

Re-examining 'professionalism' in pharmacy: A South African perspective

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Abstract

Although defining itself as a patient-centred profession, private sector (community and private hospital) pharmacy often appears to be that of a product-for-profit centred occupation. This perception has been at the core of the medical profession's attempts to reduce the professional autonomy of pharmacy, and has appeared at the forefront of the South African Department of Health's positioning of private sector pharmacy. Using as a starting point the debate surrounding attempts by the South African Minister of Health to regulate the price of medicines, I propose that the present negative positioning of private sector pharmacy in South Africa could be ameliorated by pharmacy practice that evidences a redefined understanding of professionalism.

Keywords: Pharmacy; Professionalism; Pharmaceutical care; Patient care; South Africa

Introduction

'Transformation' has been a central feature of South African society since the Nationalist government announced the unbanning of liberation movements and the release of their leaders in January 1989. Since the 1994 democratic elections the health sector has been one of the primary areas targeted for transformation. Post-1994 governments have sought to redress the substantial inequalities in health-care provision established along racial lines under colonial administration and maintained by consecutive Apartheid-era governments. While these health-related structural inequities were, and remain, most marked in respect of access to medical insurance and the provision of primary health care and hospital facilities (Cullinan, 2006), they are also reflected in the demographic distribution of community pharmacies across South Africa. As elsewhere, South African community pharmacies are concentrated in urban areas. What is more unusual is their concentration in previously White-dominated commercial centres and residential areas (Constitutional Court of South Africa (CCSA), 2005; Gilbert, 2004a; Thom, 2004a). The demographics, then, of South African pharmacy provide one of the most visible challenges to its ability to respond to the calls for transformation from a 'business as usual' approach towards a primary health care model (CCSA, 2005; Gilbert (2004a) and Gilbert (2004b)).

As part of the attempt to redress the imbalance in access to medicines, the South African government passed The Medicines and Related Substances Amendment Act (South African Department of Health—(SADoH, 2002) and the Pharmacy Amendment Act (SADoH, 1997) which directly impacted on private sector pharmacies (Gilbert, 2001; Thom, 2004a, 2004b). Supermarket chains are now permitted to operate pharmacies and on application, doctors and selected nurses are being licensed to dispense. Further to these changes, in 2004 the government introduced legislation to limit the profit margins on medicine (SADoH (South African Department of Health). (2002) and SADoH (South African Department of Health). (2005)). In combination these changes provide a substantial threat to the economic survival of private sector community pharmacies under their current product-centred practice model (Business Day, 2006; Gilbert (1998) and Gilbert (2004a); Khan, 2005; Shevel, 2004; Thom, 2004a).

Using aspects of the debate in South Africa around these transformation initiatives to frame the discussion, I argue that while such state-imposed measures may facilitate the entry of a wider range of people into the market for the provision of medicines, the substantive issue of the role of pharmacy in the provision of wider access to medicines and primary health care is unaddressed. I suggest that this needs to be addressed by beginning with a re-examination of the philosophy that underpins the practice of pharmacy. I propose that pharmacy could be better served by a service-based philosophy of professionalism (Evetts (2003) and Evetts (2006); Gilbert (2004a) and Gilbert (2004b)), rather than the current product-based approach with its focus on a fee-for-product (Gilbert (1998) and Gilbert (2001); Lubbe, Serfontein, Futter & Steyn, 2001).

Why is ‘professionalism’ an issue?

Within the context noted above, a recent concern expressed by the Registrar of the South African Pharmacy Council (SAPC) appears to have wider implications than he perhaps intended: ‘Are pharmacists acting as professionals or are they shopkeepers/dealers in medicines similar to the shoe-shop owner or grocer?’ (Masongo, 2005). While Masongo's original question was in response to the actions of a few pharmacists involved in the unethical sale of scheduled medicines (Masongo, 2005), this question has haunted pharmacy for most of the last century (Birenbaum, 1982; Denzin & Mettlin, 1968; Traulsen & Bissell, 2004). To the South African medical profession the answer to Masongo's question has appeared fairly obvious. In 1996 the chairman of the National General Practitioners Group (NGPG), argued that ‘...the reasons why pharmacists want to dispense medicines... [are]... “profit, profit, profit (it is their right as businessmen—doctors do not have business [*sic*]).... The fact that pharmacists now want to become community pharmacists [neau (*sic*) dispensing doctors], is not because they are new generation Florence Nightingales, but because they are experiencing market pressure”...’ (Pepler, 1996, in Gilbert, 1998, p. 90). Despite their protests to the contrary, South African pharmacists appear to have lent credibility to the medical profession's portrayal of pharmacy. For example, an erstwhile president of the South African Pharmacy Society appears to have missed the irony in his response to a question about pharmacy in the post-apartheid dispensation:

It was important for pharmacists to show the new government that they were anxious to get medicines to the people. Perhaps the starting point could be primary health care ... but there is no money in it. *How did one go to the profession and tell them to get involved in primary health care when there was no money in it?* (Simpson, 1994, in Gilbert, 1998, p. 91 Italics added).

Underlining this, recent research by Lubbe et al. (2001) into the extent to which pharmaceutical care serves as a philosophy of practice in South African pharmacies, found that the majority of South African pharmacists' business models are based on 'the traditional fee-for-product system' (Lubbe et al., 2001, p. 12). Most pharmacists responding to the researchers suggested that pharmacists saw the lack of financial incentive as the 'most important [barrier] to the implementation and provision of pharmaceutical care in South Africa' (Lubbe et al., 2001, p. 12).

However, setting up profit as the negation of professionalism increasingly appears to be a misleading argument based in part on understandings of 'profession' that appear in need of revision. As Evetts argues, professions should be recognised as having a 'dual character ... which include[s] both the provision of a service ... and the use of knowledge and power for economic gain' (Evetts, 2003, p. 404). To some extent this acknowledgement has been present throughout the sociological debate around pharmacy's right to be regarded as a profession. Denzin and Mettlin's (1968) seminal article begins with Carr-Saunders' definition of a profession which specifically includes the recognition of the 'purpose to supply skilled service or advice to others for a definite fee or salary' (Denzin & Mettlin, 1968, p. 375). However, what is crucial to this definition is the focus on 'service' as distinct from product. Denzin and Mettlin's challenge to pharmacy as an 'incomplete profession' (1968) focussed on the parallel moves of the so-called 'deskilling' thesis, in which retail pharmacists have lost to industry the manufacture and compounding of medicines, and on the perceived threat of 'occupational imperialism' (Larkin, 1983 in Holloway, Jewson, & Mason, 1986, p. 323) from medicine. These two structural constraints have affected South African pharmacy as much as elsewhere (Gilbert (1998) and Gilbert (2001)). However, as Holloway et al. suggest, professionalisation is a process not a product, and the resultant occupational boundaries are social constructions, and as such are neither immutable nor are they necessarily a threat (Holloway et al., 1986, pp. 330–331).

More recently Dingwall and Wilson (1995 in Traulsen & Bissell, 2004) have argued that the debate around whether or not pharmacy¹ is a profession is 'sterile'; what matters now is what pharmacists do, namely to 'transform the drug from a natural substance into a social object' (1995 in Traulsen & Bissell, 2004, p. 111). While I share in part Dingwall and Wilson's impatience with this particular sociological debate, and their suggested shift in focus, it is nonetheless apparent that the positioning of an occupation—especially a knowledge-based occupation—as 'professional' remains a powerful structural enabler (Evetts (2003) and Evetts (2006); Neal & Morgan, 2000).

[T]here is extensive agreement about the appeal of the idea of profession and professionalism and its increased use in all work contexts. It is used increasingly as a

marketing device in advertising to appeal to customers (Fournier, 1999) and it is used in mission statements and organizational aims and objectives to motivate employees. It is an attractive prospect for an occupation to be considered a profession and for occupational workers to be identified as professionals (Evetts, 2003, p. 396).

With respect to community pharmacists, whose social identity and economic existence are under threat in South Africa and elsewhere (Edmunds & Calnan, 2001; Gilbert (1998), Gilbert (2001) and Gilbert (2004a); Hibbert, Bissell, & Ward, 2002), it would appear that unless some understanding is shared by both pharmacy and society at large as to what social role pharmacy plays, then it is not certain that pharmacists do, or are needed to, 'transform the drug from a natural substance into a social object'.

The South African medicines pricing debate

The debate around medicine pricing legislation in South Africa has been marked by an implicit characterisation of South African community pharmacists as unprofessional through the positioning of pharmacy as opposed to transformation in the health care sector (SADoH, 2005; SAMoH, 2005). Health department officials on occasion have voiced generalised characterisations of community pharmacists as 'unwanted renegades' who charge 'exorbitant fees' (Schnell, 2004). However the CCSA, while agreeing with the need to reduce medicine costs, was less than sympathetic to these characterisations (CCSA, 2005).

In its judgement handed down in the matter between the South African Minister of Health and a range of bodies and persons representing the pharmaceutical industry in South Africa, the CCSA supported the professed intent of new regulations to facilitate provision of affordable medicines to a wider cross-section of the population (CCSA, 2005, pp. 340–341). However, the Court ruled that on the grounds of administrative justice (specifically the failure of the Minister of Health to give due consideration to the evidence presented by community pharmacists) the state must reconsider the aspects of the new pricing regulation pertaining to the pharmacists' dispensing fee, and take the concerns of the community pharmacy industry more seriously (CCSA, 2005, pp. 22–26; 348 para. 666). While agreeing that there is a need to restructure the provision of pharmaceutical services in the South African context, the Constitutional Court judgement provides a firm basis for the recognition of pharmacy as 'an ethical profession' (CCSA, 2005, p. 20) and a 'legitimate and respected profession, ... [which plays] ... an important social role in providing access to health care' (CCSA, 2005, p. 346 para.633). In a separate opinion included in the judgement Judge Sachs provides a sympathetic, yet demanding, narrative-like portrayal of professional pharmacy:

[T]he familiar figures of the township or Main Road chemist or the hospital pharmacist or the white-coated person behind the medicines counter at the far end of the chain store. These men and women are by vocation dedicated people who express themselves through their work and are publicly identified by the concern they show in their relationships with their customers. With their professional skill and human concern, they calm anxieties and turn their places of work into important ports of call for wide sectors of the community.

A responsive government accordingly takes account of the need not only to have prices of medicines accessible, but to have outlets for medicines that are accessible, staffed by people who are accessible, in location and in manner. (CCSA, 2005, pp. 343–344 para.658, Judge Sachs – opinion).

Nowhere in the 446-page judgement does the Constitutional Court make explicit what it understood by either ‘ethical’ or ‘profession’ with respect to pharmacy. Judge Sachs’ opinion, however, could provide useful pointers toward a social understanding of pharmacy. In what follows I offer a suggestion as to what it could mean to ‘*be* professional’ in pharmacy practice in a way compatible with the opinion of the South African Constitutional Court. This may serve to provide support for understanding the role of the practice of pharmacy in the changing health-care terrain, particularly in South Africa. The potential value of such an examination for pharmacy-under-siege is suggested by Evetts’ argument that professionalism ‘is now being increasingly used in modern organisations, and other institutions and places of work, as a mechanism to facilitate and promote occupational change’ (Evetts, 2003, p. 407).

Pharmacy in the changing South African health-care terrain

Within the limitations of this paper only the scantest consideration of the multiple transformations at work in South African health care in the early years of the 21st century is possible. As the Constitutional Court judgement makes clear, redress of past imbalances wrought by Apartheid is central to health care policy (CCSA, 2005, e.g. Judge Sachs’ opinion). Among the most significant of these imbalances is access to affordable medicines and the uneven distribution of health care practitioners and facilities, in particular community pharmacies which tend to be clustered in high density population areas across both urban/rural and pre-1994 racially defined areas (Gilbert, 2004a). In addition, as an unintended consequence of increased participation in the global community in the post-Apartheid era, South Africa increasingly faces the same changes in demands on health care that are faced world-wide, including the growing shift toward chronic illness increasingly exacerbated by HIV/AIDS (Assal, 1999; Gilbert, 2004a; Yach & Hawkes, 2004).

South African press reports related to recent medicine pricing legislation give a broad picture of the predicament in which South African community pharmacy finds itself (Pressley, 2004; Schnell, 2004; Thom, 2004a; Business Day, 2006). Many South African community pharmacies were on the brink of collapse prior to attempts to control escalating medicine prices (CCSA, 2005, p. 185 para.386; 186 para.388; Thom, 2004a), while there are generally perceived excessive profit margins across the pharmaceutical chain (Thom, 2004b). In its argument before the Constitutional Court the Department of Health made it clear that it accepts that community pharmacies will close down because of government attempts to restructure the industry and create a more equitable distribution of health-care provision:

There are presently too many pharmacies for the population served by them, and the [proposed new] pricing scheme is premised on the assumption that when it comes into force the market will become more rational and pharmacies that are not viable will close down. The volume of business of those pharmacies that remain will increase, and will be sufficient to enable them to trade profitably (CCSA, 2005, p. 181 para.372).

Gilbert (1998), Gilbert (2001), Gilbert (2004a) and Gilbert (2004b) provides a nuanced assessment of the most prominent of the structural constraints and enablements which confront pharmacy in South Africa:

- the encroachment of dispensing doctors onto the preserve of pharmacists (Gilbert (1998) and Gilbert (2001));
- the increasing emphasis on Primary Health Care (PHC) that has accompanied political transformation in South Africa (Gilbert, 2004a);
- the demand that allopathic medicine (including pharmacy) find ways of interacting with Western-denominated 'Complementary/Alternative' medicine, including traditional African medicine (Gilbert, 2004a);
- and the need to ensure an even distribution of health care provision, for example that pharmacy moves into rural settings, not merely urban centres (Gilbert (1998) and Gilbert (2004a); CCSA, 2005)

The list distilled from Gilbert finds resonance with the suggestions of the Fédération Internationale Pharmaceutique (FIP) relating to pharmacy in developing countries (FIP, 1998). The FIP notes the urgent need for, and the central role of pharmacists within, the provision of primary health care. It also acknowledges the uneven distribution of pharmacies across the urban/rural divide that characterises 'developing countries' (FIP, 1998, p. 3), and urges pharmacists to be proactive in working towards the provision of professional PHC (FIP, 1998, pp. 3–4). Hassell, Rogers and Noyce (2000) argue for a proactive role for community pharmacy in the provision of PHC even within a 'developed' country such as the United Kingdom. This serves to support the consideration of the professional role in PHC for pharmacists across the 'first world/developing world' disjunction that is found within the South African health care setting.

Questioning what pharmacy professes

As has been suggested above, the social significance of professions is not dead despite sociological rumours to the contrary (Anderson, 2004; Evetts (2003) and Evetts (2006); Gilbert, 2004a; Neal & Morgan, 2000). However, the epistemology underpinning pharmacy's understanding of 'professional' appears inadequate for pharmacy practice in the 21st century (Gilbert, 2004a, p. 311, Gray, Seneque, & Smit, 1999).

Friedson's 'professional project' (Gilbert, 2004a, pp. 311–312) is based on a conceptualisation of professional knowledge as 'technical knowledge as a commodity produced by the profession within the market place of capitalism ... Professions construct a market in scarce and tangible commodities—technical knowledge. There is an inherent tendency towards monopoly in these relationships' (Evans, 2003 in Gilbert, 2004a, p. 311). The general technical knowledge discourse of health care professions is magnified through the 'technical-instrumental framework of the biosciences' (Mishler, 1984 in Barry, Stevenson, Britten, Barber, & Bradley, 2001, p. 490) which underpins the knowledge base of these professions. Significantly technical knowledge is productive knowledge (knowledge associated with a product, rather than with process) and claims to be value neutral (Saugstad, 2002). Technical knowledge is rooted in Aristotle's concept of *techne* (Pellegrino & Thomasama, 1981) which suggests 'a disposition to act in a true and reasoned way according to the rules of the craft' (Carr & Kemmis, 1986, p. 32). However, the social space in which pharmacy finds itself is one of competing knowledge frameworks, and the 'rules of the craft' now appear blurred and uncertain as we live in an age conscious of:

... contestability, changeability, uncertainty and unpredictability These four concepts are surrounded by others such as change, turbulence, risk and chaos. Together, this set of concepts mark out the conceptual geography of our supercomplex age as an age of fragility It is an age in which nothing can be taken for granted. In short, all bets are off. It is an age of conceptual and, thereby, emotional, insecurity (Barnett, 2000a, pp. 415–416).

In such an age the technical knowledge of the expert is no longer hallowed (Barnett, 2000a; Traulsen & Bissell, 2003). Both Gray et al. (1999) and Traulsen and Bissell (2004) argue that pharmacy's emphasis on positivist, technical knowledge (something Hepler decried in 1987), is ill-suited for renewed demands for

... pharmaceutical care with responsibility for inter-professional as well as patient consultation. This role falls in areas of expertise that do not fit into the technical paradigm but belong to an entirely different paradigm: one that emphasises a disease—and patient—oriented approach to pharmaceutical decision-making (Traulsen & Bissell, 2004, p. 111).

The social space of competing knowledge frameworks is not new to health care. At the simplest level there have been, and remain, the different frameworks of the person living with a disorder *versus* that of the healer. The healer/ill person interface is framed by the dominant cultural perspective. Health related matters have been, and frequently remain, under the purview of religion and law (Lupton, 2000; Turner (1987) and Turner (2000)). For example, Chinese health discourse remains allied to its ancient Taoist religious roots, while in Sub-continental Asia, Ayurvedic medicine is concerned with maintaining balance between the body and soul (Marks, Murray, Evans, & Willig, 2000). Unlike post-Cartesian Western dualism, traditional African, Asian and Chinese worldviews regard the spiritual and physical worlds as a whole, and do not view the individual as separated from the communal or social. Health in these worldviews becomes a spiritual discourse that

entails a communal response strongly associated with a moralising discourse (Gwyn, 2002; Marks et al., 2000). Here, disease or injury (or indeed any type of misfortune) is understood as bearing spirito-social repercussions for those who become ill, and disease is easily regarded as a sign of moral/spiritual or social deviance (Ellis & Ter Haar, 2001; Mtuze, 2003). Increasingly Western biomedicine's dominance over health care decisions is being challenged, or at least supplemented or complemented, by other perspectives (Barry et al., 2001; Marks et al., 2000).

Clearly then this 'age of conceptual ... insecurity' is not unique to South African society, and has implications for health care. As Barnett argues this social space of ontological and epistemological uncertainty is better understood as an age of *supercomplexity*, an age of multiplying and competing knowledge frameworks (Barnett (2000a), Barnett (2000b) and Barnett (2000c)).

Complexity we may take to be that state of affairs in which the demands before one exceed the resources to meet them: consequently, one is faced with an overload of data, entities or clients Supercomplexity, in contrast, arises under conditions of a conceptual overload: in short, supercomplexity is the outcome of a multiplicity of frameworks No longer are the boundaries, or the forms of right knowing clear. It is not that the old forms of knowing have been discarded; to the contrary To the old definitions of knowledge have appeared rival forms of knowing, claiming legitimacy Or, to put it differently, there are a multiplicity of knowledge frameworks to inhabit ... (Barnett, 2000b, p. 415).

In such an age technical knowledge, *techne*, no longer appears as an adequate basis for the professional. It has become necessary to move beyond, but not abandon, *techne* to something nearer the 'moral² disposition of [Aristotelian] *phronesis*; the disposition to act rightly, truly, prudently and responsively to circumstances.' (Carr & Kemmis, 1986, pp. 92–93). Saugstad notes that *phronesis*:

does not consist of transforming theoretical knowledge into practical knowledge, but is the ability [*sic*] to *choose which prevailing and general knowledge should be applied in a given practical situation* (2002:385 Italics added).

As Gray et al. argue, what is needed for pharmacy is an epistemological perspective which does not conflate epistemology and ontology, but works from:

...an assumption of the relational nature of things. [That] is context-oriented and context-dependent ... [and] ...reflects a particular view of reality and ways of coming to know reality This ability to "abstract" from a situation requires a strong developed awareness of the dialectical relationship between theories (or humanly generated models of reality), and reality itself, an awareness which is not necessarily developed through exposure to traditional approaches to science (Gray et al., 1999, p. 69).

Technical discourse as a 'threat to civility'

In the context of the competing frameworks of a society in transformation such as South Africa, the controlling ideology inherent in a technical professional discourse with its demand for a monopoly (Evans 2003, in Gilbert, 2004a, above) poses what Evetts terms 'a threat to civility' (Evetts, 2006, p. 137). Such a technical, monopolistic discourse *vis-à-vis* the person seeking assistance appears, for example, in the way South African pharmacy positions itself as a profession. The following extract from *Good Pharmacy Practice in South Africa* (the guide to professional pharmacy practice published by the SAPC), provides what the SAPC presents as its 'underlying philosophy'³:

Pharmacy is a dynamic, information-driven, patient-oriented profession, through its infrastructure, competence and skills, is committed to fulfil the health care needs of South Africa and its people by being the:

- (a) custodian of medicine;
- (b) formulator, manufacturer, distributor and controller of safe, effective and quality medicine;
- (c) advisor on the safe, rational and appropriate use of medicine;
- (d) provider of accessible, essential clinical services, including screening and referral services;
- (e) accessible provider of healthcare information;
- (f) provider of pharmaceutical care by taking responsibility for the therapeutic outcome of a therapy and by being actively involved in the design, implementation and monitoring of an effective pharmaceutical service;
- (g) profession committed to co-operation with members of the health care team in the interests of the patient; and
- (h) profession committed to cost-effective pharmaceutical services (SAPC, 2004, p. 1).

A number of these features (items (c)–(e), and possibly, (g)) suggest movement toward the engagement with primary health care to which Gilbert (2004a) and the FIP (1998) refer.⁴ There are, however, two marked 'absences' from the philosophy. Firstly, there is no space created for engagement with anything other than Western biomedicine (but *cf.* Gilbert, 2004b); secondly, and particularly puzzling in the light of the prefacing commitment to being a 'patient-oriented profession', the patient then vanishes except as an object of the health care team's decisions (item (g)). The only hint of a therapeutic alliance is that which may be formed with 'members of the health care team ... in the interests of the patient'. Yet, as Wear and Nixon following Mahowald (1996 in Wear & Nixon, 2002) note, there are dangers in this supposedly altruistic assumption of acting in the 'interests' of patients, the most fundamental of which is that such a perspective is

fraught with difficulties ‘in terms of the human tendency to construe one's perspective as the “full picture” or as reality itself ...’ (Wear & Nixon, 2002, p. 97).

The dominant knowledge framework present in this ‘philosophy’ of professional practice, the technical-rational epistemology of biomedicine to which Evans (2003 in Gilbert, 2004a) refers, leaves little space for engagement with the specific demands of the transforming South African context, let alone space for the patient-as-social-actor in the ‘therapeutic outcome of a therapy’. There appears little provision in such an epistemological framework for the approach to pharmacy practice⁵ guided by *adherence*, which recognises that:

... the relationship between the patient and the health care provider (be it physician, nurse or other health practitioner) must be a partnership that draws on the abilities of each Effective treatment relationships are characterized by an atmosphere in which alternative therapeutic means are explored, the regimen is negotiated, adherence is discussed, and follow-up is planned—WHO, 2003, p. 3).

The more demanding approach proposed by the *concordance* movement in the United Kingdom (Bissell, 2003; Bissell, May, & Noyce, 2004) may founder on the monopoly of power and knowledge assumed by this technicist philosophy of practice, which fails to acknowledge the importance of the covenantal relationship with the patient which is central to Hepler's model of pharmaceutical care (Hepler (1987) and Hepler (2000)). Hepler recently re-stated this fundamental requirement pointing to his joint 1990 paper with Strand on pharmaceutical care which ‘clearly states that the ethical basis of pharmaceutical care is covenantal (relationship-based) ...’ (Hepler, 2000, p. 692). Despite claims to a commitment to pharmaceutical care, the SACP framework based on *techne*, however well-intentioned, appears to present pharmacy with a philosophical underpinning of ‘being professional’ that appears technically-oriented, product-centred, paternalistic and monopolistic, and may lend itself to pharmacy ‘practice centred on distribution’ (Nimmo & Holland, 1999, p. 1982). This philosophy, as Davis and Fallowfield have noted in the context of communications between health care professionals and patients,

... has the consequence of neglecting the patient as a person, underestimating the importance of communication, and not according the respect to patients that they merit and must be given for their long-term benefit While the model may work with comatose or anaesthetised patients, in most other circumstances the fallacy of the model becomes obvious (Davis & Fallowfield, 1991a, pp. 15–16).

A more critical, reflexive awareness of the ‘threat to civility’ inherent in its professional discourse may enable pharmacy to facilitate the creation and maintenance of the kind of social space argued for by Justice Sachs in which pharmacists are ‘[professionals who with their] skill and human concern, ... calm anxieties and turn their places of work into important ports of call for wide sectors of the community’ (CCSA, 2005, pp. 343–344 para.658).

Re-evaluating ‘profession’

A paraphrasing of Judge Sachs’ portrayal of the pharmacist suggests a number of characteristics that may serve as a rough guide for the consideration of what it means to *be* professional as a pharmacist:

... the provision of access to health care motivated by a sense of calling which is demonstrated by the concern they show in their relationships with their customers, as through their skill and human concern, calm anxieties and turn their places of work into important ports of call for wide sectors of the community.

Understandably, Judge Sachs does not seek to provide a sociological definition of professional pharmacy. Indeed some would argue that there is no need to do so, as such ‘definitional precision is now regarded more as a time-wasting diversion’, lacking in explanatory power (Evetts, 2006, p. 135).⁶ Evetts (2003) and Evetts (2006) and Traulsen and Bissell (2004) provide excellent summaries of the long-running debates around professionalism, the latter with specific reference to pharmacy. Contrary to those who suggest a Nietzsche-like ‘death of the professions’, Evetts argues that the 1970’s–1980’s sociological turn away from normative understandings of professions and professionalism has been superseded by a ‘return to professionalism as normative value ... but in addition there are new directions in the analysis’ (Evetts, 2006, p. 136). These new appraisals focus on professionalism as a form of resistance to market control through ‘decentralised occupational control’, and argue that public interest and professional interest may not necessarily be in opposition (Evetts, 2006, p. 136). Evetts argues that there are two competing discourses of professionalism at work, the one she labels *organisational professionalism*, which

... is a discourse of control used increasingly by managers in work organizations. It incorporates rational-legal forms of decision-making, hierarchical structures of authority, the standardization of work practices, accountability, target-setting and performance review and is based on occupational training and certification. In contrast, *occupational professionalism* is the more traditional, historical form. This involves a discourse constructed within professional groups themselves that involves discretionary decision-making in complex cases, collegial authority, the occupational control of the work and is based on trust in the practitioner by both clients and employers (Evetts, 2006, pp. 140–141).

These essentially opposing discourses of professionalism seem to reflect the approaches of the South African Minister of Health (organisational professionalism) versus the understanding of a commitment to a care-based pharmacy practice inherent in Judge Sach’s opinion. Which discourse dominates in (and over) South African pharmacy in particular, may depend in part on the readiness of pharmacists to engage in conversations about what it means to be professional in pharmacotherapy in a covenantal relationship with their patients.

Drawing on an extensive review of the literature, Evetts argues that the return to normative understandings of being a professional necessitates a re-evaluation of the client–practitioner relationship in terms of trust, discretion, risk and expertise, with the interests of clients and practitioners framed and protected by the reconsidered issues of service quality and professional performance (Evetts, 2006, p. 138). So understood professionalism should no longer be construed as providing unchallengeable authority (according to the arcane technical knowledge of the craft), but can increasingly be recognised as implying cooperation with the customer/patient in keeping with the moral, context-sensitive knowledge of *phronesis* (Saugstad, 2002; Tauber, 2005), and Gray et al.'s (1999) call for an epistemological shift in understanding pharmacy practice. Indeed as Nimmo and Holland note, the moral dimension is fundamental to professional pharmacy practice: ‘As declared professionals and, in particular, as members of a caring profession.... [i]t is the exercise of attitudes and values as drivers of practice decisions that differentiates the professional from an individual with a technical job’ (Nimmo & Holland, 1999, p. 1983). These sentiments are echoed in near identical terms by Hepler: ‘...values actually inform, or should inform, every part of a professional practice. The question is not whether moral philosophy is important in professional life but, rather, how clearly professionals recognise fundamental values and how well they can connect their actions to those values’ (Hepler, 2000, p. 692).

Evetts contends further that that the return to a normative understanding of professionalism presents a:

... different way of categorizing these occupations ... as the structural, occupational and institutional arrangements for dealing with work associated with the uncertainties of modern lives in risk societies. Professionals are extensively engaged in dealing with risk, with risk assessment and, through the use of expert knowledge, *enabling customers and clients to deal with uncertainty* (Evetts, 2003, p. 397 *Italics added*).

Evetts in no way denies the expert knowledge (*techne*) required of the professional (the pharmacist), but substantially shifts the *telos* (end, purpose) of professional action. Professional action should no longer be directed at acting on behalf of, but in cooperation with, those whom the professional seeks to serve. In this understanding the pharmacist is no longer responsible for the ‘therapeutic outcome of a therapy’, but is responsible for *enabling this patient to deal with uncertainty* associated with medicine- and health-related risk. Applied to medicine-taking this may mean that the pharmacist recognises that medicine-taking practice is based more on the patient's understanding of the meaning of medication than on the laboratory-tested, randomised-control trialled regimen understood by the pharmacist (Conrad, 1985; Horne & Weinman, 1999; Pound et al., 2005). The pharmacist may have to acknowledge that for the patient there is no ‘safe, rational and appropriate use of medicine’ (Horne & Weinman, 1999; Pound et al., 2005). In order to seek optimal medicine use, the pharmacist needs to engage with the lifeworld⁷ of the patient (Barry et al., 2001) and seek a negotiated agreement along the lines of the WHO's approach to adherence (WHO, 2003), and the proposed model of concordance (Bissell, 2003). Concordance is ‘based on the notion that the work of the prescriber and patient in the consultation is a negotiation between equals and the aim is therefore a

therapeutic alliance between them' (Bissell et al., 2004, p. 851). It is important, I would argue, not to misunderstand the 'equals' as attempting to negate the knowledge of the expert, but rather to recognise the moral equality required for an alliance.

'Patient education' within an approach focused on enabling *this* patient to deal with uncertainty associated with medicine- and health- related risk, involves a shift away from 'education' as information giving ('Take three times a day with food. Finish the course'). What instead may be required is pharmacy practice intended to support the patient's making sense of the health- or medicine- related concern which brought her to the pharmacy. This serves to facilitate the optimal health practice (including medicine-taking practice) of that patient, in her circumstances. This understanding of professional pharmacy practice is no more than the extension into dispensing practice of the covenantal relationship called for by Hepler (1987) and Hepler (2000).

Such a shift in the goal of pharmacy practice may serve to bring the pharmacist into closer accord with the WHO's call that, with respect to medicine-taking practice (which after all is the goal of professional dispensing), the 'relationship between the patient and the health care provider ... must be a partnership that draws on the abilities of each' (2003:3). However, attempts by pharmacists to re-negotiate their professional status may not necessarily be appreciated by the 'consumer' of medicine, at least with respect to medicine that has been deregulated (unscheduled, or reduced to lower schedules) (Hibbert et al., 2002). Hibbert et al. suggest that this resistance is rooted in part through different ways of perceiving what knowledge is valued, in the way risk is construed with respect to medicines, and by increasing attempts by the state to emphasise personal responsibility for health care. While this cautionary comment must be respected, and is indeed characteristic of the 'risk society' (Traulsen & Bissell, 2003), I would suggest that in some measure 'consumer' resistance develops in part because of the way pharmacy has often failed to respect the fundamental of pharmaceutical care: the establishment of a covenantal relationship. In addition, pharmacy's business practice appears to have underlined medicine as a product, therefore belonging in the realm of the consumer (Anderson, 2004; Gilbert (1998) and Gilbert (2004a)). It may also be that consumerism in health may be more prevalent in so-called First World countries where access to information about health and medicines is easier to attain, and where health care is generally more evenly distributed.

Finding a professional place to stand

In the South African context there is evidence, albeit cautious and hedged by some cynicism, that a model of pharmacy practice that engages with the competing knowledge frameworks involved in health care may facilitate a re-valuing of the pharmacist as a professional (Gilbert (2004a) and Gilbert (2004b)). The shift referred to by Gilbert includes engagement with 'health' discourse, which reflects many of the characteristics of 'risk' noted by Traulsen and Bissell (2003). There is also evidence that the community pharmacist is needed to play a more significant role in the accessible provision of primary health care, especially medicines, to a wider community (CCSA, 2005; Gilbert (2004a) and Gilbert (2004b)).

This is not an argument against the usefulness of Western biomedical knowledge. Nor is it an argument against pharmacists' 'provision of a service ... and ... use of knowledge and power for economic gain' (Evetts, 2003, p. 404). It is a proposal, based on calls for transformation in the practice of community pharmacy in South Africa, for the conscious rejection of an understanding of pharmacy professionalism that assumes a monopoly on knowledge in the healing relationship ('... by taking responsibility for the therapeutic outcome of a therapy ...' SAPC, 2004, p. 2), or confuses the 'furnishing information and advice to any person with regard the use of medicine' (SAPC, 2004, p. 2) with patient counselling and education. This proposal argues that pharmacy practice as a whole should be informed by the moral disposition underlying the WHO's understanding of adherence that '... the relationship between the patient and ... [pharmacist] ... must be a partnership that draws on the abilities of each' (WHO, 2003, p. 3). In such an understanding of pharmacy practice the assessment of professional service would not be based on a time-and-motion study of product dispensing (such as that evidenced in the *Dispensing Service Tool*, SAPC (South African Pharmacy Council). (2006a) and SAPC (South African Pharmacy Council). (2006b)), but through a focus on a covenantal relationship with the patient (Hepler (1987) and Hepler (2000)). Centrally, this proposal questions the technician understanding of professionalism that retains knowledge as power in the hands of the pharmacist ('determining patient compliance with therapy ...' SAPC, 2004, p. 3). In the place of this understanding, what is proposed is professional pharmacy practice which aims to engage patients and their caregivers in a context-related partnership and, 'through the use of expert knowledge, [*to enable*] patients and their caregivers to deal with the uncertainty around health and medicine related concerns' (based on Evetts, 2003, above).

Such a philosophy of practice may serve to facilitate the patient taking away from the exchange with the pharmacist not merely a product, albeit a drug, but rather a greater ability to make optimal choices about health and medicines in the face of health related, in particular medicine related, risk. An approach to pharmacy's engagement with its professional status that is informed by Evetts (2003) and Evetts (2006) understanding of what it means to *be* professional, and in line with the narrative framing of pharmacists offered by Judge Sachs, may also create possibilities for pharmacy practice to re-position itself to the mutual benefit of the profession and the public by promoting more proactive engagement with primary health care needs.

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Notes

¹ I use ‘pharmacy’ to refer to community and hospital pharmacy practice. Quite specifically I do not have the pharmaceutical industry in mind in this paper.

² Moral’ in this sense, and its usage in this paper, ‘means “valued”— as opposed to the dichotomy, and discernment, of good and evil, or right and wrong’ (Tauber, 2005:43).

³ In May 2006 the SAPC released a draft for comment of the ‘*Code of Conduct for pharmacists and other persons registered in terms of the Act*’ (SAPC, 2006c). This Code of Conduct explicitly begins with reference to the patient—but still serves to position the patient as passive, without agency.

⁴ Although it was these concerns which a past representative of South African pharmacy deemed unprofitable (Simpson 1994, in Gilbert, 1998).

⁵ ‘[T]hose activities of pharmacists that most closely and directly impact on or interact with the final consumer of medicines, be they patients or users’ (Wingfield, Bissell, & Andersen, 2004:2384).

⁶ However, one must acknowledge that this may be as much because ‘the sociology of the professions is in “an intellectual shambles”... ’(Freidson 1994, in Annandale, 1998, p. 230), as because trying to confine professions in such a period of transition is a futile exercise.

⁷ ‘The voice of the lifeworld refers to the patient’s contextually-grounded experiences of events and problems in her life’ (Barry et al., 2001, p. 487).