IJPP INTERNATIONAL JOURNAL OF Pharmacy Practice

ROYAL PHARMACEUTICAL SOCIETY

IJPP International Journal of Pharmacy Practice

Research Paper

International Journal of Pharmacy Practice 2013, 21, pp. 322–332

Who do you think you are? Pharmacists' perceptions of their professional identity

Rebecca Elvey, Karen Hassell and Jason Hall

School of Pharmacy & Pharmaceutical Sciences, University of Manchester, Manchester, UK

Keywords
pharmacists; professional identity

Correspondence
Dr Rebecca Elvey, School of Pharmacy and Pharmaceutical Sciences, The University of Manchester, Stopford Building, Oxford Road, Manchester M13 9PT, UK.
E-mail: rebecca.elvey@manchester.ac.uk

Received November 4, 2011
Accepted November 4, 2012

doi: 10.1111/ijpp.12019

Abstract

Objectives The aim of this study was to examine pharmacists' perceptions of their professional identity, both in terms of how they see themselves and how they think others view their profession.

Methods A qualitative study was undertaken, using group and individual interviews with pharmacists employed in the community, hospital and primary care sectors of the profession in England. The data were recorded, transcribed verbatim and analysed using the framework method.

Key findings Forty-three pharmacists took part in interviews. A number of elements help determine the professional identities of pharmacists, including attributes (knowledge and skills), personal traits (aptitudes, demeanour) and orientations (preferences) relating to pharmacists' work. The study identified the presence of nine identities for pharmacists: the scientist, the medicines adviser, the clinical practitioner, the social carer, the medicines maker, the medicines supplier, the manager, the business person and the unremarkable character. While the scientist was the strongest professional identity to emerge it nevertheless seemed to overlap and compete with other professional identities, such as that of the medicines maker.

Conclusions The relatively high number of identities may reflect some degree of role ambiguity and lack of clear direction and ownership of what makes pharmacists unique, but also suggests a flexible view of their role.

Introduction

There is still much debate in the academic as well as the policy literature about the role of pharmacists and their unique contribution to health care. Pharmacists have been variously characterised as makers of medicines,[1] as pill pushers,[2] pill counters and bottle labellers,[3] as health advisers,[4] as medicines experts,[5,6] as managers,[7,8] as entrepreneurs,[9] as public health experts,[10] as clinicians,[11] as substitutes for general practitioners.[4] To add to the confusion, professional boundaries between pharmacists and other healthcare practitioners are sometimes described as blurred, while at the same time professional specialisation within pharmacy is also becoming increasingly common. Given this variety of roles the 'professional identity' (that is, a person's sense of 'who they are', or self-concept, in relation to their work) of pharmacists could be viewed as problematic or confused. Having a clear professional identity has been shown to provide a sense of worth, belonging, or purpose[12] for the individual as well as the group and if that identity is clear and unambiguous then the process of socialisation into the profession also becomes clearer and more focused.[13]

Back in 1995, Dingwall called for more empirical research about pharmacists and their work, to 'focus attention on finding out just what kind of occupation pharmacy is'.[14] Later, researchers argued that the 'raison d'etre' of the pharmacy profession, and its place and contribution to the UK National Health Service, were ambiguous and unpredictable,[15] and that there was a need to consider the different 'types' of pharmacist that might exist and to validate these by clearly identifying the characteristics that define and distinguish them.[16]

Since the 1960s, the professional identity of pharmacists has been investigated by various researchers. Some studies

have investigated trainee pharmacists' views of their own professional group, in comparison with others, in terms of skills and personal characteristics.[17,18] In one such study, pharmacists rated their own profession as more empathic but less powerful than medical specialists,[17] while another found that pharmacists rated themselves similarly to medical specialists on academic ability.[19] Other researchers have developed 'typologies' of pharmacists determined by their preferences for particular types of work, such as business, clinical or managerial work,[6,8] or particular roles or identities, such as being a 'drug expert'[6] a 'clerk' or 'care manager'.[7] Pharmacists' emerging family practice identity has also been noted.[3]

As well as referring to the self, identities also exist in relation to other people; therefore, it is also relevant to take into account how pharmacists believe others (colleagues and lay clients) perceive them. Research has shown that some pharmacists feel valued by their professional colleagues and lay clients. However, such positive views are outweighed by negative material: pharmacists think that doctors find them frustrating to communicate with, and associate them with large volumes of paperwork,[3] do not recognise their knowledge about disease,[20] feel threatened by them encroaching on their roles or look down on them as mere 'shopkeepers'.[21] Two studies suggested that being seen as a 'pill counter' was of concern to both trainee[22] and practising[23] pharmacists.

While the existing literature provides some useful evidence about professional identity in pharmacy, various gaps remain. Many studies were undertaken outside the UK, and/or date back several decades. In terms of study populations, there is a perceptible lack of information about the identities of hospital pharmacists. In addition, some methodological weaknesses are present, particularly with some quantitative studies using research tools which were originally developed outside pharmacy practice research and not validated with pharmacists before being applied in these studies.

Considering the changes that the pharmacy profession has been faced with in recent years, combined with the gaps and shortcomings in the evidence base outlined above, it seems timely to seek to clarify the issue of professional identity in pharmacy, and to increase understanding of what it means to be a pharmacist today. Unpacking what makes pharmacists distinct from other healthcare professionals, and therefore what is unique about pharmacy, could perhaps help pharmacists, and others, to value their profession. A study was undertaken to investigate professional identity in pharmacy from the points of view of pharmacists themselves, the public, and other healthcare professionals.[24] This paper reports the findings from pharmacists. It describes the professional identities that exist and how they are characterised and valued, and discusses the degree to which they were clear, strong or well-developed. The aim of this study was to examine pharmacists' perceptions of their professional identity, both in terms of how they see themselves and how they think others view their profession.

Methods

This study used a purposive sample, that is, one designed to generate different kinds of data and give the analyst different views or vantage points from which to consider the topic under investigation. A two-stage study was undertaken. In the first stage, sector-specific group interviews were undertaken with practising pharmacists from the community, hospital and primary care sectors who were connected (as research, teaching staff or doctoral students) to one university department. The group discussions were structured around devising descriptions of pharmacist 'personas'. Thus, imaginary characters which represent a real group of people, understood as 'abstractions or caricatures' of people's perceptions of their own work roles, or the roles of others around them, with a few fictional personal details to make the persona a realistic character, were devised.[25] Participants were also asked about their perceptions of the pharmacy profession in general, whether they thought there was one major type, or whether they discerned many different types of pharmacist.

Preliminary analysis of the data generated in stage one suggested that professional identity in pharmacy was a complex topic, that there was variation between different sectors of the profession and also individuals. Subsequently, stage two of the study was designed to further investigate pharmacists' identity, using a more diverse and more 'grass roots' (based outside academia) sample than stage one.

In stage two, semi-structured interviews were carried out with individual pharmacists. The topic guide focused on pharmacists' views on professional identity, so how they saw their own identity as pharmacists, as well as views on the profession more generally. Participants were asked mostly open questions, including: 'Describe a pharmacist in five words'; 'What makes you different from a doctor/other healthcare professional?'; 'How do you think your clients see you?' 'What do clients want/expect from you?' A visual prompt, with eight pictures of pharmacists fulfilling different types of roles was also shown to generate further discussion.

For both stages of the study, potential participants were contacted initially by telephone or e-mail, and were sent an invitation to take part. Interview arrangements were made with those who agreed, and this usually took place at their place of work. A snowballing strategy was employed, whereby interview participants were asked whether they knew of any colleagues who might also be approached to take part in the study. All participants were given information sheets and all provided written consent. The interviews were audio-recorded (all except one, where the participant declined to be recorded but was happy for the researcher to take notes). All

the interviews were transcribed verbatim. Field notes were also taken during the interviews. Data analysis followed the comparative approach; the 'framework' method was employed. Framework involves working through five stages: familiarisation – listening to interviews, transcribing and reading transcripts; identifying a thematic framework; indexing; charting; mapping; and interpretation.[26]

The first stage of the study was reviewed by the University of Manchester's ethics committee and approval was confirmed on 31 October 2007. Stage two was reviewed by a NHS research ethics committee and approval was confirmed on 14 March 2009. Research and development approval was obtained from the NHS trusts and primary care trusts which covered all areas that participants were recruited from. All recruitment and data collection was carried out by RE. The stage one group interviews were conducted between February and April 2008 and the stage two interviews between March and September 2009.

Results

In total, 43 pharmacists took part in interviews, of these, 20 participated in group interviews and 23 in individual interviews. Further details about the participants are provided in Table 1. Emerging from the narrative, it became apparent that identity as a concept was made up of number of elements including attributes (e.g. knowledge and skills), personal traits (aptitudes, demeanour) and orientations (preferences) relating to pharmacists' work. The process of comparative analysis allowed related elements to be grouped together, and nine professional identities for pharmacists were distinguished; the remainder of this paper describes these in turn.

The scientist

The scientist emerged as a clearly discernable identity for pharmacists. Although pharmacists were not asked any direct questions about their knowledge or training, these were mentioned repeatedly during the interviews. All pharmacists are trained in science, and while this is certainly not a new finding, it is worthy of attention as it indicates the nature of the knowledge base that underpins pharmacists' professional practice and the degree to which it is valued:

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

As well as seeing themselves as trained scientists, participants viewed pharmacists in general as having an intrinsically 'scientific' approach to their work:

> '. . . people [who] are drawn more to probably sciences, possibly more of an analytical, logical mind . . .' (Hospital pharmacist S)

Being knowledgeable is of course a desirable attribute, which contributes to pharmacists' identity in a positive way. However, participants identified a less flattering trait associated with being a 'scientist'; the notion that their social skills can be wanting was a frequent comment:

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

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

The medicines adviser

Pharmacists in both sectors identified with being a general medicines resource for professional colleagues and lay people alike:

> 'I think [doctors] now also see us as a really useful resource on the ward . . . quite happy to have you there to come up to and ask questions.' (Hospital pharmacist P)

In hospitals, pharmacists work alongside medical consultants who are highly knowledgeable about the medicines used within their specialism, but sometimes know less about other medicines their patients need, whereas the pharmacist can be a 'general medicines expert':

> 'If you go into a cardiology ward, you will have patients with cardiological conditions but because of their co-morbid states there will be loads of other types of drugs that [the doctors] don't generally come across and I think that's where the pharmacist plugs the gap, they're very good generalists, pharmacists.' (Hospital pharmacist T)

Table 1 Participant details

Sector of practice	Number of interviewees	Male	Female	Mean age
Stage one				
Community	Six	One	Five	30
Hospital	13	One	12	29
Primary care trust	Two	Zero	Two	41
	21 in total	Two	19	
Stage two				
Community	13	Six	Seven	41
Hospital	Seven	Two	Five	30
Primary care trust	Two	One	One	48
	22 in total	Nine	13	

Pharmacists' knowledge about medicines also comes into play when they check prescriptions before medicines are dispensed and the image of the 'checker' who ensures that all details are correct was a recurring one:

> '. . . an underlying trait is you've got to be precise if you like . . . whether you're a community pharmacist or a hospital pharmacist. . . . extremely important that they're attentive to detail, cos you are the final check before the patient gets the drugs . . . There are some slap-dash ones I think, then errors still creep on through and . . . you lose the point of having a pharmacist then.' (Hospital pharmacist Q)

While it is not difficult to appreciate the importance of pharmacists paying close attention to detail, participants suggested that this has the potential to become excessive:

> 'Being stereotyped about it, I suppose a lot of pharmacists are quite pernickety, erm, I think it kind of attracts a perfectionist . . . Yeah I think they can be a bit nitpicky and I can feel that sometimes in meself.' (Community pharmacist O)

> 'Meticulous is a word that always comes up quite a lot, anally retentive comes up quite lot as well (laugh).' (Hospital pharmacist P)

While the second pharmacist quote is a little pejorative in tone, the further excerpt from the same pharmacist below shows such traits need to be 'controlled' in the interests of fostering good working relationships:

> '. . . a lot of the time you're potentially going up to doctors and saying, you know 'I disagree with what you've prescribed here', you have to be able to put that across in a friendly way, without sounding like you're constantly nagging them, otherwise you don't have a very good relationship with them.' (Hospital pharmacist P)

Good social skills were also seen as important when dealing with lay clientele; five community pharmacists who had observed others in practice (through management/service development roles or tutoring trainee pharmacists), mentioned the importance of pharmacists being outgoing, convincing and reassuring:

> 'I think it's approachability and the way they're greeted . . . if it's a friendly, warm, 'How are you Mr Jones? How are you getting on?' . . . then they just love that . . . it can make a difference to them, that you are presenting an environment, where they're welcome for a start, and they feel free to ask for help and advice if they need to . . . I always encourage people to ask me questions anyway, but looking around others, a lot of pharmacists would stay in the back . . . and not venture forth very often unless they really have to.' (Community pharmacist P)

As well as having knowledge about medicines, pharmacists often use reference sources or research evidence to answer detailed queries, typically when working in a 'medicines information' function in a hospital. Several participants particularly enjoyed this type of work:

> 'Really enjoyed it . . . when the consultants or the patients or whoever is ringing you up, you have to know where to find the information . . . and I liked looking it up and sending it back to them.' (Community pharmacist R)

The social carer

Several participants in this study described how the pharmacist can be a key figure in the local community, to whom people bring a wide range of issues:

> '. . . pillar of the community . . . somebody that they can obviously come to with anything . . .. . . a confidante, who's trustworthy . . . who can give them information about problems . . . be it social, emotional or physical.' (Community pharmacist S)

As well as being beneficial to pharmacy users psychologically or emotionally, pharmacists themselves found getting to know patients on a personal level rewarding:

> 'I've got one guy who's just been diagnosed with hepatitis C, which he was devastated about, and on the same day he'd signed a lease for a flat and the landlord then said, 'I don't want you.' . . . he came to me to ask my advice . . . he showed me this letter, he trusted me with confidential information, which I thought was rather lovely . . .' (Community pharmacist O)

The participant quoted below recalled a pharmacist she had worked with:

> '. . . a lot of the elderly patients would phone up and say "I can't come and pick up my prescription; I'm not feeling well enough. Can one of the girls drop it round?" . . . and she'd be like "could they pick up some bananas on the way?" So we'd end up doing a bit of their shopping en route for them . . . there was one woman who used to phone up all the time, and then when she stopped phoning, he got worried about her and went round to check. She'd fallen over. . . . he was quite inspirational, cos you know he wasn't just dishing out tablets, he really helped people . . .' (Hospital pharmacist P)

While the trusted community figure seemed a well-developed identity for community pharmacists, there was a marked difference between sectors here; while hospital pharmacists

noted that their counterparts in community often build a 'rapport' with regular clients, they found the way that hospital work is organised provided less opportunity for them to do the same. This participant also reflected that the manner of some hospital pharmacists might be a factor:

> '[patients] think that pharmacists are either too busy, or, not stuck up, but a bit too proper, to sort of get into the nitty gritty and things . . . it shouldn't be like that, but I can imagine some pharmacists do come across like that.' (Hospital pharmacist O)

The clinical practitioner

During the interviews conducted for this study, clinical work and what it means for pharmacists in practice were discussed at length. Pharmacists understood clinical work to mean that undertaken at the level of the individual, which involves applying knowledge about medicines to a person's condition. The clinical practitioner identity was more prevalent in the hospital sector:

> '[I consider] . . . the whole patient, all their medical problems . . . side-effect problems, allergies . . . I think in community they're not really able to do that . . . Whereas . . . on the ward, we've got a lot more information at our fingertips.' (Hospital pharmacist P)

Interestingly, however, the hospital pharmacist quoted below expressed some discomfort about the 'onus' that she felt was on her to diagnose. Despite being recently trained (and undertaking a hospital pharmacy diploma), she seemed to have a 'traditional' view of the boundaries of her profession and its work, and did not identify with being a diagnostician:

> '. . . you've got doctors, who are prescribers. We're not prescribers, unless we've done the course and qualified as a non-medical prescribers. They [doctors] put the pen to paper and sign it, yet we're expected to know the disease state and to diagnose it sometimes . . . [there is] a lot of onus, especially my diploma . . . on diagnosing, we don't diagnose, that's not what we do.' (Hospital pharmacist O)

While community pharmacists may not have access to laboratory test results, they did, however, describe work which they undertake at the individual level. Although this was never referred to explicitly as 'clinical work', it nonetheless involves spending time talking with clients about their symptoms, sometimes even examining physical symptoms, and finding a treatment for the condition.

> '. . . if it's a rash it's, 'can you show me where it is without embarrassing yourself?' If not, we go into the consultation room and have a look at it there . . .' (Community pharmacist O)

Community pharmacists do not tend to 'diagnose' or treat acute serious illnesses, but their functions do go beyond supplying or advising on medicines, into areas of work that overlap with that of general practitioners.

Community pharmacists in this study thought that lay people consulted them because they found them approachable, and also because they were available without an appointment, unlike for example general practitioners (GPs). This is undoubtedly beneficial for clients, but perhaps sometimes less so for pharmacists:

> '. . . [a client] came in to me many years ago and said . . ."Hope you don't mind me asking you see, but I'm asking you because the doctor's so busy." So the inference was that we're not as busy as the GP, therefore she could take my time and it wouldn't matter quite so much. That could say in a way she felt the doctor more important, but in another way it was quite a compliment in that she felt she could approach me . . . It didn't bother me, it just sort of amused me a little bit. But it led me to think that you know some people, they don't feel they can ask the doctor often because of time constraints, whereas they could ask the pharmacist so they do perceive us as being more accessible and approachable, because of being under less time pressure.' (Community pharmacist P)

The medicines maker

The 'visual prompt' shown in interviews included a picture of a pharmacist in an old-fashioned pharmacy, decanting liquid from a large bottle and this picture generated an unexpected amount of talk about pharmacists as makers of medicines. Although interviewees commented that the scene looked old fashioned, it seemed that the type of pharmacist it represented was not merely remembered by participants in this study, but also missed:

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

Whilst older pharmacists recalled their own previous working practices, other pharmacists expressed a more general nostalgia for 'community pharmacy of the past':

> '. . . a more old-fashioned . . . pill counting and compounding pharmacist (laugh) . . . the traditional pharmacist . . . there used to be a lovely old pharmacy near where I live that had all those lovely old wooden shelves . . . and the old bottles in the window.' (Community pharmacist R)

As well as the 'lovely' pharmacists and pharmacies of previous times, the personalised service inherent to individually made medicines was something that the pharmacist quoted below thought his clients had particularly valued:

> 'I've worked in shops where we used to make gallons of our own cough medicine and it used to fly out, customers used to come specially for it . . . they thought they were being treated specially, you could tailor it to their needs . . .' (Community pharmacist Q)

Today, some (high risk) medicines are prepared in hospital aseptic dispensing units. Pharmacists working in these were seen as different from the traditional medicines makers, and associated more with technical procedures:

> '. . . I think they're less clinically based . . . people who've been technicians and then become a pharmacist tend to go into aseptics.' (Hospital pharmacist L)

> 'But they're very detail orientated, very sort of serious, focussed individuals . . . everything's got to be black and white, it's very procedure-led.' (Hospital pharmacist K; Hospital pharmacist group interview four)

The supplier

Pharmacists were asked the question 'What do you think your clients/patients want from you?'; analysis of the responses revealed three supply-related attributes: being willing to supply medicines, supplying them quickly and doing so accurately. The pharmacist quoted below referred to all three when she imagined what was important from the perspective of the lay pharmacy user:

> 'When I go to the pharmacy I want them to be safe with me, I want them to do the right thing with me prescription and me medicines, and to do it reasonably quickly.' (Community pharmacist O)

Running throughout the data generated for this study, was a sense that pharmacists are not supposed to be suppliers of medicines any more, but they perceive they are still seen as such:

> Interviewer: 'Describe a pharmacist in five words'

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

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

All pharmacists who held practising (not managerial) roles undertook some dispensing work, with the minimum time spent in a dispensary being 1 h per week. While no pharmacists in the study expressed enjoyment of assembling prescriptions, some community pharmacists seemed to accept this neutrally as part of their jobs. However, for other pharmacists, medicines supply work is in conflict with who they want to be; they find dispensing boring, pressurised and wasteful of their skills and training.

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

> Respondent: 'generally the hospital locums work in the dispensary . . . generally they're used in the engine room . . . doing all the dirty work really'

> Interviewer: 'How do feel about that, do you enjoy working there?'

> Respondent: 'No . . . it's extremely busy, it's disorganised, it's hard work actually . . .' (Hospital pharmacist T)

The business person

During the interviews there was a notable amount of talk about the way pharmacy practice is structured and organised. Two pharmacists in this study, suggested that the public might see them as shopkeepers, although this was not something that they identified with themselves, nor did they think was a desirable image:

> '. . . some [patients] just think you're a glorified shopkeeper. You've got stuff on the shelf . . .' (Community pharmacist Q)

> 'We're just perhaps seen as businessmen, rather than as clinicians.' (Community pharmacist P)

While pharmacists did not identify with being 'shopkeepers', being a business person was an important part of the identity of some interviewees. The pharmacists quoted below expressed both the satisfaction gained from attaining their own business, and also the autonomy which running your own business can provide:

> 'That was my baby . . . the very first one I bought, it was my little pride and joy . . .' (Community pharmacist S)

> '. . . I'm glad I don't work for a multiple, I'm glad I'm my own boss . . .' (Community pharmacist Q)

The manager

The trend towards increasing ownership of pharmacies by multiple contractors has been ongoing for over a decade. Therefore, many pharmacies have been run by pharmacists who are 'employee–managers', a role which is well established.

While these pharmacist managers do not own the businesses they run, a sense of pride gained from successfully running a shop was also considered a key part of their identity, as illustrated by the following quote, which describes an employee-manager pharmacist:

> 'They want the shop perfect, they want it to be the best, so I would say they work about 40 hours to keep it perfect . . .' (Community pharmacist C)

> 'That's her shop . . . she's looking after it.' (Community pharmacist D; Community pharmacist group interview two)

More recently, pharmacy chains have increasingly started to employ non-pharmacist managers in their shops. Three participants saw this as a positive trend, because it releases pharmacists from operational and managerial tasks, such as maintaining the premises, or drawing up staff rotas, and allows them to focus on providing pharmacy services. However, several expressed discomfort about working with non-pharmacist managers, owing to lack of clarity over responsibilities, and some pharmacists seemed to feel that their authority was undermined, particularly when faced with working to meet targets:

> '. . . I mean I understand . . . the company sets you a target, but it's down to the pharmacist to understand when an MUR [medicines use review] is due . . . there are some shops in which managers . . . push the pharmacist every time to do MURs, and that's not good . . . Even if there's no reason to do an MUR . . .' (Community pharmacist P)

A further issue to emerge from the data was that ownership by large chains can lead to pharmacies being less diverse and more standardised in terms of the way the shop is presented and the actual products stocked. This pharmacist described changes within the company that she worked for:

> 'I think they're going for a much more sort of universal face of pharmacy, like [large pharmacy chain] would have . . . what they're going to try and do is put in products that are stocked in every single one of the stores . . . across the board, so what they keep in each pharmacy is sort of generic . . .' (Community pharmacist F; Community pharmacist group interview three)

There was less discussion about changing pharmacy management in the hospital sector. Indeed, one focus group described a senior hospital pharmacist who seemed accustomed to working within rules implemented by managers:

> '. . . they have to be good at toe-ing the party line don't they? They've got to be very politically aware. . . . "yes-people" . . .' (Hospital pharmacist K)

> 'Nowadays. In the past I don't think they were, but I think they are now, because I think the managers of the trust [will] come to them and say, "We want you to be open longer hours, we want you to do this" and they don't really expect the Director of Pharmacy to say "That's not gonna happen." They just expect it to happen . . .' (Hospital pharmacist L; Hospital pharmacist group interview four)

Of course pharmacists themselves can move into management roles, and several interviewees described a type of pharmacist who enjoys work such as service development, or managing budgets and performance measures:

> '. . . these other elements of the organisational bit is I think the bits that keep people interested in say running your own shop "I can run this I can run my own shop I can hit all my targets, I can set up all these extra services and things"." (Hospital pharmacist S)

The unremarkable character

Lastly, data generated for this study suggested that there are some aspects of pharmacists' professional identity which can be difficult to discern clearly; indeed, to the extent that the notion of the pharmacist as a character devoid of distinctive characteristics was perceived. For example, the hidden nature of much pharmacy work was mentioned:

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

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

While hospital pharmacists now have more contact with patients, they often experienced being indistinguishable from others in the hospital workforce:

> Interviewer: 'When you go on the ward rounds, do you think patients know who you are?'
> 'Mm very difficult, I'm always mistaken for a doctor . . .' (Hospital pharmacist O)

Interviewees in both sectors suggested that pharmacists' skills are not recognised or appreciated as much as they could be, and that there is more work to be done to promote these:

> '. . . with GPs, if you haven't got the rapport with your local practices . . . they'll say, "well what's the pharmacist?" ' (Community pharmacist S)

> '. . . to be a good pharmacist, you need to be a bit of a self-promotionist . . . patients don't really understand what you do, doctors . . . nurses don't really understand what you're there for . . . [pharmacists need to do] a lot

> more approaching patients and trying to figure out whether they understand their drug therapy.' (Hospital pharmacist T)

The idea of pharmacists as either unseen or anonymous in the real world, was reflected by comments on their portrayal in fictional media:

> 'They must think we're uninteresting . . . We do need somebody, a role model in one of these soaps, because people believe them, because doctors do get a better showing, nurses as well . . .' (Community pharmacist P)

However, while participants did recall several examples of fictional pharmacists, the character most frequently mentioned was that of 'George' the pharmacist in the TV drama *Desperate Housewives*, who used drugs from his pharmacy to poison someone, and the following quotes are illustrative of the generally negative recollections:

> 'We're shy (laugh) . . . We're not really . . . in fictional or drama very much. And whenever we are, it's always bad (laugh) . . .' (Primary care pharmacist C)

> '. . . we tend to be alcoholics as well, on television programmes.' (Hospital pharmacist R)

Discussion

Through analysis of the data generated for this study, nine professional identities for pharmacists were identified. These identities were: the scientist, the medicines adviser, the clinical practitioner, the social carer, the medicines maker, the medicines supplier, the manager, the business person and the unremarkable character.

The research reported in this paper contributes to the evidence about professional identity in pharmacy. The aim of the study was to examine pharmacists' perceptions of their professional identity, both in terms of how they see themselves and how they think others view them and their profession. This was achieved by generating data that helped reveal the elements through which a pharmacist's identity is formed. The detailed understanding of the concepts that ensued is a particular strength of the study, facilitated by the qualitative approach taken. As well as investigating the issue of identity in depth, the study also addressed a previous gap by examining contemporary work identities of the hospital pharmacist.

The findings reported here were generated with one relatively small sample, recruited from one geographical area so cannot be generalised to all pharmacists. However, the sample was heterogeneous, so is likely to have captured the range of views and perceptions held by pharmacists. Although interviews can be criticised for their potential subjectivity, they were all conducted by the same researcher (a non-pharmacist), thus, reducing the risk of interviewer variation. The same researcher also coded the data, but co-investigators discussed and checked the emerging findings helping to ensure the rigour of the analysis process and to validate data interpretation.

This study identified the presence of nine professional identities with 'the scientist' arguably emerging as the clearest identity for the contemporary pharmacist. Pharmacists perceive their scientific knowledge being applied practically, in the supply of medicines, and intellectually via their identity as advisers on medicines; particular traits often associated positively with scientific training, such as being methodical, precise, organised were commonly used by the interviewees to describe a typical pharmacist. Furthermore, the scientists' academic ability and high level of knowledge are put to use in both main settings of the profession, albeit in different ways. The idea of the pharmacist as an 'expert in medicines' is not a new one – it was mentioned by a report of the UK Council of the Pharmaceutical Society in the 1940s.[5] and is well-established in the research literature.[7,14,27]

While pharmacists may well be highly trained scientists, their knowledge remains theoretical in nature until it is applied in practice. This is achieved by advising others about medicines. Pharmacy policy of the last decade has consistently positioned pharmacists as providers of information and advice about medicines, and the views of participants in this study seemed aligned with this. The self as medicines adviser is undoubtedly a core identity for pharmacists today, partly because it manifests in a variety of settings and roles. However, although this is a strong identity for pharmacists which contributes a great deal to forming who they are, this diverse application is also linked with the complexity of the medicines adviser identity.

Although the scientist was the strongest professional identity to emerge it nevertheless seemed to overlap and compete with other professional identities, such as that of the medicines maker. Medicines manufacturing in the UK shifted to the pharmaceutical industry during the 1960s.Nowadays, medicines tend to arrive at pharmacies ready-made and often pre-packed, ready for supply to clients and making medicines forms a very small part of pharmacy work. Therefore, the volume of data generated in relation to the medicines maker was at first surprising, but on closer examination, was interesting both for the clarity with which this identity could be discerned and also the strength of emotional attachment to it. However, this identity was perhaps unique among all those to emerge in that it was located mostly in the past rather than the present. A certain fondness and yearning for the role was apparent, and it could be argued that since medicines making stopped being a regular feature of pharmacy practice, the future direction and identity of the pharmacy profession has been unclear. Birenbaum previously referred to traditional

pharmacists as 'craftspeople' and claimed that when they stopped compounding medicines they lost their niche area of work which had defined them professionally.[1] Harding and Taylor suggested that patients appreciated receiving handcrafted products made in the pharmacy,[28] and also found that pharmacy students thought that learning to make medicines (in extemporaneous dispensing classes) helped give them an identity as pharmacists which distinguished them from students on other science-based degrees.[29]

Regardless of policy-makers' aspirations for pharmacy, evidence from this study suggests that pharmacists have never regained as clear or as strong an identity as that of the traditional maker of medicines.

This is not to suggest that there were ever pharmacists who were purely medicines makers, but perhaps because this identity relates to observable activities – producing material objects, which provide clear points of reference, it was both easy to recognise and had real practical meaning. In contrast, contemporary pharmacy policy sets out numerous shifts in pharmacists' roles, but the impact these might have on professional identity, in terms of shaping what pharmacists perceive themselves to be, can be difficult to discern. The primacy of the findings relating to the scientist identity, for example, may be partly due to pharmacists drawing strength and security in their professional status from the sturdy foundation provided by the 'hard', scientific academic training they get at university. However, there are on-going debates about the content of pharmacy degrees in Great Britain (that is, the MPharm degree) and concern has been expressed that reducing the scientific content (dumbing down) the MPharm could result in loss of status and a de-professionalization of pharmacy. Perhaps the focus from study participants on scientific training could be understood in this context. Conversely, it may be that this identity also reflects a very real sense of worth, in the scientific training of pharmacists and what they can do. Furthermore, perhaps the considerable number of identities, and the variation within them, should be seen in a positive light, in that pharmacists certainly do not have a restricted perception of their role, compared to, for example, GPs who have been shown to have a restricted view of their own identity.[30]

Notwithstanding that there were identities (such as the scientist) and particular elements (having good attention to detail) found among pharmacists in all sectors and roles, some were more dominant in one sector. The clinical practitioner, for example, manifested most clearly in the hospital environment, where pharmacists work as part of teams, providing services to patients with serious conditions, and where they have access to patients' medical records. Hospital pharmacists expressed a strong orientation to this type of work and a positive affinity with being 'clinical'. Being a 'medicines supplier', however, was seen very differently by hospital pharmacists, who tend not to see themselves as such, and feel frustrated when they think that others do so. The idea of pharmacists as suppliers of medicines has been increasingly played down in policy documents, which contend that pharmacists should be 'freed' from manual work in order to concentrate on clinical work. However, community pharmacists in this study thought that service users still looked to them for quick and accurate supply of medicines. Perhaps for some pharmacists at least, the supply of medicines – a vital function of any healthcare system – is still a positive aspect of their professional identity.

While the data revealed several strong, positive aspects of pharmacists' professional identity, others were more problematic. For example, aseptic pharmacists were associated with a technical mindset and while all pharmacists must be precise in their work, there can be a fine line between useful checking and *excessive* focus on technical details, which can make them appear rigid or aggressive. Concerns about social skills cut across several identities such as geeky scientists, aloof hospital pharmacists, and community pharmacists who remain hidden at the back of their shops. This chimes with previous work on stereotypes perceived by student health professionals, which found that pharmacists were rated highly on academic ability, but received relatively low ratings for social skills.[31]

Other data suggested that pharmacists are often anonymous characters, and in the media are generally ignored or portrayed negatively. Concerns about a lack of a pharmacy presence in the media have been raised previously.[22] While it is difficult to link these directly to particular elements of practice, or show evidence of their relation to any actual harm, being unremarkable, or lacking a distinctive or positive identity, cannot be good for the status of the profession.

It is also worthwhile considering what pharmacists *do not* perceive as contributing to their professional identity. Studies undertaken with other health professions have found that doctors, for example, saw themselves as 'healers' and 'health promoters'[32] while physiotherapists perceived a 'treater' self-identity.[33] Comparing these findings with those of the current study helps to show further ways in which pharmacy is different from other healthcare professions.

As well as no longer making medicines, community pharmacists have been dislocated from other traditional aspects of their identity such as running a shop. Previously, most community pharmacies were owned and operated by pharmacists who were independent business-people. The fact that community pharmacists run private businesses has been treated in the research literature as problematic, in that pharmacists are shopkeepers,[21] selling goods for money, which is assumed to be in conflict with the values of a healthcare professional.[34] Whilst participants in this study did not identify with being shopkeepers, some did see themselves as business people and as managers. The new contractual mechanisms do make provision for community pharmacists to be paid for

services other than dispensing, which may help some pharmacists' identity to develop in positive ways. However, a sense of being 'over-managed' or constrained seems to be frustrating some community pharmacists; more research into the changing management and organisational structures in community pharmacy and their relation to pharmacists' identity, may be warranted. A further area which might merit further investigation is that of pharmacists' identity as social carers;– community pharmacists' pastoral role has been documented by other researchers, such as Dingwall's 'neighbourhood consultant'[14] and Rogers's 'community pharmacy haven'[35] but their informal relationships with clients who do not actually visit pharmacies, as seen in this study, could be an important one, especially if their public health role becomes more firmly established.

Conclusion

Nine is a relatively high number of identities to find amongst members of a single profession – more than previous comparable studies (which identified types of pharmacist or orientations within pharmacy),[6–8,27] have done. Perhaps to some extent this is a reflection of pharmacy's leadership rhetoric, which results in role ambiguity and lack of clear direction and ownership of what makes pharmacists unique. It may also be a sign of the strength of the current study in that it was able, in its method and analysis, to drill down and dissect role identity in far more detail than has been possible before. On the other hand so many identities may be a sign that practising pharmacists simply have a sophisticated or multi-faceted self-concept and a flexible view of their roles given the wide range of sectors in which they work and the range of duties they perform.

Declarations

Conflicts of interest

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

Funding

The study received funding from The University of Manchester.

Acknowledgements

The Authors thank all the study participants for their time and the journal referees and editor for their input during revisions of this paper.

Authors' contributions

All Authors' contributions adhere to the International Committee of Medical Journal Editors' definition of authorship. All Authors contributed to the conception and design of the study, RE collected the data, all Authors had full access to the data that support the publication and contributed to analysis and interpretation of the data. RE drafted the article, all Authors contributed to re-drafting and revising critically and all Authors gave final approval of the version to be published.

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