Pharmacists' lack of profession-hood: Professional identity formation and its implications for practice

Paul Gregory, BA, MLS; Zubin Austin, BScPhm, MBA, MISC, PhD, FCAHS

ABSTRACT

Background: Understanding the internalized, psychological sense of being a professional may provide important insight into understanding pharmacists' behaviours and attitudes in practice.

Methods: It is difficult to directly or quantitatively measure an internalized psychological state such as profession-hood. An indirect method was selected in which pharmacists who were themselves patients or caregivers were identified and invited to discuss their experiences, as a vehicle for better understanding how they relied upon personal and professional identities during high-stress, impactful times.

Results: A total of 17 community pharmacists from southern Ontario participated in this study. Regardless of demographic background, participants reported little reliance on professional identity, knowledge or role as a pharmacist when advocating for themselves or a loved one.

Interpretation: These findings suggest that community pharmacists have incomplete, separated or functional (rather than existential) professional identities. This lack of professional identity may influence behaviours in practice such as interactions with other health care professionals or patients or self-confidence in clinical decision-making.

Conclusions: Further work is necessary to better understand the socialization and professional identity formation of pharmacists to help support them through the current evolution of pharmacy towards more interdependent and complex clinical roles and decision-making. *Can Pharm J (Ott)* 2019;152:251-256.

Background

For generations, there have been arguments as to whether pharmacy is a profession or an occupation,¹ the implication being that professions are more valuable and important than simple jobs. Professional status confers privileges but also involves responsibilities related to self-sacrifice, altruism and adherence to ethical and behavioural standards that may at times be uncomfortable.^{2,3} If pharmacists are indeed professionals (not just workers),⁴ how does the internalized sense of profession-hood actually develop and evolve from university and throughout practice?

Professional identity formation (PIF) has emerged as a major issue in health professional

education, particularly in medicine.⁵⁻⁷ Authors have described PIF as a foundational experience resulting in the transformation of an individual from “just” being a person to being a physician.^{6,8} It involves establishment of core values, moral principles, self-awareness and self-regulation.⁶⁻⁸ PIF has become an issue in medicine due to concerns about the declining quality of professionalism and professional behaviours, in particular, concerns that novice physicians are less willing to be altruistic and self-sacrificing and adhere to the ethical and behavioural standards of that profession.^{5,9} Understanding and reinforcing PIF in school, in residency programs and in practice has emerged as an important strategy to address

Without our own clear understanding of who we are as a profession, our self-identity, is it any wonder that patients, physicians and other health professionals don't really know what to make of us and our claims to be medication experts? This study has revealed a lack of clear professional identity among pharmacists and raises questions regarding its impact on practice, patient care and professional motivation.

Notre propre perception de la profession que nous exerçons, à savoir notre identité professionnelle, n'étant pas claire, il n'est pas surprenant que les patients, les médecins et les autres professionnels de la santé ne savent pas quoi penser de nous et du fait que nous affirmons être des experts en médicaments! Cette étude a mis en lumière l'absence d'une identité professionnelle claire chez les pharmaciens et soulève des questions sur les répercussions d'une telle lacune sur la pratique, les soins aux patients et la motivation professionnelle.

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KNOWLEDGE INTO PRACTICE

- Professional self-identity is a hallmark of professional status and an important part of what motivates and supports practice.
- Pharmacists have weak or incomplete professional self-identity formation. We found that in times of crisis, when it matters most, pharmacists do not identify as pharmacists.
- Weak or incomplete professional self-identity formation may adversely affect patient care and practice. This may explain pharmacists' lack of confidence, reluctance to take responsibility and, ultimately, why a full scope of practice is difficult to achieve.

this existential drift within medicine.^{6,7,9} While similar concerns have been expressed in pharmacy education and practice,^{10,11} there has not been a significant focus on PIF among pharmacy educators, regulators or advocates.

Why does this matter? As noted by Schon¹² over 40 years ago, professional work is unique in society because it exists in areas where there are no clear-cut right answers—professionals work in messy situations dealing with messy problems. They must act and make decisions based on judgment, wisdom, ethics and intuition.¹² To manage the cognitive and emotional demands of work in such ambiguous situations, psychologists posit that an internalized professional identity is essential—a sense of profession-hood that provides psychological support for the difficult work that is inherent in professional fields such as medicine, law¹³—and pharmacy.

In 2006, Mahamed¹⁴ (in a master's degree thesis) explored the issue of professional identity in a novel manner, examining the experiences of pharmacists who had become patients or caregivers and were therefore reliant upon the health care system for personal reasons. Her work built upon the literature of physicians who had similar experiences. This literature suggested that when physicians become patients, they cannot help but leverage their physician-hood in their own, personal care.¹⁵⁻¹⁷ In general, they identify themselves to their care providers as physicians, vigorously question and frequently debate care options and closely monitor their own treatment and progression, using their specialized professional knowledge to help themselves.^{16,17} This literature suggests that professional and personal identity for physicians is fused: they do not simply *do* medical work; they *are* (psychologically and existentially) physicians.¹⁶ Mahamed's

interviews involving 12 community pharmacists in southern Ontario suggested that no similar pattern existed in pharmacy: community pharmacists rarely if ever volunteered their occupation, nor did they overtly question care plans or treatments (including prescriptions). She concluded that this behavioural pattern suggested that community pharmacists demonstrated incomplete professional identity formation; as she noted, "Now, when it counted the most for their own personal lives, pharmacists in this study preferred to rely upon their personal identity to advocate for themselves or their loved ones, rather than risk reliance upon their professional knowledge, skills and identity."¹⁴

Since this exploratory research was conducted close to 15 years ago, pharmacy has undergone a significant transformation,¹⁸ including regulation of pharmacy technicians, significant expanded scope of practice, accelerated integration in inter-professional teams and the shift to the PharmD as the entry-level degree. All of these changes have been undertaken to signal a greater role, enhanced respect and a heightened social need for and expectation regarding the importance and professionalism of pharmacists. Examining the implications of these shifts on the professional identity formation of pharmacists today is a valuable method for understanding their profession-hood.

Objectives

The objective of this research was to examine the experiences of community pharmacists in southern Ontario who had themselves become patients or primary caregivers for loved ones. Based on these experiences and building upon the method used by Mahamed,¹⁴ inferences related to professional identity formation would be drawn.

Methods

Mahamed's method was repurposed for this study.¹⁴ A purposive snowballing sampling method was used to recruit community pharmacists from southern Ontario who practised at least 24 hours/week. The first participant in this study was known to the investigators due to previous work as a clinical rotation supervisor; this individual helped identify others who were either patients or caregivers, who in turn also suggested other potential participants who could be contacted. Mahamed's method included both pharmacist-patients and pharmacist-caregivers;

psychologically, the distinction in roles with respect to professional identity formation was identified as being substantially similar and thus both were included in the study.^{14,17} All participants provided informed consent pursuant to a Research Ethics Board–approved protocol. Participants were asked to commit to a 30- to 45-minute audiotaped semistructured interview (using the same interview protocol Mahamed had used in her study), by phone or in person. Verbatim transcripts were produced for each interview and were analyzed and coded by 2 independent coders using content analysis methods described by Chi, used by Mahamed.¹⁴ The analysis aimed to identify common themes related to participants' experiences, using the guiding theoretical framework of professional identity formation described by Goldie.⁵ Interviews were undertaken until saturation of themes occurred, and no new information or concepts were elicited from interview participants.

Findings and Discussion

A total of 17 community pharmacists were interviewed for this research (see Table 1 for demographic details), divided evenly between those who were currently patients in the health care system and those who were caregivers for loved ones.

Similar to Mahamed's findings,¹⁴ most participants in this study neither actively participated in care planning nor fully disclosed their educational and professional backgrounds to their health care teams unless explicitly asked.

Patient (P) 4: No, I didn't think it was actually necessary to say, "Hey, I'm a pharmacist." Right now, you know, when I'm with my mother in an ICU, I'm actually not a pharmacist, right? I'm a daughter first and foremost.

Interviewer: What if you were asked, even casually by, let's say a nurse or a doctor, "Hey, what do you do for a living?"

P4: Oh well then—well, it wasn't a problem to say what I did, of course, it just didn't seem relevant to bring it up on my own.

Interviewer: So what would you say if you were asked about yourself, what you do for a living?

P4: Well then of course I'd say I work in a pharmacy, in a drugstore.

Interviewer: You "work in a pharmacy, a drug store." Would you say that you were a pharmacist as well?

MISE EN PRATIQUE DES CONNAISSANCES

- L'identité professionnelle est une particularité de la condition du professionnel. Elle est ce qui motive et appuie en grande partie la pratique.
- La formation de l'identité professionnelle des pharmaciens est peu développée ou incomplète. Nous avons découvert qu'en situation de crise, dans les moments qui comptent le plus, les pharmaciens ne se reconnaissent pas comme tels.
- Une formation de l'identité professionnelle peu développée ou incomplète peut avoir des répercussions négatives sur les soins aux patients et la pratique. Cela pourrait expliquer le manque de confiance, la réticence à prendre des responsabilités et, finalement, la non-réalisation du plein potentiel dans la pratique.

P4: Uhm—I'm not really sure, probably not, I guess it doesn't come up very often?

Later in this interview, to explore this issue of self-disclosure to other health care professionals upon whom this individual was now personally dependent for the care of her parent, further details were provided:

Interviewer: Why do you think you may hesitate to tell the people taking care of [your mother] what you do?

P4: Well, I don't want them to think that I'm second guessing their work, their decisions. That would be awkward, right? Not that I could—I mean I'm just a community pharmacist after all so what do I know about [intensive care medicine]?

Most participants in this research described similar experiences and provided similar explanations regarding their interactions with members of their/their loved ones' care teams. A strikingly similar behavioural pattern emerged in which:

a) Personal identity was more important than professional identity:

P6: It's not like I was specifically—consciously—thinking about it or anything, but I knew at that time, well, my main job is to just get better, to recover. I'm not working when I'm in a hospital bed, I'm a patient so that's my job.

P11: I don't even think about it when I'm [at my loved one's care facility]. I'm not at work, I have to focus on being supportive and caring, not on the stuff that's other people's jobs, right?

TABLE 1 Participant profile

Participant	Sex	Age, y	Years in Practice	Highest Degree	Years since Graduation	Practice Type	Patient/Caregiver
P1	Male	40	15	BScPhm	15	Chain	Patient
P2	Female	39	15	PharmD	3	Chain	Caregiver
P3	Female	41	10	BScPhm	10	Independent	Caregiver
P4	Male	52	27	PharmD	8	Grocery	Patient
P5	Female	63	31	BScPhm	31	Grocery	Patient
P6	Male	37	12	PharmD	4	Banner	Caregiver
P7	Female	59	37	BScPhm	37	Chain	Caregiver
P8	Male	39	17	BScPhm	17	Chain	Patient
P9	Male	44	21	PharmD	8	Chain	Patient
P10	Female	63	31	BScPhm	31	Independent	Caregiver
P11	Male	45	23	BScPhm	23	Chain	Caregiver
P12	Female	58	30	PharmD	10	Chain	Caregiver
P13	Female	54	30	BScPhm	30	Grocery	Caregiver
P14	Female	39	17	BScPhm	17	Chain	Caregiver
P15	Male	62	40	BScPhm	40	Independent	Patient
P16	Female	63	41	BScPhm	41	Chain	Patient
P17	Female	49	27	PharmD	2	Chain	Caregiver

b) Trust in other health professionals' competence is integral to personal identity:

P8: You just have to believe—well, you know, you have to trust that the people [in the health care facility] know what they're doing, you can't always be asking too many questions otherwise you are labelled, I don't know, like a troublemaker or a know-it-all. And then they don't want to come see you or take care of you and that's when you get into trouble.

P1: They're all professionals too—I think it would be disrespectful, maybe rude to be questioning everything everyone does. Just let them do their jobs. I know as a pharmacist how aggravating, how irritating it gets when people are, you know, always telling you what to do.

c) Lack of self-confidence around potential value of self-disclosure as a pharmacist:

P9: What difference would it make anyway? I mean, really, there's nothing I know or can do that is

better than these people, is there? I'm just a community pharmacist, so what's the point of anything I could do here?

P15: Well, to be honest, I don't think any of us know all that much when it comes to real, acute situations like this. I mean, sure, if [my loved one] was in hospital for, I don't know, athlete's foot, I could give some advice or something, but this is way out of my league.

d) Reliance upon ingratiation and personal identity as tactics for advocating for care rather than professional knowledge and skill:

P2: What's the expression? Flies are attracted by honey or something? You've got to be nice, you have to be pleasant and sweet, that's how you get people, especially nurses, to take care of you. If you're always complaining or you're always asking too many questions, then they—well, you know, they think you're a troublemaker and they can punish you for that. Not punish but just, well, they won't come as quick or won't be as nice to

you. So just be nice—you know be yourself, not like a show-off, oh, I'm a pharmacist so I know how to do your job better than you. You'd be crazy to do that.

P3: Everyone knows that the best way to get the best possible care in a hospital—you have to be pleasant, you have to be cooperative and nice and always smile and say thank you. Or you have to be a total pain in the ass always screaming and shouting and threatening to sue. One extreme or the other. It's just easier to be nice, not ask too many questions, not be too [bothersome].

The behavioural patterns reported by pharmacists in this study are similar to Mahamed's work¹⁴ close to 15 years ago and are in clear contrast to the literature reporting physician's experiences when they become patients or caregivers. As noted by Domeyer-Klenske and Rosenbaum,⁶ physician-patients frequently have issues managing personal health team boundaries and frequently request access to laboratory information and medical charts. They are also more likely to negotiate diverse care options, insist upon fuller discussion and disclosure of details and options and can at times use nonverbal and verbal communication in more direct and assertive ways than nonphysician patients.⁶ They note that a heightened sense of self-confidence and elevated expectations regarding their own care are also features of the physician-patient.⁶

As scientifically trained health care professionals, it would be reasonable to assume physicians and pharmacists would have similar responses and behaviours to becoming patients/caregivers, yet this study has highlighted (and replicated) findings that these patterns are strikingly dissimilar. There could be many plausible reasons for these observed differences; we hypothesize one reason may be that the psychological and internalized sense of profession-hood—the professional identity—for each profession is substantially and significantly different, and this in turn leads to the differences observed in this study. As noted earlier, physicians do not simply perform medical work; they *are* physicians in a fuller psychological and existential sense, while pharmacists perform pharmacy work but may not have fully acquired a fused personal-professional identity similar to their medical colleagues. The self-advocacy, self-confidence and self-interest demonstrated by physician-patients may in part be due to this fused professional-personal

identity, while the somewhat more trusting, acquiescent and cooperative behaviours demonstrated by pharmacists may suggest a professional identity that is separated, incomplete or functional, rather than existential.

What are the implications for professional practice for these findings and differences? First, it is striking that most pharmacists in this study commented frequently and confidently about the need to “trust” other health care professionals and not “second-guess” the medical team. Considering that a central *raison d'être* for the pharmacy profession is actually to provide sober second thought and examination of medical decisions, it is curious that in their personal lives and when it counted the most, pharmacists in this study chose not to rely upon their professional identity. Second, a strong reliance on ingratiation and “niceness” as a personal advocacy strategy (as opposed to confidence in scientific knowledge and professional judgement) may be reflected in the interprofessional communication dynamics pharmacists rely upon in their daily practice, which may limit their effectiveness and the respect they receive from other health care professionals. Third, the lack of self-confidence reflected in this behaviour pattern may reflect other, underlying psychological traits or beliefs that may limit the impact and constrain the interactions pharmacists have with others. Whether this is a function of professional identity formation and socialization in pharmacy school and pharmacy or whether it is a stable trait of those selecting pharmacy as a field in the first place requires further exploration.

Limitations and strengths

This study was designed to address an inherent limitation in attempting to examine a hidden, internalized process such as professional identity: it defies robust quantitative measurement and is difficult to observe directly. The indirect assessment of professional identity through reflections upon real-world behaviours during time of personal crisis is innovative and unique. However, it is an indirect assessment that relies upon an untested theoretical framework and assumptions, so caution must be exercised in generalizing from this study to all pharmacists. Further geographical and practical limitations on the participants in this study must be considered. While thematic saturation of interview data did occur, the 17 participants in this research were all from the same

geographical area, which limits generalizability to other settings. Finally, while 2 independent coders reviewed and categorized all transcript data in this study, based upon an (untested) theoretical framework in order to establish reliability and trustworthiness, interpretive and implicit bias is inevitable in this kind of research.

Nonetheless, in replicating findings from close to 15 years ago, several key issues are highlighted. First, despite significant changes and advances in pharmacy practice and responsibilities, there does not appear to have been significant evolution in professional identity of pharmacists during this time. Second, across all demographic backgrounds of participants in this study (e.g., male vs female, PharmD vs BScPhm, urban vs rural), similar behavioural patterns were elicited, suggesting demographic characteristics alone may not be as important as the fact that one is a pharmacist, with one very significant exception. The reality of life is that (fortunately) many younger pharmacists (e.g., <35 years old) would not be included in this study; they may be too young to personally experience major health issues and may not yet have elderly

parents or children with significant health needs. Despite deliberate attempts to identify this age cohort for inclusion in the study, we were unable to do so and consequently this important demographic (i.e., the future of the profession) was not reached through this particular research method. Finally, this research opens important opportunities for further research in the area of professional identity and professional identity formation in pharmacy as important tools for education, regulation and advocacy.

Conclusions

This study has replicated findings of previous work suggesting that professional identity formation of community pharmacists may be incomplete, separated or functional rather than existential. Pharmacists perform pharmacy work but may not have a fully developed internalized psychological sense of profession-hood. While the implications of these findings for professional practice require further elucidation, it may explain some of the difficulties in achieving a full scope of practice—lack of confidence and reluctance to take responsibility. ■

From the Leslie Dan Faculty of Pharmacy, University of Toronto, Ontario. Contact zubin.austin@utoronto.ca.

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