent future practitioners then professional development must of necessity be a priority which is embraced by all pharmacy educators. In all phases of the study many of the participants and respondents considered their role in pharmacy education to encompass the development of future professionals. However, the importance that they placed on this aspect of their role varied.

Throughout the study the greatest sense of reward and fulfilment for many of the pharmacy educators was perceived to be found in their interaction with students and more particularly in the professional development of students. This was specifically noticeable in the third phase of the study where despite many of the respondents having been attracted to higher education for their own personal development through postgraduate studies, one of the most rewarding aspects of their work was reported to be student development and empowerment.

Many of the participants and respondents were aware that as a consequence of their pharmacist identities they had a responsibility to be role models for students. This aspect of their identity was also reinforced by the metaphors by which some chose to describe themselves as professionals. Words used to describe the metaphors included “moulding” (R1), “guidance and inspiration” (R17) and “excellent representation”; all referring to the process of socialising students into the profession.

While some considered participation in multiple communities of practice as a means to reinforce their professional identity as a pharmacist, there were others who also viewed it as a way of modelling responsible professional behaviour to students; believing that if students witnessed pharmacy educators taking an active interest in the profession, they might be motivated to do likewise. The value of active role modelling in this manner is supported by the suggestion of Hammer and co-authors (2003), that professional socialisation commences with the initial interactions of a student with pharmacists and the consequent evaluation by the student of the behaviours, beliefs and attitudes which he or she sees modelled.

In keeping with the concept of educational care described by Popovich (1992), as expressed by Kiron in the first phase of the study, some respondents in the third phase recognised their responsibility to actively model pharmaceutical care through the manner in which they extended care to their students. Notably, it has been proposed that the impact of pharmacy

educators on the caring ability of students is not only a consequence of what or how they teach, but is also dependent on their professional identity - who they are as teachers – and how they model care in that role (Fjortoft & Zgarrick, 2001).

7.2 Personal reflections

As I explained in the background to the study and made evident in the auto-ethnographic account of my own story in Chapter 1, this study emerged in the context of personal reflection and commenced with real questions about my own professional identity and my effectiveness as an educator. Furthermore, I was particularly concerned about the multiple identities I possessed and my desire to achieve a holistic integrated sense of myself professionally. Since this process can be considered “insider” research (Corbin Dwyer & Buckle, 2009, p. 58), for the sake of completeness, in this section I provide a description of some of the similarities and differences between my own experiences and that of my fellow pharmacy educators reflected in the findings presented in this thesis. In addition, I consider my understanding of my own professional identity and give consideration to the manner in which it has changed through this research process.

Like many of my fellow pharmacy educators, I was attracted into higher education for the purposes of acquiring a postgraduate Master’s degree. The purpose for the degree was linked to my zeal to enhance my effectiveness as a patient-centred pharmacy practitioner and through it I sought to increase my knowledge, skills and self-confidence. However, being in the university environment provided me with the opportunity to teach and despite difficulties associated with under-preparedness for teaching; I discovered an affinity and passion for it.

Life’s circumstances saw me moving away from the university community and moving through various other pharmacy-related communities of practice. In a similar manner to that described in the participant narratives in the first phase of the study, each trajectory through a community of practice contributed to the formation of my professional identity, particularly as a patient-centred pharmacist. On reflection, however, I recognise how in each of these various communities of practice I sought out opportunities to teach and how even outside of the academic environment, my professional identity as a teacher was beginning to develop.

My first full-time appointment back in academia provided me with an opportunity through the development of experiential learning programmes, to give full expression to both the pharmacist and academic, or more specifically, teacher facets of my professional identity. At that time, like many of the participants in this study, I would have said that although I was a

teacher, being a pharmacist was central to defining who I was and I called myself a pharmacist/teacher. Unlike many of my colleagues however, I have never felt comfortable with the term lecturer or used it to describe myself. Within the academic spectrum of the identity continuum, I also consider myself a teacher rather than a researcher. Although throughout the study process I have, in my personal reflections, considered the extent to which this might change should I acquire my doctorate, I believe that I will remain predominantly a teacher. On a personal level, I view the doctorate primarily as a means to clarify my professional identity and enhance my capacity to be able to guide and mentor others in the process of teaching and research.

I resonate with the feelings of under-preparedness for teaching expressed by many in this study and in an effort to address my lack of previous training and perhaps to take the teacher aspect of my professional identity more seriously; I immersed myself in a variety of pedagogical learning opportunities and my teaching also became the focus of any research that I undertook. Furthermore, I began to seek out opportunities for participation in education-related communities of practice beyond the pharmacy domain. This aspect of my professional development and identity seems to be in contrast to many of the participants in the study, although some have participated in the occasional educational workshop very few have sought participation in education-related communities of practice. It needs to be noted, however, that despite providing greater stimulus for my interest in education, beyond the immediate academic departments in which I have worked, I have always felt on the periphery of educational or pedagogical communities of practice. Although the shared practice aspect has normally been present, I have always felt that I was lacking in the shared pedagogical knowledge base and therefore was not always able to engage fully within them.

It was my move to the UK and the loss of my recognised professional status as a pharmacist because I did not meet the requirements for professional registration as a pharmacist in the UK, and the inability to practice outside of the higher education domain, that gave me the first real sense of the extent to which being a pharmacist was integral to my professional identity as a pharmacy educator. It was during that time that I shifted toward calling myself, and perhaps perceiving myself, as a teacher rather than the pharmacist/teacher perception I had previously held. Through this experience, I can understand how some of the participants in the study only used academic descriptors, such as lecturer, teacher or researcher to identify themselves.

It has become clear to me through this study that one of the key determinants of my professional identity is my practice as an educator or as a pharmacist. It was only when I eventually returned to practice, as a pharmacist in a community pharmacy that the

pharmacist descriptor started to creep back into what I called myself. At the outset of the study I would have been tempted to argue that it was my passion which was the key determinant of my professional identity, but the manner in which I dropped pharmacist from my self-description and my hesitancy to re-introduce it, until I perceived that I was once again practicing as a pharmacist, suggests otherwise.

This view of only being a "practicing pharmacist" when it is outside of the academic environment is in itself a contradiction and relates directly to the original question asked of me by my daughter: "What is it like to spend so long studying for a profession, and then not to practice it?", and to the response I received when completing the Annual Declaration Practice Profile questions - "According to your practice profile you are a non-practicing member of the South African Pharmacy Council"! It begs the question why academic work and particularly the work of developing the next generation of pharmacists is not considered "practice" of pharmacy. McAlpine and Akerlind (2010, Kindle Locations 328-333) suggest that with respect to academic practice: "The term 'practice' brings into play the underlying, sometimes implicit, purpose(s) that motivate us to be academics and through which it is possible to integrate an array of multi-faceted duties, responsibilities, skills and knowledge into a coherent sense of academic identity". I have therefore, through the course of this study come to the conclusion that I am a pharmacist working in academia, my "practice" is primarily my academic work, and I am by very nature an "academic pharmacist". As a consequence I am increasingly adopting the term "academic pharmacist", offered and explained by one of the focus group participants (FGP6) (see Section 6.2.3), to describe myself professionally since it offers a means of integrating the various facets of my professional identity into a single descriptor.

The other aspect of my thinking that has been severely challenged by this research and by the opportunity to engage with fellow pharmacy educators is the concept of pharmaceutical care. I have always been a proponent of the "pure model" of pharmaceutical care as defined by Hepler and Strand (1990) and further developed by Cipolle and colleagues (2004) and furthermore, this is the model of pharmaceutical care I have taught. Although I remain convinced that as academic pharmacists we should be driving the profession increasingly toward a patient-centred or perhaps even a relationship-centred approach, strengthened by my community pharmacy experience, I now find myself together with some of the pharmacy educators in this study, questioning the feasibility and suitability of pharmaceutical care in its "pure" form, for the South African healthcare context, and suggesting that as pharmacy educators and as a profession we need to revisit the concept.

This research has enabled me to look beyond my own experiences of pharmacy education and practice and issues of professional identity, and to consider a diverse range of other perspectives offered by the participants and respondents. I am truly grateful to each of the participants and respondents who have offered the many voices and opinions which have been described here. Not only have they contributed to the collective understanding of who it is that teaches pharmacy represented by the findings reported in this thesis, but they have enabled me to better understand my own perceptions of who I am as a pharmacy educator and my beliefs about pharmacy education and pharmacy practice.

In keeping with the multi-faceted, contextual and dynamic nature of identity, echoing the sentiments of the poet May Sarton, this study has been for me a conscious process of "becoming", and one which I recognise will continue into the future. More specifically the opportunity to share in the stories of other people's lives and in the construction of their professional identities empowered me to honestly explore and to construct and reconstruct my own professional identity, to become more fully myself – an academic pharmacist.

7.3 Study limitations

Although some of the potential study limitations were discussed in Section 4.5 when attention was given to the ethical issues that needed to be considered in this study, in this section I draw attention to some of the methodological limitations that need to be borne in mind when considering the findings and the conclusions offered in this thesis. These relate in particular to the research paradigm, my role as an "insider" researcher and the necessity to respect the participants' anonymity and confidentiality.

A constructivist-interpretive research paradigm is based on the understanding that multiple realities are co-created in the interaction between the researcher and the participants (see Section 4.2.1). The purpose of the research is not to create generalisable theories; the research is by nature idiographic - that is focused on the individual –and every voice is significant. I am aware that in my efforts as the researcher to summarise the findings in a meaningful whole and to draw conclusions, the focus has often been on the "louder" voices which are also in many instances the voice of the majority. I therefore acknowledge that some of the opinions, beliefs and perceptions of some of the participants or respondents may have been overlooked, particularly in the summaries and in this concluding chapter and ask that these should not be considered to have been of any lesser significance in their contribution to an understanding of the professional identities of pharmacy educators.

In addition, as an "insider" researcher I recognise that, at times, I might have had undue influence on both the collection of the data and also on the interpretation thereof. For example I am aware that in Hypatia's interview my use of the word "teacher" prompted her use of it and it only became evident at a late stage in the interview that she did not identify herself as a teacher, but rather as a lecturer and that she saw a distinct difference between the two (see Section 5.9.1.2). It was for this purpose that I did try as best as I could to use fairly neutral terms – such as pharmacy educator - in all my correspondence and communication with participants. It is also for this reason that I included the auto-ethnographic account of my own narrative in the first chapter and my personal reflections in this final chapter, making my own experiences, assumptions and beliefs as visible as possible.

The use of "member-checking" of not only the interview and focus group transcripts and the constructed stories but also my interpretation of them was a further effort to guard against inappropriately imposing my own interpreted meaning on the constructed lived experiences and narratives of the participants. However, as Bell (2002, p. 210) suggests, "participants can never be quite free of the researcher's interpretation of their lives". Furthermore, when we are dealing with the actual lives of real people, as Josselson (2007, p. 559) cautions: "we can never know for sure at the outset that we will not have an impact on them that could be in some way painful". Despite paying very careful attention to details and particularly the manner in which I worded difficult issues, and at times leaving pertinent comments out, in order to avoid causing harm or pain, the challenge that avoiding causing participants pain poses, became clearly evident for me in the member-checking process. For example, one of the participants in the first phase of the study described the initial reading of her story and my interpretation of it as emotionally troubling. She did however, go on to suggest that what I had written was "absolutely the truth" and that in my interpretation I had "captured the essence" of who she was (see Section 5.10) and furthermore, through the process she had gained deeper insight into her identity. Therefore, the need to balance in-depth, credible reporting of findings with respect for the wellbeing and dignity of participants may be considered to be a limitation of a study of this nature.

Similarly, throughout the data collection, transcription and analysis stages of the research, the need for participant confidentiality and anonymity had to be constantly balanced against the need for sufficient detail necessary to make meaningful interpretations. With a relatively small study population, where many of the potential participants are well-known to one another in the pharmaceutical education domain, certain demographic details, for example race, which may have made a significant contribution to the study findings, could not be

included in order to protect the anonymity of the participants. Thus, the need to exclude certain demographic data may be considered to be a further limitation to insights gleaned in the study.

7.4 Implications and recommendations

This study responds to a challenge issued over a decade ago for pharmacy educators to do the "heavy mental work" of exploring "who" it is that teaches in the hope that it might "strike at the root of our ineffectiveness and enable us to produce positive educational reform and improved teaching" (Smith, 2000, p. 100). The findings have not only contributed to a collective understanding of "who" it is that teaches pharmacy, but the study has involved almost half (46) of all the pharmacy educators (approximately 85) in South Africa in some reflection and exploration of issues around their own professional identity and their purpose and effectiveness as educators of future pharmacists.

Arising out of this study I offer the following recommendations:

1. All pharmacy educators be encouraged to reflect on "who" they are as educators and on issues of professional identity. Furthermore, in the exploration of the multiple facets that may comprise their identities they are encouraged to reflect on their relationship with the broader pharmacy profession and their perceptions of their own practice and the practice of pharmacists in other sectors. By maintaining an awareness of "who" they are and their own practices relative to the wider profession they might be enabled to more consistently prepare students for the realities of the practice environment and positively socialise them into the profession.
2. In the context of many of the participants in this study admitting to their under-preparedness for and their lack of pedagogical knowledge, pharmacy educators should be encouraged to address the possible short-comings in their pedagogical knowledge and skills, and seek out opportunities for both informal and formal training in this regard. The career path of new academic pharmacists in particular should include be encouragement and support towards obtaining a formal qualification in education such as a postgraduate certificate or diploma in higher education.
3. As a consequence of the manner in which participation in multiple communities of practice supports the development of professional identity and informs the teaching and research of pharmacy educators, they should be encouraged to seek out opportunities for participation in both pharmacy and education related communities of practice. In addition, such voluntary participation should be both supported and recognised by the universities as legitimate community engagement.

4. Within suitable forums such as the Academy of Pharmaceutical Sciences, pharmacy educators should engage in discussions around the adoption and common use of a descriptive term, such as “academic pharmacist” to describe themselves. This may not only assist pharmacy educators to integrate the various facets of their academic and pharmacist identities, but may serve to reinforce and empower academic practice as a recognised aspect of pharmacy.
5. Pharmacy educators should lobby the South African Pharmacy Council to recognise academic pharmacy as a speciality. Furthermore, that the terms and requirements for registration as an academic pharmacist be negotiated with the Council, with the possible requirement of a formal educational qualification, as mentioned in 2 above, in addition to a pharmacy-related postgraduate degree. This may serve the dual purpose of encouraging academic pharmacists to further develop themselves as educators and also make pharmacy education a more attractive career option for pharmacists.
6. Universities and in particular faculties, schools and departments of pharmacy be encouraged to address clarity of career path development and mentoring of new and emerging academic pharmacists. I specifically suggest that pharmacy educators who have effectively reconciled the various aspects of their professional identity and successfully negotiated an academic identity, be encouraged to take an active role in mentoring others in the process. Furthermore, I propose that the mentoring of new academics not only focuses on the “public aspects” of academic practice, such as structures, expectations and requirements, but that these be balanced with a focus on the “personal aspects” including emotions, experiences and issues of identity, value and purpose (Akerlind & McAlpine, 2010, Kindle Location 3632). Since identities are constructed through narrative, the simple act of assisting others to think and talk about “who” they are as educators and explore issues of professional identity has the potential to facilitate the process of identity negotiation. For example, discussions around the use of a term such as “academic pharmacist” to describe oneself could stimulate thinking and talk about the various aspects that comprise professional identity. The formative role of the academic internship as preparation for an academic career should also be further explored and developed. In particular the inclusion of a requirement for formal training and mentoring in educational issues as part of the academic internship should be considered.
7. That pharmacy educators and in fact the entire pharmacy profession, through the South African Pharmacy Council and professional organisations such as the Pharmaceutical Society, be encouraged to revisit the concept, definitions and applicability of pharmaceutical care, particularly within the context of the proposed

changes within the healthcare environment of South Africa, such as the move toward National Health Insurance. Furthermore, within the milieu of such discussions, a needs based approach to pharmaceutical education as proposed by the International Pharmaceutical Federation (FIP) Pharmacy Education Taskforce (Anderson *et al.*, 2010), particularly with respect to pharmaceutical care, be given careful consideration.

The insights from this study and the recommendations offered as a consequence have the potential to enhance the effectiveness of pharmacy educators and to develop their sense of professional identity as academic pharmacists. Additionally, they could serve to make academic pharmacy a more attractive career option which may have positive implications for the attraction and retention of pharmacists into academic posts within faculties, schools and departments of pharmacy within South African universities.

7.5 Future research directions

Many of the recommendations offered in the previous section also suggest areas for future investigation and research which include:

1. The focus on identity in this study was on self-perceived identity, however authors such as Wenger (1998) suggest that the manner in which others perceive us and make sense of who we are, and furthermore, reify us, also impacts on our identity. This would suggest that in order to more fully understand the professional identity of pharmacy educators, how they are perceived by others would be an interesting study. Other perspectives could specifically include those of students, new graduates, the wider pharmacy profession, colleagues within the broader university environment, and those involved in policy development - for example the South African Pharmacy Council.
2. Furthermore since “pharmacist” is an integral facet of the identity of pharmacy educators, further research investigating the self-perceived professional identities of pharmacists in other practice sectors, such as community, hospital or industrial pharmacy, could also inform the findings described in this study.
3. A study involving new graduates and an investigation of their perceptions of the influence of the professional identities of their pharmacy educators on their socialisation into the profession and preparation for practice could also add to our understanding in this area. Such a study could also give specific attention to how the perceived “caring” attributes of their pharmacy educators have contributed toward the development of their own “caring” attributes.

4. A study to specifically determine the relevance of the concept of pharmaceutical care within the changing healthcare environment in South Africa would also assist pharmacy leaders and educators in future decision making.

7.6 Concluding remarks

In so far as I have been what Kvale (1996, p. 4) metaphorically describes as a fellow "traveller" in this research process, I am immensely grateful to my academic pharmacist colleagues for their willingness to share with me their stories, perceptions, attitudes and beliefs, such that we could in many senses co-construct an understanding of "who" we are as pharmacy educators.

This study has also been a personal journey of construction and re-construction of my own professional identity as an academic pharmacist. Hearing other people's stories, experiences and beliefs has assisted in developing my own understanding of the factors that have been and are important to my personal sense of professional identity. Furthermore, it has forced me to question some of my fundamental understandings of both education and pharmacy practice.

However, based on the literature review, the research process, the findings reported in this study and my developing personal experience I have to acknowledge that professional identity is multi-faceted, relational, contextual and dynamic and moreover it is constructed and understood through narrative. I therefore recognise that for myself and hopefully for my fellow travellers – the academic pharmacists who participated in this study, this is a journey that is only beginning. But it is a journey that if we are prepared to continue upon is one that may "enable us to produce positive educational reform and improved teaching" (Smith, 2000, p. 100).

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APPENDICES

APPENDIX A: SOUTH AFRICAN PHARMACY COUNCIL ANNUAL DECLARATION PRACTICE PROFILE QUESTIONS

1. Evaluation of a patient's medicine related needs by determining the indication, safety and effectiveness of the therapy;

2. Dispensing of any medicine or scheduled substance on the prescription of a person authorised to prescribe medicine

3. Furnishing of information and advice to any person with regard to the use of medicine

4. Determining patient compliance with the therapy and follow up to ensure that the patient's medicine related needs are being met

5. The compounding, manipulation, preparation or packaging of any medicine or scheduled substance or the supervision thereof

6. The manufacturing of any medicine or scheduled substance or the supervision thereof

7. The application for the registration of a medicine in accordance with the Medicines Act registration of medicine

8. The purchasing, acquiring, importing, keeping, possessing, using, releasing, storage, packaging, re-packaging, supplying or selling of any medicine or scheduled substance or the supervision thereof

9. The re-packaging of medicines

10. The promotion of public health

11. Procurement, storage and distribution of medicine

12. Management and administration (excluding human resources development)

13. Dispensing medicines and ensuring the optimal use thereof including the provision of pharmacist-initiated therapy

14. The formulation of any medicine for the purposes of registration as a medicine

15. Providing information and education relating to medicine

16. The initiation and conducting of pharmaceutical research and development

17. The distribution of any medicine or scheduled substance

18. Training and Human resource development

APPENDIX B: PERMISSION LETTER – HEADS OF DEPARTMENT

Department of Pharmacy
Nelson Mandela Metropolitan University
Tel: (041) 504-4212
Fax: (041) 504-2744
Email of researcher: susan.burton@nmmu.ac.za

Ref: xxxxxxx
Contact person: Susan Burton
Date: _____

Professor _____
Department of Pharmacy
University _____

Dear Professor / Dr _____

I would like to request your permission to approach the staff within your department to participate in a research study entitled: "Self-perception of professional identity of pharmacy educators". The aim of the study is to identify, describe and analyse the self-perceived professional identity of pharmacy educators within the South Africa context.
The study is comprised of three phases:

1. Semi-structured interviews conducted with eight pharmacy educators, one from each school or department of pharmacy, to gain an in-depth understanding of their self-perceived professional identity and to explore how their lived experiences, across various communities of practice, has formed their self-concept.
2. In the second phase focus groups to be held at a pharmacy conference will be used, to explore, within a broader interactive context, some of the factors and communities of practice identified by participants in the first phase, as contributing to development of professional identity.
3. The third phase of the study will use a purpose-designed questionnaire, developed from the insights gained in the first and second phases, to explore with all pharmacy educators, their self-perceived professional identity, attitudes, beliefs and practices related to pharmaceutical care and the socialisation of students into the pharmacy profession.

Participants from the academic pharmacy community will be sought for each of the three phases of the research, which will be conducted over the next six months. In each phase, participation will be voluntary and participants will be free to withdraw at any stage of the process. Confidentiality and anonymity will be ensured at all times and no names of participants or universities will be divulged in the thesis or in any report, article or presentation emerging from it.

The study forms the basis of a doctoral study and has been approved by the Research Ethics Committee (Human) (REC-H) of the Nelson Mandela Metropolitan University (NMMU) (No H11-HEA-PHA-006).

It is envisaged that the findings from the study will provide valuable insights into how the professional identities of pharmacy educators in South Africa, are formed through the communities of practice with which they engage. It will also afford opportunities to better comprehend “who it is” that teaches within our faculties and schools of pharmacy, and the potential impact this has on the professional socialisation of future pharmacists.

The participation of academic staff from your department is critically important to the success of the research and therefore your permission to invite their participation, is very important. I hope that this request meets with your favourable consideration.

Yours sincerely

Sue Burton
Principal Researcher and PhD Student
Department of Pharmacy
NMMU

susan.burton@nmmu.ac.za

041-5044212

0733556849

Prof C.N. Hoelson
Study Promoter
Department of Psychology
NMMU

christophernorman.hoelson@nmmu.ac.za

041-5044594

APPENDIX C: PHASE ONE IN-DEPTH INTERVIEWS PARTICIPANT INVITATION AND IN FORMATION SHEET

Nelson Mandela Metropolitan University
for tomorrow

SELF-PERCEIVED PROFESSIONAL IDENTITY OF PHARMACY EDUCATORS

Dear Pharmacy Educator

You are being invited to take part in a research study entitled "Self-perceived professional identity of pharmacy educators". In order for you to make an informed decision regarding participation, it is important for you to understand the purpose of the research and what it will entail. Please take time to read the following information and do not hesitate to ask for clarity if there is anything that is not clear, or if you would like further information.

Purpose of the study:

The aim of this research study is to identify, describe and analyse the self-perceived professional identity of pharmacy educators within the South Africa context.
The study is comprised of three phases:

1. Semi-structured interviews conducted with eight pharmacy educators, to gain an in-depth understanding of their self-perceived professional identity and to explore how their lived experiences, across various communities of practice, have formed their professional identity.
2. In the second phase a focus group approach will be used, to explore, within a broader interactive context, some of the factors and communities of practice identified by participants in the first phase, as contributing to development of professional identity.
3. The third phase of the study will use a purpose-designed questionnaire, developed from the insights gained in the first and second phases, to explore with all pharmacy educators in South Africa, their self-perceived professional identity, attitudes, beliefs and practices related to pharmaceutical care and the socialisation of students into the pharmacy profession.

You are being asked to participate in the first phase of the study, the in-depth interviews.

The research forms the basis of a doctoral study in the pharmacy department of the Nelson Mandela Metropolitan University (NMMU). It is hoped that the findings from the study will provide valuable insights into how the professional identities of pharmacy educators in South Africa, are influenced by the communities of practice with which they engage. It will also afford opportunities to better comprehend "who it is" that teaches within our faculties and schools of pharmacy, and the potential impact this has on the professional education and socialisation of future pharmacists.

Processes and procedures:

Participation in the study involves an interview with me, the researcher, which will last about 120 minutes. The interviews will be conducted face-to-face at a mutually agreed upon location. With your permission the interviews will be digitally recorded and later transcribed for the purpose of data analysis. Following the

interview you will be invited to continue the conversation with me, via email communication. You will also be invited to review interview transcripts for accuracy. I will also request that you comment on my summary and analysis of your interview, and seek your agreement on my understandings. This is in order to validate my interpretations and to ensure, where possible, that my own bias is not in any way, unduly distorting my interpretation. It will also be an opportunity for you to screen the analysis for any features, which you feel may lead to you being deductively identified in the report, and thus having your confidentiality breached. These will be removed subject to your satisfaction.

Participation in the study:

You have been chosen to participate in the interviews because you are a registered pharmacist, and you teach on an undergraduate pharmacy programme.

Benefits:

Although, no direct benefit, either monetary or resulting from the experience itself, is offered or guaranteed, it is my hope, that our conversation will be mutually enjoyable and beneficial. Research suggests that it is through the telling of one's story that an individual's perception of their identity can be constructed, and made sense of in the context of their life experiences. Participation in the interviews will therefore provide you with the opportunity to reflect on "who" you are as a teacher, and to deepen your self-understanding.

Confidentiality:

All information gathered during this study will remain confidential, and will be stored in a password-protected computer throughout the course of the research, and beyond. In order to protect participants' identities I will use pseudonyms, and only I will have access to information that could connect responses to participants. Neither you, nor your university will be identified in the analysis. All recordings and other data will be securely retained for three years after completion of the study, after which they will be destroyed.

Withdrawal without prejudice:

Participation in this study is voluntary; you always have the option of not answering any questions that might make you feel uncomfortable or withdrawing from the interview or research process at any point.

Ethical approval:

Ethical approval for this study has been obtained from the NMMU's Research Ethics Committee (Human) (REC-H) and the Faculty of Health Sciences' Research, Technology and Innovations Committee.
(Reference number H11-HEA-PHA-006)

If you are willing to participate, I ask that you please complete and return the attached consent form, and I will contact you as soon as is possible to confirm your participation and arrange for the interview.

Many thanks

Sue Burton
Principal Researcher and PhD Student
Department of Pharmacy
NMMU

susan.burton@nmmu.ac.za

041-5044212

Prof C.N. Hoelson
Study Promoter
Department of Psychology
NMMU

christophernorman.hoelson@nmmu.ac.za

041-5044594

APPENDIX D: PHASE ONE IN-DEPTH INTERVIEWS

PARTICIPANT CONSENT FORM

Department of Pharmacy
Nelson Mandela Metropolitan University
Tel: (041) 504-4212
Fax: (041) 504-2744
Email of researcher: susan.burton@nmmu.ac.za

Date: _____

Ref: xxxxxxx
Contact person: Susan Burton

INFORMED CONSENT FORM

I, …… , identity number …… , hereby confirm my participation in the interviews which form part of a study, entitled: "Self-perceived professional identity of pharmacy educators", undertaken by Sue Burton (principal investigator) of the Department of Pharmacy in the Faculty of Health Sciences at the Nelson Mandela Metropolitan University.

I have read the information sheet and the following aspects of the study have been explained to me, the participant:

1. The aim of the study is to identify, describe and analyse the self-perceived professional identity of pharmacy educators within the South Africa context.
2. My participation in the study will involve an in-depth interview with the researcher, and possible continuation of the conversation via email communication thereafter.
3. My confidentiality as well as that of my university will be ensured as no names or other identifying features will be divulged or published.
4. I will be invited to review all transcripts, summaries and analyses arising from the interview and email communications in order to validate the accuracy of transcripts and the researcher's interpretation thereof. I will also be free to request that any features which may lead to divulgence of my identity be removed.
5. I am participating voluntarily and no pressure has been exerted on me to consent to participate.
6. I understand that this consent form is not a contract and I am free to withdraw from participation in the study at any time in the research process.
7. Participation in the study will not result in any cost to me.

I, …… , hereby voluntarily consent to participate in the study.

Signed and confirmed at …… on …….. 2011.

_____	_____	_____
(Interviewee)	(Principal Investigator)	(Witness)

APPENDIX E: PHASE ONE IN-DEPTH INTERVIEW PROTOCOL

Introduction: - explanation of the purpose and procedure of the interview

1. **Please tell me the story of your career thus far?**
   - How would you describe your current occupation?
   - How have your life and work experiences shaped how you now view yourself professionally?

2. **Can you think of a metaphor, analogy or an image which might describe how you view your professional identity; in other words what is your image of yourself as a pharmacy educator?**

3. **In what way is your professional identity shaped across communities of practice?**
   - How do you perceive your role within the university?
   - What is your role within the broader pharmacy profession?
   - What occupation-related organisations do you belong to and what is your role within them?
   - In what way does the university hinder, facilitate or support your engagement with other organisations? For example do they give you time off for involvement, or any form of recognition?
   - What conferences do you attend?
   - In what way does the university hinder or facilitate conference attendance?

4. **What do you think of the concept of pharmaceutical care?**
   - Does the concept impact on your practice/teaching in any way?

5. **How do you understand your role in terms of educating the next generation of pharmacists?**

Closure – the interviewer will summarise the main points that have emerged and clarify them with the interviewee who will also be invited to add any further comments or reflections.

APPENDIX F: PHASE ONE CODE BOOK FOR THEMATIC ANALYSIS

Code-Filter: All

HU: In_depth_Interviews1
File: [C:\Users\sfburton\Desktop\Identity Research\atlas\In_depth_Interviews1.hpr7]
Edited by:Super
Date/Time: 2012-11-06 11:18:49

A lot of pharmacy is about practice
Academia - exiting reasons
Academia - intellectualism
Academia - practice relationship
Academia - reason for entry
Academia preparing for practice
Academia: attitude toward: own
Academia: attitude towards: others
Academia: difficulties
Academic development
Academic internship
Academic tasks
Academic: identification with the term
Academic: lifestyle
Acknowledgement: lack of
Actor
Attitude to patient care
Attitude: academia
Attitude: academic
Attitude: community pharmacy
Attitude: hospital pharmacy
Attitude: industrial pharmacy
Attitude: pharmaceutical care
Attitude: pharmacy profession
Attitude: research: enjoyment
Attitude: status
Attitude: students
Attraction to academia: Role models
Attraction to pharmacy
Attraction to research
Attraction: Parental
Authenticity
Belief: pharmacists as team players
Belief: pharmacists in practice
Belief: profession
Belief: self as a professional
BPharm
Career decision process: cognitive
Career decision process: factors affecting
Career decision process: fate
Career decision process: prior experience
Career decision process: role model
Career progression
Career progression: future
Career satisfaction
Change: need for in the profession
Clinical pharmacy
Community engagement
Conferences
Congruence: academia and practice
COP: community pharmacy
COP: department
COP: educational organisations
COP: general

COP: hospital
COP: industry
COP: other organisations
COP: personal life
COP: pharmacy organisations
COP: professional formation
COP: research community
COP: teaching
COP: university
COPs: university support
Discipline vs profession
Distant aunt
Educational care
Educator: identification with the term
Expected role - what am I paid to do
Extrinsic reward
Fine interaction with students..
Gender related issues
Goal of research
I am a pharmacist
Identification with discipline
Identification with teaching
Identification: academic: early
Identification: pharmacist
Identity: naming
Impact: students
Impact: teachers
Influence of academics
Initially I wanted to become a..
Intrinsic reward
It was just something to do wh..
Ivory tower
Jack of all trades
Knowledge base
Lecturer
Locum experience
Masters
Masters entry to academia
Medicine first choice
Mentoring: other academics
Mentors
Metaphor: academic
Metaphor: production pharmacist
Metaphor: professional
Mirror perhaps?
Not first choice
Okay what attracted me to pharmacy..
Passion
Pharmaceutical care: barriers
Pharmaceutical care: curriculum
Pharmaceutical care: knowledge of
Pharmaceutical care: patient focus
Pharmaceutical care: practice
Pharmaceutical care: teaching
Pharmacist vs teacher
Pharmacologist
Pharmacy academic
Pharmacy qualification: teaching
Pharmacy: attitude towards
PhD entry into academia
PHD is a minimum
PhD: attitude towards: others
PhD: attitude towards: own
PhD: reasons: opportunity
PhD: reasons: logical progression
PhD: research
PhD: time

Practice
Preparing students for practice
Priest
Priorities outside of academia
Professional development
Professional status
Reflection
Relationship: students
Relationships: colleagues
Research: attitude towards
Research: early exposure to
Researcher
Satisfaction: source of
Satisfiers
Self-image
Socialisation of students
Student perception of academics
Students: attitudes
Teaching development
Teaching difficult
Teaching experience: early
Teaching mentoring: lack
Teaching vs Research
Teaching: assessment
Teaching: attitude towards
Teaching: attitude: positive
Teaching: difficulties
Teaching: human touch
Teaching: impact of experience
Teaching: knowledge
Teaching: own experience
Teaching: pharmacist
Teaching: postgraduate study
Teaching: practice relationship
Teaching: reflection
Teaching: research
Teaching: skills
Teaching: subject area
Teaching: time
Teaching: under preparedness
Teaching; focus
Tomato
University experience
Value: academia
Values
When I was in matric, I really..
White jacket

APPENDIX G: PHASE TWO FOCUS GROUPS

PARTICIPANT INVITATION AND INFORMATION SHEET

SELF-PERCEIVED PROFESSIONAL IDENTITY OF PHARMACY EDUCATORS

Dear Pharmacy Educator,

You are being invited to take part in a research study entitled "Self-perceived professional identity of pharmacy educators". In order for you to make an informed decision regarding participation, it is important for you to understand the purpose of the research and what it will entail. Please take time to read the following information and do not hesitate to ask for clarity if there is anything that is not sufficiently explained, or if you would like further information.

Purpose of the study:

The aim of this research study is to identify, describe and analyse the self-perceived professional identity of pharmacy educators within the South Africa context.
The study is comprised of three phases:

1. Semi-structured interviews conducted with eight pharmacy educators, to gain an in-depth understanding of their self-perceived professional identity and to explore how their lived experiences, across various communities of practice, has formed their professional identity.
2. In the second phase a focus group approach will be used, to explore, within a broader interactive context, some of the factors and communities of practice identified by participants in the first phase, as contributing to development of professional identity.
3. The third phase of the study will use a purpose-designed questionnaire, developed from the insights gained in the first and second phases, to explore with all pharmacy educators in South Africa, their self-perceived professional identity, attitudes, beliefs and practices related to pharmaceutical care and the socialisation of students into the pharmacy profession.

It is for the second phase of the study, the focus groups, which you are being asked to participate.

The research forms the basis of a doctoral study in the pharmacy department of the Nelson Mandela Metropolitan University (NMMU). It is hoped that the findings from the study will provide valuable insights into how the professional identities of pharmacy educators in South Africa, are influenced through the communities of practice with which they engage. It will also afford opportunities to better comprehend "who it is" that teaches within our faculties and schools of pharmacy, and the potential impact this has on the education and professional socialisation of future pharmacists.

Processes and procedures:

Participation in the study involves participation in a focus group with other pharmacy educators, which will last approximately 90 to 120 minutes. The focus groups will be held at the Academy of Pharmaceutical Sciences Conference, to be held in September this year. The focus groups will be digitally recorded and later transcribed for the purpose of data analysis. One focus group participant will

be asked to volunteer to review the transcript for accuracy, and to comment on the summary and analysis of the transcript. This is in order to validate my interpretations and to ensure, where possible, that my own bias is not unduly distorting my interpretation of the transcript. The transcript, summary and interpretation will also be available, on request, to any of the other participants for similar scrutiny and validation.

Participation in the study:

You have been chosen to participate in the group because you are a registered pharmacist, and you teach on an undergraduate pharmacy programme.

Benefits:

Although, no direct benefit, either monetary or resulting from the experience itself, is offered or guaranteed, it is my hope is that the discussion within the group will be enjoyable and mutually beneficial. Participation in the group will provide you with the opportunity to reflect on "who" you are as a teacher, and to deepen your self-understanding.

Confidentiality:

All information gathered during this study will remain confidential, and will be stored in a password-protected computer throughout the course of the research, and beyond. In order to protect participants' identities I will use pseudonyms, and only I will have access to information that could connect responses to participants. Neither you, nor your university will be identified in the analysis. All recordings and other data will be securely retained for three years after completion of the study, after which they will be destroyed.

Withdrawal without prejudice:

Participation in this study is voluntary; you always have the option of not answering any questions that might make you feel uncomfortable or withdrawing from the interview or research process at any point.

Ethical approval:

Ethical approval for this study has been obtained from the NMMU's Research Ethics Committee (Human) (REC-H) and the Faculty of Health Sciences' Research, Technology and Innovations Committee. Reference number: H11-HEA-PHA-006

If you are willing to participate, I ask that you please complete and return the attached consent form, and I will contact you as soon as is possible to confirm your participation and provide details of the arrangements for the focus group.

Many thanks

Sue Burton
Principal Researcher and PhD Student
Department of Pharmacy
NMMU


susan.burton@nmmu.ac.za


041-5044212

Prof C.N. Hoelson
Study Promoter
Department of Psychology
NMMU


christophernorman.hoelson@nmmu.ac.za


041-5044594

APPENDIX H: PHASE TWO FOCUS GROUPS

PARTICIPANT DEMOGRAPHIC DETAILS

Nelson Mandela Metropolitan University
for tomorrow

PROFESSIONAL IDENTITY FOCUS GROUP
PARTICIPANT DEMOGRAPHIC DETAILS

Thank you for agreeing to participate in this focus group. Please will you provide the following demographic details.

1. Gender

☐ Male ☐ Female

2. Occupation (please specify)

3. Age category?

☐ ≤ 30 years
☐ 31 – 40 years
☐ 41 – 50 years
☐ 51 – 60 years
☐ > 60 years

4. Years of registration as a pharmacist

☐ ≤ 5
☐ 6 – 10 years
☐ 11 – 20 years
☐ 21 – 30 years
☐ > 30 years

5. Years of experience teaching pharmacy?

- ☐ ≤ 5
- ☐ 6 – 10 years
- ☐ 11 – 20 years
- ☐ 21 – 30 years
- ☐ > 30 years

6. Do you currently work, or locum in any other pharmacy sector besides the academic sector?

☐ Yes ☐ No

If yes, please specify which sector or sectors?

7. Please specify the disciplines in which you currently teach or have taught

	Currently Teach	Have Taught
Pharmaceutics		
Pharmacology		
Pharmaceutical Chemistry		
Pharmacy Practice		
Other, please specify:		

8. Please provide a list of the professional organisations or bodies (pharmacy or educational) to which you belong and please indicate the level of your involvement, (eg member , committee etc)

Organisation	Nature of membership
1.	
2.	
3.	

Many thanks!

Sue Burton

APPENDIX I: PHASE TWO FOCUS GROUPS

PARTICIPANT CONSENT FORM

Department of Pharmacy
Nelson Mandela Metropolitan University
Tel: (041) 504-4212
Fax: (041) 504-2744
Email of researcher: susan.burton@nmmu.ac.za

Date: _____

Ref: xxxxxxx
Contact person: Susan Burton

INFORMED CONSENT FORM

I, …… , identity number …… , hereby confirm my participation in the focus group which forms part of a study, entitled: "Self-perceived professional identity
of pharmacy educators", undertaken by Sue Burton (principal investigator) of the Department of Pharmacy in the Faculty of Health Sciences at the Nelson Mandela Metropolitan University.

I have read the information sheet and the following aspects of the study have been explained to me, the participant:

1. The aim of the study is to identify, describe and analyse the self-perceived professional identity of pharmacy educators within the South Africa context.
2. My participation in the study will involve participation in a focus group with other pharmacy educators.
3. My confidentiality as well as that of my university will be ensured as no names or other identifying features will be divulged or published.
4. I will be free to review all transcripts, summaries and analyses arising from the group, in order to validate the accuracy of the transcript and the researcher's interpretation thereof. I will also be free to request that any features which may lead to divulgence of my identity be removed.
5. I am participating voluntarily and no pressure has been exerted on me to consent to participate.
6. I understand that this consent form is not a contract and I am free to withdraw from participation in the study at any time in the research process.
7. Participation in the study will not result in any cost to me.

I, …… , hereby voluntarily consent to participate in the study.

Signed and confirmed at …… on …….. 2011.

_____	_____	_____
(Participant)	(Principal Investigator)	(Witness)

APPENDIX J: PHASE TWO FOCUS GROUP PROTOCOL

Participants demographic detail forms to be completed, and informed consent form to be signed on arrival.

1. **Introduction**
   - Explanation of the purpose and procedure of the group
   - When you completed pre-focus group questionnaire, how did you respond to the question "What is your occupation?", how easy was it to respond and is this how you would describe yourself professionally?

2. **Issues around role as pharmacy educator:**
   - When you came into academia was there a clear career path mapped out for you?
   - Did you have mentors in the process?
   - How prepared were you for teaching?
   - What is your relationship as an educator with practice?

3. **How do you view pharmaceutical care?**
   - How does pharmaceutical care impact on your practice as an educator?

4. **What is your role in the education of a future generation of pharmacists?**
   - Can you impact on the future of pharmacy through education?

5. **Closure**
   - Presenting themes will be summarised by the facilitator and the group will be asked for confirmation of those presented and invited to add any others which have emerged and have not been identified.
   - Group will be thanked for their participation.

APPENDIX K: PHASE THREE EMAIL QUESTIONNAIRE

SELF-PERCEIVED PROFESSIONAL IDENTITY OF PHARMACY EDUCATORS

Please complete the following questionnaire (or the online version) as fully as you are able and return it to the researcher by email (susan.burton@nmmu.ac.za) before 15th July 2012.

This questionnaire is confidential and the anonymity of all participants will be maintained. Completion of the online version of the questionnaire will ensure absolute anonymity with the researcher being unable to identify the source of the respondents.
http://www.nmmu.ac.za/websurvey/q.asp?sid=447&k=yhrgzizxqm

Consent to participate in this phase of the study will be implied by return of the questionnaire to the researcher, or by completion of the online version of the questionnaire.

Section 1 – About you

1.1 Are you?

☐ Male ☐ Female

1.2 What is your age category?

☐ ≤ 30 years
☐ 31 – 40 years
☐ 41 – 50 years
☐ 51 – 60 years
☐ > 60 years

1.3 Please indicate the year that you first registered as a pharmacist.

Click here to enter text.

1.4 What is the highest level of pharmacy-related academic qualification that you hold?

- ☐ Diploma or Bachelors degree
- ☐ Honours degree
- ☐ Masters degree
- ☐ Doctorate

1.5 Please explain when you attained this qualification relative to your appointment in higher education (HE)?

(For example: Completed 2 years prior to taking up a post in HE, Studying for this when appointed in HE and completed 2 years after appointment; or commenced 3 years after appointment and completed 5 years later)

Click here to enter text.

1.6 Are you currently registered for a post-graduate qualification? If so, please indicate the nature of the qualification, length of registration and when you commenced it, relative to your appointment in higher education.

(For example: Yes, registered for five years for a PhD, first registered 2 years after appointment)

Click here to enter text.

1.7 Do you hold any academic qualifications in education? If so please provide details (nature of the qualification and year obtained).

(For example: Post-graduate certificate in higher education, MEd, PhD in education)

Click here to enter text.

1.8 If you hold any other academic qualifications, other than in pharmacy or education, or followed a different career path prior to becoming a pharmacist, please outline briefly.

Click here to enter text.

1.9 Please briefly describe your pharmacy-related work experience, prior to your appointment in higher education.

Click here to enter text.

Section 2 – Employment in Higher Education

2.1 How long, and in what capacities have you been employed in a higher education environment?

Click here to enter text.

2.2 What first attracted you to, or brought you into employment in the higher education environment

Click here to enter text.

2.3 In your first appointment in higher education, what were your main responsibilities? Please indicate the priority level for each responsibility described.

(For example: Research was my main priority, teaching was secondary, and my departmental role was very small)

Click here to enter text.

2.4 Have these priorities changed as your career in higher education has progressed? If so please explain how, and describe what your main priorities are in your current post.

(For example: In my post as senior lecturer, teaching became a major priority, my departmental role secondary and research a minor role. When I was appointed as Head of Department my departmental role and university role became primary, with both teaching and research being very secondary)

Click here to enter text.

2.5 What are the most positive aspects of your experience of working in higher education?

Click here to enter text.

2.6 What have been the most difficult aspects of your work experience in higher education?

Click here to enter text.

2.7 In what ways do you think that your *PERSONAL* strengths have been utilised in your work in higher education?

Click here to enter text.

2.8 In what ways do you think that your *PROFESSIONAL* strengths have been utilised in your work in higher education?

Click here to enter text.

2.9 In what other pharmacy-related activities, professional organisations, or sectors, are you involved or do you work? Please describe the nature of this work or involvement and the relationship with, or influence this has on your work in higher education.

(For example: Locum in community pharmacy and this keeps my teaching relevant)

Click here to enter text.

2.10 What do you see as your own professional development priorities, and where do you see yourself in five years time?

(For example: Completion of a postgraduate certificate in education which would place greater focus on my teaching; completion of PhD and in a senior lecturer role; or, further training in management and movement into a managerial position within the broader university)

Click here to enter text.

Section 3 – Perception of self as a professional

3.1 When asked to complete a form that asks for your occupation what do you normally write?

Click here to enter text.

3.2 When you are asked for your occupation do you ever have any hesitation in responding? If you have any hesitation, please specify the other options you consider writing and the nature of your dilemma in choosing one above the other.

Click here to enter text.

3.3 How do you perceive your role within the wider university?

Click here to enter text.

3.4 How do you perceive your role within the broader pharmacy profession?

Click here to enter text.

3.5 Can you think of a metaphor, analogy or an image which might describe how you view yourself as a pharmacy educator? (A metaphor is a figure of speech in which an implied comparison is made between two apparently unlike things that actually have something in common, for example, life is *a journey*, where *journey* is a metaphor for life.)

Click here to enter text.

3.6 Do you think that academic pharmacy should be recognised as a speciality by the South African Pharmacy Council? Please motivate your answer.

Click here to enter text.

Section 4 – Perception of pharmaceutical care

4.1 What are your feelings or thoughts regarding the concept of pharmaceutical care?

Click here to enter text.

4.2 Does the concept of pharmaceutical care relate to your teaching? If so, please motivate your answer.

Click here to enter text.

Section 5 – Educating future pharmacists

5.1 How do you perceive your role in terms of educating the next generation of pharmacists?

Click here to enter text.

5.2 As a pharmacy educator, do you think you have an influence on the future practice of your students? If so, please motivate your answer.

Click here to enter text.

5.3 Do you think that pharmacy education should drive changes in the practice of pharmacy? If so, how do you think this should be done?

Click here to enter text.

5.4 To what extent and in what way do you think that pharmacy education should be responsive to changes in practice?

Click here to enter text.

In closing please indicate any previous participation in this study:

- ☐ None
- ☐ Phase 1 – In-depth interview with the researcher Sue Burton
- ☐ Phase 2 – Participation in a focus group conducted at the Academy Congress September, 2011

Thank you for taking the time to complete this questionnaire, your time and input are greatly appreciated.

Sue Burton

APPENDIX L: PHASE THREE INVITATION OF PARTICIPATION

SELF-PERCEIVED PROFESSIONAL IDENTITY OF PHARMACY EDUCATORS

Dear Pharmacy Educator,

You are being invited to take part in a research study entitled "Self-perceived professional identity of pharmacy educators". In order for you to make an informed decision regarding participation, it is important for you to understand the purpose of the research and what it will entail. Please take time to read the following information and do not hesitate to ask for clarity if there is anything that is not sufficiently explained, or if you would like further information (email and phone numbers are included at the end of this letter).

Purpose of the study:

The aim of this research study is to identify, describe and analyse the self-perceived professional identity of pharmacy educators within the South Africa context.

The study is comprised of three phases:

1. Semi-structured interviews conducted with eight pharmacy educators, to gain an in-depth understanding of their self-perceived professional identity and to explore how their lived experiences, across various communities of practice, has formed their professional identity.
2. In the second phase a focus group approach was used, to explore, within a broader interactive context, factors and communities of practice contributing to development of professional identity.
3. The third phase of the study will use an in-depth purpose-designed questionnaire, developed from the insights gained in the first and second phases, to explore with all pharmacy educators in South Africa, their self-perceived professional identity, attitudes, beliefs and practices related to pharmaceutical care and the socialisation of students into the pharmacy profession.

It is for the third phase of the study, the survey, which you are being asked to participate.

The research forms the basis of a doctoral study in the pharmacy department of the Nelson Mandela Metropolitan University (NMMU). It is hoped that the findings from the study will provide valuable insights into how the professional identities of pharmacy educators in South Africa, are influenced through the communities of practice with which they engage. It will also afford opportunities to better comprehend the self-perceived professional identity, attitudes and beliefs of educators within our faculties and schools of pharmacy, and the potential impact this has on the education and professional socialisation of future pharmacists.

Processes and procedures:

Participation in the study involves completion of the attached questionnaire, which will take approximately forty minutes. The questionnaire is confidential and the anonymity of all participants will be maintained. Completion of the online version of the questionnaire will ensure absolute anonymity with the researcher being unable to identify the source of the respondents. This is available at: available at: http://www.nmmu.ac.za/websurvey/q.asp?sid=447&k=yhrgzizxgm

Consent to participate in this phase of the study will be implied by return of the questionnaire to the researcher (susan.burton@nmmu.ac.za), or by completion of the online version of the questionnaire.

Withdrawal without prejudice:

Participation in this study is voluntary; you always have the option of not answering any questions that might make you feel uncomfortable or withdrawing from the research process at any point.

Ethical approval:

Ethical approval for this study has been obtained from the NMMU's Research Ethics Committee (Human) (REC-H) and the Faculty of Health Sciences' Research, Technology and Innovations Committee.
Reference number: (H11-HEA-PHA-006).

If you are willing to participate, I ask that you please complete and return, by email, the attached questionnaire, or complete the online version of the questionnaire at: by the 31st[h] of July 2012.

Many thanks

Sue Burton
Principal Researcher and PhD Student
Department of Pharmacy
NMMU

 susan.burton@nmmu.ac.za

 041-5044212

 0733556849

APPENDIX M: ETHICS APPROVAL LETTER - NMMU

Nelson Mandela Metropolitan University
for tomorrow

Copies to:
Promoter: Prof CN Hoelsen

Summerstrand South
Faculty of Health Sciences
Tel. +27 (0)41 5042121 Fax. +27 (0)41 5042854
nouwaal.ahmed@nmmu.ac.za

Student number: 204069661

Contact person: Ms N Ahmed

22 October 2012

Mrs S Burton
9 Hagen Villas
Marrisa Way
Providentia
Port Elizabeth
6070

FINAL RESEARCH PROPOSAL
TITLE: SELF-PERCEIVED PROFESSIONAL IDENTITY OF PHARMACY EDUCATORS
QUALIFICATION: PhD GENERAL HEALTH SCIENCES

Please be advised that your final research proposal was approved by the Faculty Research, Technology and Innovation Committee on 11 August 2011, reference number H11-HEA-PHA-006.

FRTI granted ethics approval.

Kind regards

Ms N Ahmed
Manager: Faculty Administration
Faculty of Health Sciences

APPENDIX N: APPROVAL LETTER – UKZN

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

9 September 2011

Ms S Burton
Principal Researcher and PhD Student
Department of Pharmacy
NMMU

Email: susan.burton@nmmu.ac.za

Dear Ms Burton,

RE: PERMISSION TO CONDUCT RESEARCH

Gatekeeper's permission is hereby granted for you to conduct research at the University of KwaZulu-Natal towards you PhD at the Nelson Mandela Metropolitan University (NMMU) in the following project:

1) Self-perception of professional identity of pharmacy educators

Please note that the data collected must be treated with confidentiality and anonymity.

Yours sincerely,

Prof JJ Meyerowitz
Registrar