Professional identity formation: A shared responsibility for academia and pharmacists

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THE RECENT ARTICLE BY GREGORY AND AUSTIN¹ PUBLISHED IN the July/August issue of the *Canadian Pharmacists Journal* was both thought-provoking and discouraging. The authors conducted interviews with 17 community pharmacists who also had experienced being a patient or a caregiver for loved ones. The conclusions from the research were that many of the pharmacists studied had a professional identity that could be viewed as incomplete or not fully developed. As an academic and a pharmacist, it was disappointing to read comments such as “I’m just a community pharmacist, so what’s the point of anything I could do here?” or “I don’t think any of us know all that much when it comes to real, acute situations like this.” Equally discouraging, the authors noted that the findings were essentially unchanged when compared to the results of similar research conducted 15 years previously.

One can argue about the relative merits of the study design or the degree to which the pharmacists studied are representative of the community pharmacist population as a whole. Some of these comments have been summarized in an editorial in the September/October issue of *CPJ*.² That being said, the conclusions are not necessarily surprising, and many of us have encountered community pharmacists whose professional identity is consistent with that described by Gregory and Austin.¹ If we accept that the conclusions arrived at in this article are valid, the important question is “How do we fix it?” and a good beginning is to agree on what sort of professional identity pharmacists should have. Elvey et al.³ studied pharmacists from a variety of practice settings in the United Kingdom and identified a number of different identities, including scientist, medicines’ adviser, social carer, clinical practitioner, medicines’ maker, supplier, businessperson and manager. Somewhat surprisingly, the authors concluded that the strongest professional identity in their sample was the scientist. While pharmacists may assume many of these roles at various times, the document “AFPC Educational Outcomes for First

Professional Degree Programs in Pharmacy in Canada 2017” is clear in declaring that the primary goal of pharmacy education in Canada is to “graduate Care Providers who use their medication therapy expertise to benefit patients, communities and populations.”⁴ This article further states that “Care Provider is the core of the discipline of pharmacy.” The Pharmacy Examining Board of Canada (PEBC) appears to endorse this concept, given that patient care is by far the most heavily weighted component in the PEBC qualifying exam blueprint.⁵ Indeed, pharmacy would be a clear outlier among the health professions in Canada if care provider was not the primary desired professional identity.

If the objective of pharmacy education in Canada is to produce pharmacists who identify as care providers, do the results of the study by Gregory and Austin¹ indicate that universities are failing in their attempts to achieve this goal? Alternatively, do students have a professional identity as a care provider at graduation, albeit somewhat fragile, only to lose this identity along the way as they accumulate experience in community pharmacy practice? Although there is no definitive answer to this question, what is clear is that both academia and practising pharmacists have a shared role and responsibility in developing a strong professional identity focused on the provision of patient care.

On the academic side, it is imperative that our universities admit students who have not only the academic ability but also the personal characteristics that are suited for patient care. We are fortunate in Canada that pharmacy continues to be an attractive career choice and most programs across the country have a strong pool of applicants. Admissions procedures have shifted in recent years from what was formerly a complete reliance on grades to a more holistic process in which a variety of additional metrics are considered. These may include personal interviews, multiple mini-interviews (MMIs) and tests such as CASPer (Computer-Based Assessment for Sampling Personal Characteristics), designed to assess traits such as ethics,

professionalism and empathy. These additional assessments are widely used in medicine and other health professional programs. It makes sense that evaluating communication skills and personal traits that are important for the provision of patient-centred health care should result in graduates whose capabilities are more closely aligned with the professional identity that pharmacy education is seeking to develop.

It is important to note that the design of the study by Gregory and Austin¹ resulted in a cohort of participating pharmacists that received their pharmacy education a number of years ago. Study subjects ranged in age from 37 to 63 years, with more than half having been in practice for longer than 25 years. As a result, the educational experience of these individuals was considerably different from that of today's graduates. The curriculum in pharmacy programs in Canada has undergone significant revision over the past few years with the transition from the Bachelor of Science in Pharmacy to the PharmD degree, and there is reason to be optimistic that the current program of study that is being offered across the country will do a much better job in developing an appropriate professional identity. Curriculum changes that support the formation of a care provider identity include:

- 1) Increased emphasis on the development of communication skills
- 2) Greater focus on interprofessional education and the distinct role of the pharmacist in the health care team
- 3) Integrated courses focused on patient-centred care as opposed to courses that are built around drugs or drug classes
- 4) More time in the professional practice laboratory where students have the opportunity to practise or experiment with their role as care provider in a simulated and safe environment
- 5) A significant increase in the number of hours devoted to both early and late experiential education

All of these curricular elements play a valuable role in enhanced professional identity formation, but perhaps the most important is the expansion in experiential education. As pointed out by Noble et al.,⁶ students “need to reconcile their curricular learnings and aspirations for professional practice with the realities of authentic practice.” Early experiences are critical in that a negative experience can be a significant

setback in a student's tenuous formation of professional identity. Importantly, early experiences are interspersed in the didactic curriculum. Identity formation is an iterative process, and shifting between the classroom and the practice environment allows students the opportunity to reflect on their own experiences, share these with instructors and integrate their experience with what they learn from fellow students. Late or concluding practice experiences must be a minimum of 32 weeks in duration according to the most recent standards established by the Canadian Council for Accreditation of Pharmacy Programs (CCAPP)⁷ and are expected to provide students with extensive exposure to positive role models of patient-centred care along with opportunities to affirm their professional identity in an authentic environment.

While the universities may initiate the process of forming an appropriate professional identity, it is practising pharmacists who complete (or possibly undo) the process, and we need to ensure that all of our students are exposed to as many outstanding community pharmacist care providers as possible throughout their pharmacy education. It is essential that students be able to see themselves as care providers and they need to observe pharmacists fulfilling this role in the real world as opposed to the classroom or practice lab. We are all painfully aware that there are numerous barriers in community pharmacy that make it challenging for pharmacists to practise in a fully patient-centred manner. The physical environment, volume of work, lack of access to the patient's medical record and inadequate technician support can be significant challenges. As highlighted recently in this journal, community pharmacists in some jurisdictions in Canada continue to be asked to engage in medication management without access to a patient's laboratory results,⁸ a situation that pharmacists working in settings such as the hospital or health teams would find ludicrous. Despite these barriers, many community pharmacists have dedicated themselves to caring for their patients, rising above these challenges. We need further research to understand why some are clearly able to develop a professional identity as care provider while others are not. Academia and those in positions of influence within community pharmacy must continue to support pharmacists in their quest to overcome barriers to providing patient-centred care. Only then will we be able to ensure that all current and future pharmacy students are able to develop an appropriate professional identity and maintain that identity throughout their professional career. ■

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