Changing status in health care: community and hospital pharmacists' perceptions of pharmacy practice

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Abstract

Objectives This study aimed to explore experienced community and hospital pharmacists' perceptions of how their pharmacy practice and status in health care are affected by others' views of them.
Methods A qualitative collective case study was conducted. The primary data were 20 in-depth semistructured interviews of community and hospital pharmacists in England that were audio-recorded, transcribed and analysed thematically.
Key findings Thematic analysis of the data identified four themes: (1) ambiguities about being professionals, (2) internal divisions, (3) medicines experts and (4) shopkeepers as healthcare providers.
Conclusions Pharmacists want to be recognised as medicines experts in health care. They are aware that their status is assessed by the public based on their practice, which is dispensing of medicines, and that the public's image of all pharmacists is that of 'a typical community pharmacist' working in a retail shop while having little experience of pharmacists in other healthcare settings. Pharmacists consider that the public does not view them as registered healthcare professionals. They mainly associate being registered professionals with being controlled from afar by their professional regulator, instead of utilising this as an enabling strategy to support their reprofessionalisation efforts. Pharmacists remain the hidden healthcare profession and need to act in practice as healthcare professionals, so the public is aware of their place and contributions in health care to maintain or enhance their status. Internal divisions between community and hospital pharmacists appear to be due to differences in practice, knowledge and aspirations having the potential to adversely affect the pharmacy profession's status.

Introduction

Pharmacists' status in health care has not been widely examined in the literature.[1–5] The functionalist trait approach has been used to argue for or against pharmacy being described as a marginal profession, whereas Dingwall and Wilson maintain the importance of examining the 'everyday work of pharmacists' to assess their status.[2,6,7] Abbott dismisses the functionalist trait approach due to inadequate theoretical rationale to support it.[2,8,9] Abbott draws attention to the work professions do and how they maintain jurisdictional control in the workplace, with jurisdiction being the link between a profession and its practice.[8] Jurisdiction is considered an area of work that a profession controls including defining best practice standards and has

justifiable social claims and legitimate responses from the public and the State to these claims.[8,10] The State is the government including an ensemble of institutions collectively forming the direction it takes enabling it to govern.[11] Status is associated with a profession's practice and is considered a lasting and general strategy for professions.[10,12]

Professionalisation comprises dynamic and continuous social processes affecting a profession's efforts to maintain, enhance or defend its status including control of jurisdiction.[8,10] Several external and internal factors facilitate (reprofessionalise) or hinder (deprofessionalise) these professionalisation processes.[8,13,14]

Pharmacists have a peripheral role within health care.[5,15,16] National policy drivers aim to extend pharmacists' practice beyond their jurisdiction of dispensing into clinical patient-centred roles, as with increasing healthcare needs, pharmacy is seen as an underutilised resource.[17–20] In England, this includes pharmacists gaining prescribing rights, establishing consultant pharmacist roles and working for general practitioners.[21–25] Despite these initiatives, the Nuffield Report, 2014, 'Now more than ever: Why pharmacy needs to act' concludes there has been limited development of pharmacists' jurisdiction over the previous few decades.[26,27] The State, other stakeholders and the public lack understanding of what pharmacists do and can do in health care.[20,26]

The undergraduate degree for pharmacists in Great Britain is a 4-year Master of Pharmacy course followed by a preregistration year concluding with a registration examination set by the General Pharmaceutical Council, the statutory professional regulator for pharmacists. There are two main sectors in pharmacy: community and hospital. Just over 70% of pharmacists work in community pharmacy and about a quarter in hospital pharmacy.[28] In England, community pharmacies are privately owned businesses contracted to deliver publicly funded pharmaceutical services within the National Health Service (NHS), mainly dispensing with some limited non-dispensing pharmaceutical services which are gradually increasing.[29] Hospital pharmacists are employed by the NHS. For decades, they have delivered non-dispensing clinical pharmaceutical services, working on inpatient wards and having access to patients' medical notes and blood tests results.[30]

Existing studies have concentrated on community pharmacists (CP), and few have included hospital pharmacists.[1,3] This study aimed to explore experienced community and hospital pharmacists' perceptions of how their pharmacy practice and status in health care are affected by others' views of them.

Methods

Qualitative collective case study methodology was used within a constructivist enquiry emphasising pharmacists' perceptions which consisted of four case studies.[31–33] Each case study included five pharmacists representing a healthcare setting: community pharmacy, acute hospital, mental health and community health services, respectively. The latter three are public NHS organisations.

The sample size of 20 pharmacists was based on what was considered to be large enough to provide enough breadth and small enough so as not to lose much depth.[32] The sampling was purposive, a non-random method, to gain insight into pharmacists' perceptions.[34] The entry criteria were that pharmacists had been registered for at least 5 years, worked in the relevant healthcare setting for 2 years or more and provided written informed consent. Pharmacists from researcher IA's NHS workplace were excluded.

Community pharmacists on the university's student practice placement list were invited to participate. Acute hospital (AHP), mental health (MHP) and community health services (CHSP) pharmacists, collectively referred to as 'hospital pharmacists', were emailed by their chief pharmacist with information about the study and an invitation to contact IA. It was unknown how many hospital pharmacists were emailed.

A single face-to-face semistructured interview was used to solicit each pharmacist's perceptions about how they viewed their practice, contributions made, the future and how others viewed them. Pharmacists completed a 5-day diary recording positive contributions or frustrations experienced to obtain data in real time.

Pharmacists were emailed the study information sheet and consent form in advance of the semistructured interview and asked to agree to it being voice-recorded, otherwise notes were taken. Arrangements were made for the semistructured interview to take place at pharmacists' workplace or university.

The semistructured interviews and transcriptions were undertaken by IA, who also took notes to capture reflections throughout the research process.[32,35] The data for each case study were analysed using inductive thematic analysis followed by the cross-case analysis.[36–38] This was an iterative process, which included going back and forth between the individual cases and the cross-case analysis.[37]

Emerging themes were discussed with PM and PG. The findings were shared in 2016 with two peer groups: one included 12 CP and the second 15 pharmacists and five pharmacy technicians from acute hospital, mental health, community health services

and community pharmacy. This was to give the findings credibility and check they resonated with them, which they did.[36]
The University Research Ethics and Governance Committee approved the study 12 March 2012. NHS research and governance approvals were obtained between 18 April and 18 July 2012 from five NHS organisations.

Results

Twenty pharmacists (five in each case) from the South of England, who all fulfilled the entry criteria came forward, provided written informed consent and were interviewed. On average, pharmacists had been registered for 21 (range: 5–37) years and had worked in their current healthcare setting for 13 (range: 2.5–27) years. All CP were employees.

All semistructured interviews were undertaken at pharmacists' workplaces, university and one at IA's NHS workplace on request. They were voice-recorded, except for one pharmacist who asked for this not to be voicerecorded. The average interview took 53 (range: 36–67) minutes. Fifteen diaries were returned by post covering all healthcare settings.

The data analysis generated four themes (1) ambiguities about being professionals, (2) internal divisions, (3) medicines experts and (4) shopkeepers as healthcare providers.

Ambiguities about being professionals

Pharmacists were busy practitioners. They did not actively engage with what it meant to be professionals.

> I have never thought about it (AHP3).

Pharmacists associated being a professional with conforming to regulations, displaying certain behaviours and being registered with their regulator. They questioned whether being registered equated to being a professional having observed that when pharmacy technicians became registered their behaviour did not alter. Pharmacists emphasised the negative aspects of being registered such as being reported to their regulator, having sanctions imposed or 'being struck off' (CHSP1) and this made public.

Pharmacists believed they were answerable for their behaviour and conduct 'whether in work or outside work' (CP3).

Pharmacists used terms such as ‘shopkeepers’ and ‘sticking labels on boxes’ to describe images others had of them. They explained that the public viewed all pharmacists as CP. Patients were surprised to see pharmacists on hospital wards.

> Patients turn around and say; ‘Oh I didn’t know they had pharmacists in hospitals (CHSP1).

Pharmacists felt other healthcare professionals and patients believed their practice was ‘just dispensing’ (CHSP1), because it was this aspect that ‘is most important to them’ (MHP5) regardless of the healthcare setting.

Pharmacists did not think the public viewed them as registered healthcare professionals.

> I do not think that pharmacy itself is particularly perceived as a profession by the general public (CP1)

Internal divisions

Hospital pharmacists viewed themselves as clinical, and CP as dispensers. Hospital pharmacists were in the process of handing over control of the dispensary to pharmacy technicians allowing them to develop their ‘expertise differently’ (AHP1). Hospital pharmacists had limited solidarity with CP who were not working to the professional standards they expected, reflecting adversely on the whole profession.

> I get really furious with that because that is my profession (CHSP2).

Hospital pharmacists felt CP did not see ‘further than their dispensing role’ (MHP5), with no ambition to elevate the profession.

Community pharmacists had difficulties in rising above their workload to develop their practice due to ‘increasing scripts [prescriptions] figures’ (CP5).

Differences in practice, knowledge and aspirations resulted in divisions between hospital and CP, to the point where they considered them to be two different professions.

> They are almost distinct professions. Community pharmacy is completely different to hospital pharmacy (MHP3).

There was no or limited collaboration or communication between pharmacists across the different healthcare settings in a systematic and consistent manner related to patient care.

Medicines experts

Pharmacists articulated the importance of being recognised as medicines experts because they have ‘a set of skills nobody else possesses’ (CP4). This allowed them to be ‘proud of what you do and who you are’ (AHP4). They linked this to their professional status, ‘that means you should be able to be a bit more of a pillar of society’ (AHP4).

Hospital pharmacists continually increased their clinical knowledge including completing postgraduate courses working in a professional environment that facilitated this. They aspired to be recognised as specialists including having ‘as much knowledge as certainly a [medical] registrar or consultant’ (AHP2) and could progress from junior to chief pharmacist. Community pharmacists did not have similar aspirations, having limited access to postgraduate education and training while working as isolated practitioners making it ‘difficult to judge your own performance’ (CP1). They had no career progression.

Pharmacists were frustrated if their advice was not considered by others or when other healthcare professionals claimed to be medicines experts (e.g. nurses) as this questioned their integrity.

> Everyone thinks they are an expert in medicines when they are not (CHSP 4).

Shopkeepers as healthcare providers

Community pharmacists balanced two conflicting roles as pharmacists and business managers explaining that they were ‘two separate things as much as the two collide’ (CP2). They were aware of the contradictory images of community pharmacy as a retail shop versus a place where health care was delivered contributing to the uncertainty of their role in health care. They reinforced the retail aspects by referring to ‘the shop’ during the study interviews.

> People do not understand, are we part of the NHS or are we a shop? (CP1).

They avoided tackling certain health care and lifestyle matters with patients as they operated within a business ethos of customers ‘always being right’ and felt the retail environment was not always conducive to do this.

> Tackle people's weight with them is unrealistic if you wish to have good customer relations. The pharmacy is not a place for that (CP1).

Regulations placed them in situations between trying to satisfy their customers' requests for over-the-counter medicines and their own judgement as they found it difficult to challenge customers' choices to maintain good customer relations.

They felt it was demeaning having to contact prescribers to substitute a prescribed medicine to another generic medicine which prevented them from using their own judgement.

For CP working in a retail environment, having to achieve targets for pharmaceutical services and being constrained by medicines regulations adversely affected their autonomy and judgement introducing an element of disempowerment.

Discussion

Community and hospital pharmacists were aware that the public had one uniform image of them as a 'typical community pharmacist' dispensing medicines in retail shops while having limited experience of pharmacists in other contexts. Community and hospital pharmacists emphasised their differences. This is congruent with Abbott's theory that the public has a narrow view of a profession which does not take account of intraprofessional differences and that a profession's status is assessed by the public based on its act or nature of practice.[8,10]

Images of pharmacists as 'shopkeepers' and 'sticking labels on boxes' are not associated with health care nor with special knowledge or skills.[39–41] Pharmacists felt the public did not view them as registered healthcare professionals. They reinforced this by focusing on the controlling aspects of being registered instead of utilising this to improve their status and ownership of an area of expertise to support new jurisdictional claims. Other authors have made similar findings arguing that being registered can be regarded as a tool for the State, via the regulator, of exercising control and influence over professionals with limited cost implications as they themselves meet the cost of being registered.[42,43] The State utilises being registered as leverage to influence, control and facilitate professional change, although professions and the State are not two opposing forces due to interdependencies.[44,45] The State mediates between pharmacy, patients and the public by determining what type of pharmaceutical services will receive funding.[11] To effectively bargain with the State and other stakeholders, the pharmacy profession needs to be united and corporately organised to maintain or enhance its status.[11,46]

Study strengths and limitations

The strength of this study was that data collected were from community and hospital pharmacists with collective case study methodology facilitating identification of themes which may not otherwise be discovered, such as internal divisions within pharmacy. In qualitative research, the researcher is the primary instrument for data collection and analysis which adds subjectivity.[36] To ensure rigour and quality, researcher IA aimed to maintain transparency by being reflective and sense-checked the findings with two peer groups.[32,36] As well as exploring pharmacists' status, the study addressed a gap in the literature by including hospital pharmacists. The findings were based on a small sample, recruited from one geographical area that cannot be generalised to the broader pharmacy workforce but provides new insights adding to existing knowledge on pharmacists' status.[32,36] A limitation is that the study is based on interviews with pharmacists and did not include observations or other healthcare professionals, key stakeholders and patients.

Intraprofessional divisions in pharmacy

Hospital pharmacists are what Abbott describes as professional 'purists' because they have a career structure, work in a professional environment focusing on developing their clinical pharmacy knowledge while enjoying a higher level of pharmacy practice than CP resulting in greater intraprofessional status.[8] In contrast, CP are isolated practitioners, working in a retail environment, with no career structure, also being concerned with non-pharmaceutical issues and dealing with patients and the public. Hospital pharmacists have started to separate their clinical and dispensary functions. CP remain in the dispensary undertaking routine work with pressures to meet commercial targets, with limited time to provide non-dispensing pharmaceutical services.[47,48] They wish to maintain the status quo possibly due to an increasing workload and uncertainty over the long-term sustainability of nondispensing pharmaceutical services.[47] A profession that relies on the status quo will lose status.[11] There is a lack of ideological solidarity between community and hospital pharmacists.[12,46] Most professions have internal subdivisions that lead to intraprofessional divisions.[8,49] Diversity within a profession can result in intraprofessional changes and developments forming part of its reprofessionalisation efforts or can move it towards a split producing a deprofessionalisation effect.[49,50] Internal divisions are relevant in an international context.[18] The international pharmacy workforce predominately works in community pharmacy with a minority practising in hospitals.[19] Community pharmacies are mainly remunerated based on dispensing fees, with few financial incentives to deliver non-dispensing pharmaceutical services.[19,51] In parts of Europe, the Middle East and North America, hospital pharmacy is considered an almost separate profession with different and additional postgraduate educational requirements to take on the

challenges of working within the hospital setting.[52–55] Internal divisions in pharmacy appear to be due to differences in knowledge, practice and aspirations resulting in different subgroups denoted by differences in approach to professional problem-setting (i.e. how problems are framed influencing how a subgroup thinks about solutions).[49,56]

Internal divisions are often contained within a profession making it appear to outsiders as united.[8,11] The problem occurs when these internal divisions are visible at national level reducing a profession's ability to bargain with the State affecting its reprofessionalisation efforts.[11,26,27,46] Larson speculates that professional socialisation fosters ideological solidarity and improves professional cohesion, which can be achieved in pharmacy through embedding a formal postgraduate clinical career pathway with additional relevant training that is represented in practice.[12,57]

Implications for practice

This study suggests that pharmacists should start to act in practice as healthcare professionals including taking social responsibility for appropriate medicines use in society.[8,18,58,59] This includes displaying professional unity and generating public demand for their non-dispensing pharmaceutical services to support them in influencing the State to legitimise these jurisdictional claims.[8]

As long as pharmacists remain the hidden healthcare profession, they have little hope of making new jurisdictional claims to maintain or increase their status. The image of a retail shop continues to be a barrier for the public and pharmacists themselves in being viewed as healthcare professionals.[5,16,60,61] This in turn affects the pharmacy profession as the public bases its assessment of the whole profession on a 'typical community pharmacist'.[8]

Future studies

Future research should explore how key stakeholders, the public and patients' perceptions of pharmacy affect its practice and status. Research on intraprofessional divisions is warranted.

Conclusion

Pharmacists want to be recognised as medicines experts within health care. They acknowledge that their status is assessed by the public based on their act of practice, which is traditionally the dispensing of medicines, and that the public's image of all pharmacists is that of 'a typical community pharmacist' working in a retail shop, having limited experience of pharmacists in other contexts. Pharmacists consider that the public does not view them as registered healthcare professionals. They reinforce this

view by focusing on the controlling aspects of being registered instead of utilising this to improve their status and ownership of an area of expertise to support new jurisdictional claims. Internal divisions between community and hospital pharmacists appear to be due to differences in practice, knowledge and aspirations.

Pharmacists remain the hidden healthcare profession. They need to act in practice as healthcare professionals so the public and wider society is aware of their contributions to health care.

Declarations

Conflict of interest

The Author(s) declare(s) that they have no conflicts of interest to disclose.

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Authors' contributions

Dr Iben L. Altman was a researcher as part of a PhD thesis, contributed to the article and undertook the data collection. Dr Phil J. Mandy was the first academic supervisor for research study and contributed to the article. Professor Paul R. Gard was the second academic supervisor for research study and contributed to the article. All Authors state that they had complete access to the study data that support the publication.

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