Professional Identity Construction amongst Thai Pharmacists

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Abstract

Internationally, the pharmacy profession's paradigm of practice has been shifting from a product-oriented role to a patient-oriented role. Despite increasing public interest, there has been a lack of research into the experiences of pharmacists as they make the transition to a patient-oriented role. Furthermore, it is important to understand how individual pharmacists construct their identity in making this transition, as well as how they behave or react within the role prescribed by their work contexts. This issue of analysing identity construction at the personal level, especially in professionals, is one which empirical research has failed adequately to investigate.

With a focus on Thailand, this research thus explores how the paradigm shift to a patient-oriented role influences pharmacists' identity construction in two different work contexts: a public hospital setting and a private drugstore setting. This enables a comparison of how pharmacists construct identities differently in the two contexts, thus highlighting how a particular context influences individuals' identity construction by providing multi-discursive resources.

This thesis employs negotiated order theory and the social arena concept to examine how pharmacists negotiate to establish their role boundaries, and how they engage with the consequences of these role boundaries. It is found that pharmacists construct identities differently, depending on the context in which their role is situated. Consequently, identity construction is influenced by personal identity, role identity and work and family contexts, as well as professional values.

In summary, this thesis contributes to currently under-researched areas of the pharmacy profession literature associated, in particular, with identity and negotiation. At the theoretical level, the thesis also sheds light on using negotiated order theory and the social arena concept to examine negotiations in the less institutionalised context of private drugstores. Finally, the thesis offers a more comprehensive model for identity construction, which includes the role of personal identity, role identity, contexts and social interactions to explain how pharmacists construct their identity, and in so doing highlights the dynamics behind the identity construction process.

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Acknowledgements

Author's Declaration

I declare that all the work recorded in this thesis is original unless otherwise acknowledged in the text or by references. None of the work has been submitted for another degree in this or any other university.

Chapter 1: Introduction

1.1   Introduction

This thesis aims to fill gaps in two bodies of literature relating to the pharmacy profession and to identity theory. With regard to the literature on the pharmacy profession, this is a profession in transition, for which the paradigm of practice has recently been directed more strongly toward patient care. There has been a global paradigm shift in role boundaries toward patient-oriented practices. In conjunction with the new paradigm, the concepts of "pharmaceutical care" and "clinical pharmacy" that emerged during the mid-1970s (Hepler and Strand, 1990) promote pharmacists' involvement in patient care, thus encouraging multidisciplinarity with the aim of improving patient outcomes.

From a policy perspective, pharmacy can contribute to patient care by improving patient outcomes (Department of Health, 2005; 2006; 2008, World Health Organization, 2006). Many studies relevant to pharmacy have also focused on the value of the pharmaceutical role to patient care. Many empirical studies have demonstrated the contribution of the clinical role of pharmacists to improving patient treatment outcomes (e.g. Nkansah et al., 2010; Hanlon et al., 1996).

Nevertheless, from a sociological perspective, the pharmacy profession is unsettled with respect to its status and its public image as shopkeeper (Denzin and Mettlin, 1968). Furthermore, expanding the role boundary of one profession has an impact on the role boundaries of other professions (Abbott, 1988), and boundary expansion may give rise to boundary encroachment between professions (Nancarrow and Borthwick, 2005). At the empirical level, some studies demonstrate perceived inter-professional conflict between medical and pharmaceutical professions as a consequence of expansion of the pharmaceutical role into patient treatment (Hughes and McCann, 2003).

Thus, the empirical literature indicates boundary conflict as a consequence of expansion of the pharmaceutical role, while the new paradigm continues to be promoted internationally. However, few studies shed light on how pharmacists are responding to the transition of their profession and negotiating the establishment of

professional boundaries, in their day-to-day practice. Mesler. (1989; 1991) and Eaton and Webb (1979) have examined how pharmacists negotiated with doctors in order to expand their roles in the clinical setting, which they perceive as the most conflicting boundary. Nevertheless, these studies have failed to identify the social arenas[1] within the hospital setting, which are important for identifying the area of conflict, and have failed to identify all the social actors involved in the negotiations.

This thesis thus finds that pharmacists negotiate not only with doctors, but also with other social actors, including pharmacists and nurses, to set their role boundaries. Therefore, by clearly demonstrating the social arenas operating within the hospital context, this thesis offers a much more detailed insight into the negotiations conducted within a hospital.

In addition, previous studies have focused only on the hospital context. This study, however, examines the negotiations conducted in a commercial context, specifically private drugstores, which are less institutionalised than hospitals. This is important as, in contrast to pharmacists in the hospital setting, within the private drugstore setting the pharmacist is the sole professional who negotiates with service users. Pharmacists in the hospital setting are subordinates and are under a doctor's autonomy, whereas pharmacists in private drugstores have full autonomy in deciding regimens for their service users.

In addition, previous studies have failed to link pharmacists' negotiations and their professional identities. In particular, the studies have failed to distinguish the differences in pharmacists' identities between the commercial setting and the public hospital setting. In this regard, this study provides a comparative analysis of the shift of pharmacists' identities in these two different work contexts, as well as how this shift determines the different social resources and negotiation strategies of pharmacists in the two work contexts.

In light of this discussion, the first research question addressed in this thesis is:

> *How do pharmacists negotiate the establishment of role boundaries in the light of professional transition?*

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[1] A social arena is a boundary setting which contains all the actors and all the groups which are usually in conflict committed to acting within it (Renn, 1992; Jaeger et al., 2001; Clarke, 1991).

Examination of the identity theory literature reveals a further gap in the existing literature in terms of a lack of empirical studies addressing specific processes and situations of identity construction at the individual level (Sveningsson and Alvesson, 2003). In addition, despite the existence of research into the identity construction of individuals in an organisational context, relatively few studies have addressed how individuals whose careers are regarded as professional construct identity in and around their work and organisations (Ibarra, 1999; Pratt et al., 2006). This thesis argues that professionals are different from employees, because one tends to talk about oneself as an employee of an organisation in terms of where one works, whereas when talking about a profession it is more about what one does, regardless of where the work is carried out (Pratt et al., 2006). This is because professionals are assumed to maintain their professionalism no matter where they carry out their work. In order to understand the processes of the identity construction of pharmacists, the second research question of this thesis is:

> *How do pharmacists engage with the consequences of the role within*
> *the boundaries of pharmacy?*

In order to develop an understanding of professional identity construction processes and situations, this research is conducted within the context of the pharmacy profession, which has been extensively criticised in the existing literature as being an "incomplete", "semi" or "marginal" profession (Edmunds and Calnan, 2001).

The concept of identity work is used to explore dynamic characteristics of pharmacists' identity construction. This refers to individuals being engaged in ongoing processes in which identity is formed, repaired, maintained, strengthened or revised to provide a sense of coherence and distinctiveness (Sveningsson and Alvesson, 2003).

Existing models of identity construction are unable entirely to explain how individuals construct their identities. Previous studies have often adopted a single approach to identity construction; thus, they have failed to observe other aspects or elements which also influence identity construction. For instance, Sluss and Ashforth's (2007) model explains how individuals' role identity and personal identity influence interpersonal identity construction; however, the model lacks consideration of how personal and role identity impact on each other and play out in

the light of identity work. Moreover, the model lacks consideration of how contexts impact on identity construction.

Thus, at the theoretical level, this thesis develops a model of identity construction which demonstrates the interplay between the personal and role identities of individual pharmacists and explores how this interplay is evidenced in the light of identity work. It also identifies the role of family and discursive resources, including the sense of security and belonging in the work context and the role of professional values as a discursive resource, which also play a role in shaping pharmacists' identities.

Thus, the model developed in this thesis offers a more comprehensive model which explains the interdependence of individual agency, work contexts, family background and professional bodies in shaping individual identity construction.

The remainder of this chapter proceeds as follows. Section 1.2 presents the research questions. Section 1.3 discusses the contributions of the thesis. Section 1.4 concludes with a structure of the thesis.

1.2 Research Questions

Based on the gaps identified in the literature, two research questions are addressed in this thesis:

1) How do pharmacists negotiate the establishment of role boundaries in the light of professional transition?

2) How do pharmacists engage with the consequences of the role within the boundaries of pharmacy?

1.3 Contributions of the Thesis

In examining how pharmacists negotiate the establishment of role boundaries and how they engage with the consequences of the role, this thesis contributes to both empirical and theoretical knowledge.

Previous research has failed adequately to explain the process by which pharmacists, generally labelled as semi-professionals, construct their identity. However, this is

important because they belong to a profession in transition (Denzin and Mettlin, 1968; Harding and Taylor, 1997). In addition, there is a debate in the sociology literature about the mixed image of pharmacists and their incomplete status.

In this regard, this thesis finds that pharmacists construct identities differently depending on the context in which they are working. This is because different work contexts provide different discursive resources. For example, within the private drugstore setting, pharmacists present the two conflicting identities of professional and businessperson. This is due to the conflicting discourses and professional and business values which are presented in the private drugstore context. On the other hand, within the hospital setting there is no business discourse; rather, pharmacists draw on a single value – professional value – to construct their identity as a professional.

Therefore, some pharmacists in the private drugstore setting maintain both identities but display each identity differently depending on the situation. This thesis likens the process they use to maintain both identities and not attain synergy between them as a *compartmentalisation* mechanism (Pratt and Foreman, 2000). On the other hand, some pharmacists felt "guilty" about conducting themselves as businesspeople and, as a result of this guilt, they terminated the role. The processes involved in this situation are therefore explained as dis-identification, identification (Hogg and Reid, 2006) and integration (Pratt and Foreman, 2000).

In addition, by employing the social arena concept (Jaeger et al., 2001, Renn, 1992) to examine the area of conflict in the healthcare context, this chapter is able to define the shift of the social actors' roles, and their resources in different work contexts, and offer an understanding of how these impact on different identities and negotiated strategies of pharmacists between public hospitals and private drugstores.

With regard to its contribution to theory, although negotiated order theory (Strauss et al., 1963) was first developed to examine negotiations within a hospital context, this thesis uses the theory to examine negotiations in the private drugstore context. This application to the private drugstore context shows that it is possible to utilise the theory in this way.

In addition, Chapter 6 contributes to theory by creating a more complete model of the identity construction processes which occur during macro and micro role transitions. In this regard, the identity construction model used includes the role of discourses within the work contexts, on which pharmacists drew in the processes of identity construction. Furthermore, the model also highlights negotiation between personal and role identities and how this impacts on identity construction in the light of *identity work*.

Overall, this thesis shows that identity construction occurs through the role of pharmacists as social actors negotiating their role boundaries. It also shows the impact of family background, work contexts, professional value and different discursive resources, which all interact to influence the identity construction of individual pharmacists.

1.4   *Structure of the Thesis*

This thesis consists of seven chapters. Chapter 1 introduces the research. It provides an introduction to the scope of enquiry for this thesis, presents the research questions, and establishes the original contribution. The chapter concludes by outlining the structure of the thesis. Chapter 2 examines the relevant literatures, including literature on the pharmacy profession, identity theory, negotiated order theory and the social arena concept. Chapter 3 presents the research methods and the methodology used to analyse the data. Chapter 4 offers background information on the individuals and work contexts of the pharmacists who provided data for this study.

The first empirical chapter, Chapter 5, examines how pharmacists establish their role boundaries in two different work contexts. In particular, the chapter offers a comparative analysis of the context of a public hospital and a private drugstore. The outcomes of this chapter demonstrate a shift in pharmacists' roles and social resources in negotiations. The second empirical chapter, Chapter 6, examines how pharmacists engage with the consequences of their role in the light of identity work.

Chapter 7 presents a summary of the findings and their significance, as well as policy implications and recommendations for the Thai pharmacy profession, and directions for future research.

Chapter 2: Literature Review

2.1   Introduction

This thesis addresses the identity construction of individual pharmacists. This chapter examines the relevant literatures, including current literature associated with the pharmacy profession, identity theory and negotiated order theory. The chapter has three key sections.

Section 2.2 provides a review of the literature on the pharmacy profession, which highlights that pharmacy is a profession in transition, with an unsettled status and public image.

Section 2.3 defines the term "identity" in order to understand its various meanings and how it has been conceptualised in the existing literature. The section then moves on to examine the literature on identity. This highlights a lack of studies into the processes of individuals' identity construction, especially of professionals.

Lastly, Section 2.4 provides a review of the literature on negotiated order theory and the concept of social arenas, which are used as frameworks to analyse how pharmacists, as social actors, construct identities by establishing role boundaries.

2.2   Pharmacy as a Profession in Transition

> *Pharmacists should move from behind the counter and start serving the public by providing care instead of pills only. There is no future in the mere act of dispensing. That activity can and will be taken over by the Internet, machines, and/or hardly trained technicians. The fact that pharmacists have an academic training and act as health care professionals puts a burden upon them to better serve the community than they currently do* (Van Mil, et al., 2004, pp.309-10).

Over recent decades, the pharmacy profession has been the subject of major discussion amongst policymakers globally. Its importance is associated with a changing paradigm of practice, from behind the counter toward interacting with patients. Evidence from international institutions such as the World Health Organization (WHO) demonstrates the development of the pharmacy role toward

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patient care practice. For example, WHO's most recent handbook (2006) clearly promotes the role of pharmacists beyond traditional compounding and dispensing to clinical tasks and patient care. It also outlines dimensions of practice covering pharmaceutical care, evidence-based pharmacy, meeting patients' needs, chronic patient care, self-medication, quality assurance of pharmaceutical care services, clinical pharmacy and pharmacovigilance.

Pharmacy practice is moving towards patient care and clinical services. Such a development is often seen as a result of new policy implementations in many countries (for example Department of Health, 2005; 2000).

2.2.1 Paradigm Change in Pharmacy Practice

In the past, pharmacists were drug experts, whose role since the foundation of the profession had involved gathering and compounding natural drug products into dosage forms and ensuring safety, stability, effectiveness, accessibility and palatability (Maine, 1996). Their competence in and knowledge of medicines allowed them to employ their specialist knowledge and enjoy the status of a profession comparable with medicine (Edmunds and Calnan, 2001). However, their function in compounding was eroded as a consequence of the establishment of mass production during the nineteenth century (Maine, 1996). This de-skilling and loss of function in society resulted in a loss of professional status for pharmacy.

Concerns about de-professionalisation and loss of status due to loss of role have resulted in a pervasive view of pharmacy as "marginal", "incomplete", "quasi" or "limited" in its professional status (Edmunds and Calnan, 2001). Some have viewed pharmacy as an "invisible" healthcare profession (Adamcik et al., 1986), as it has received minimal interest from practitioners, consumers and academics.

Pharmacists' responses to de-professionalisation have been visible in attempts to create professional organisations, set high standards of training and performance and develop roles in clinical care as strategies to re-professionalise their status in society (Birenbaum, 1982). Efforts have been made to re-professionalise pharmacy, with pharmacists seeking to expand their role into clinical pharmacy and become involved in public health. Developing a role in clinical pharmacy services has been

seen as one of the most promising strategies for the re-professionalisation of pharmacy's status (Hepler and Strand, 1990).

Recently, utilisation of the skills and knowledge of pharmacists has been of public interest. WHO (2006) and, in the United Kingdom, the Department of Health (2000; 2005) have supported and promoted the role of pharmacists.

2.2.2 New Concepts of Practice: Pharmaceutical Care and Clinical Pharmacy

Pharmacy directing its role toward patient care involves adopting a new concept of pharmacy practice known as pharmaceutical care. Pharmaceutical care is a concept which emerged during the mid-1970s in the United States and has now been adopted in practice globally (WHO, 2006). Originally proposed by Hepler and Strand (1990), the concept of pharmaceutical care is "the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life" (p.539).

Hepler and Strand (1990) argue that the provision of dispensing or pharmaceutical services is insufficient for pharmacy to retain the status of a profession; rather, pharmacists and their institutions must adopt pharmaceutical care as a philosophy of practice in order to re-professionalise. They insist that pharmacists must play a role in patient-centred pharmaceutical care and emphasise the individual patient:

> *Pharmacy's reprofessionalisation will be completed only when all pharmacists accept their social mandate to ensure the safe and effective drug therapy of the individual patient* (p.533).

They suggest that the role of pharmacists in the provision of pharmaceutical care includes preventing drug-related morbidity and mortality. In order to achieve the goal of improving patients' quality of life, pharmaceutical care also encourages the integration of pharmacists with other health professionals in patient care.

Together with the emergence of pharmaceutical care, the concept of clinical pharmacy was also developed and first practised in a hospital setting. Clinical pharmacy is an area of pharmacy practice in which pharmacists provide patient care. The role of pharmacists in clinical pharmacy includes interviewing and assessing

patients, making individual therapeutic recommendations, monitoring patient responses to drug therapy, and providing medical information (WHO, 2006).

2.2.3 Evidence of Pharmacy's Contribution to Patient Care

Existing evidence clearly demonstrates the contribution of pharmacists to public health, showing that pharmacists now go beyond their traditional dispensing role and can improve patient outcomes. Nkansah et al. (2010) carried out a systematic review and examined the role and intervention of pharmacists in targeting patients and in relation to physicians. In terms of outcomes for patients, the study found that pharmacists were generally effective in controlling blood pressure in hypertensive patients, blood glucose levels in diabetes patients and total cholesterol in patients with hyperlipidemia. They also found improvements in prescribing patterns by physician participants following intervention by pharmacists.

The implications of this systematic review are that pharmacists are capable of performing roles beyond traditional dispensing, and that they have proved their competency in patient intervention and educating physicians. They could therefore serve as potential healthcare providers in primary care settings.

2.2.4 Debates in the Existing Literature

Despite the role of pharmacy being directed toward patient care, it is evident that such role extension creates ambiguity in role boundaries between pharmacists and medical professionals. For example, should pharmacists be involved in patient care and prescribing? Sociological research has debated the underlying assumption that developing a clinical role would create tension amongst the professions and thus present barriers to collaboration (Eaton and Webb, 1979; Nancarrow and Borthwick, 2005; Spencer and Edwards, 1992).

Traditionally, the division of labour in a hospital is characterised by pronounced differentials of power and authority between professions. In this division of labour, medicine is the profession which has exclusive power over prescribing and clinical decision making. Freidson's (1970) concept of medical dominance defines a dominant profession as one which has autonomy to control its own activities as well as freedom to regulate other professions. Hence, in a hospital setting, the medical profession is dominant because it has the power to govern its own activity,

particularly in deciding how to treat and what regimen to use, as well as a right to control the activities of other professions within the healthcare system. Accordingly, professional role boundaries in the patient care arena are constructed around this differential power in the division of labour; that is, doctors prescribe, pharmacists dispense and nurses administer drugs to patients (Shepherd et al., 1996).

In the literature, a professional role boundary is viewed as a "battleground" (Britten, 2001) in which professions compete to gain jurisdiction to control the role within the boundary (Abbott, 1988). Existing evidence shows that prescribing power, which was previously regarded as the exclusive prerogative of medicine, has been reduced by the state and by other professions (e.g. Britten, 2001; Shepherd et al., 1996; Gilbert, 1998; Nancarrow and Borthwick, 2005). Prescription-only drugs are being reclassified as pharmacy drugs in order to increase the accessibility of drugs to the public (Britten, 2001). In some countries, including the United Kingdom, allied health professionals such as nurses and pharmacists, having completed an accredited programme, may also become independent prescribers with the right to prescribe controlled drugs previously prescribed only by medical professionals (Department of Health, 2006; 2008).

Nancarrow and Borthwick (2005) conclude that professional boundaries in healthcare are dynamic. Healthcare boundaries are being contested by the healthcare professions, and continue to change. For example, expanding the role of one profession may change not only the status of that profession, but also the roles of other healthcare professions, as the professions are considered to be dynamic in terms of their own disciplinary boundaries and roles (Nancarrow and Borthwick, 2005).

With regard to the encroachment of role boundaries, researchers also warn of a loss of professional identity and role ambiguity for newly-qualified staff moving to a setting with high levels of role overlap (Nancarrow and Borthwick, 2005). Moreover, because the new roles are performed without clear boundaries, pharmacy may still be regarded as an incomplete and quasi-profession (Denzin and Mettlin, 1968).

In contrast to medicine, Denzin and Mettlin (1968) suggest that pharmacists have failed to view drugs as social objects to which to direct services. Based on this

assumption, pharmacists may profit from drugs as they regard them as products. Debates around profit orientation continue and remain a major area of conflict within the pharmacy profession. Denzin and Mettlin (1968) clearly demonstrate how pharmacists have failed to meet the attributional criteria of a profession. From their viewpoint, pharmacy is regarded as a marginal or quasi-profession, based on the shopkeeper image of pharmacists in the retail environment. By their own justification, pharmacists can advertise drugs and earn profits from product sales. Unlike medicine, pharmacy does not transform drugs into social objects which become a direct service for the benefit of patients. According to Denzin and Mettlin (1968), the pharmaceutical profession has no altruistic goals or values, and therefore pharmacists profit from the sale of drugs as they would from any other products in the retail environment.

Furthermore, as can be seen from its history, the work context of pharmacy in private drugstores has an image which combines profession and business (Denzin and Mettlin, 1968; Birenbaum, 1982). For centuries, pharmacists have dispensed drugs and received payment in return. This service has often been debated by both sociologists and practitioners with regard to dispensing being motivated by profit. From a sociological perspective, the businessman or shopkeeper image is stated as the main characteristic of pharmacists preventing them from achieving full professional status (Birenbaum, 1982; Denzin and Mettlin, 1968).

In contrast, Dingwall and Wilson (1995) argue that, like pharmacy, medicine may also fail to fulfil the established criteria of a profession; therefore, justification by criteria is insufficient to determine whether pharmacy is a profession. Moreover, they criticise Denzin and Mettlin (1968) for their failure to interpret drugs as social objects for pharmacists. To Dingwall and Wilson, drugs are the symbolic transformation of inert chemicals and, therefore, it is not important that community pharmacy has failed to fulfil its role as a profession.

Supporting Dingwall and Wilson's debate, Harding and Taylor (1997) also view advances in technology, including transforming medicines into easy-to-use packages with standard written instructions, as an opportunity for pharmacists to capitalise on their knowledge and expertise by transforming natural substances into medicines (social objects).

Debates about the shopkeeper image are based not only on debates amongst sociologists, but are also presented in empirical studies. There is evidence that pharmacists in private drugstores encounter resistance to collaboration from doctors as a result of their shopkeeper image. For instance, Hughes and McCann (2003) demonstrate negative attitudes of GPs to collaborating with community pharmacists and strong opposition to a prescribing role. Their study identifies a lack of knowledge of pharmacists' training and professional development in the private drugstore context and the perception that pharmacists have a shopkeeper image and work in a purely commercial environment.

2.2.5 Summary

In conclusion, pharmacy's changing role is at the centre of debates around the profession. Since the erosion of its functional compounding role, pharmacy has been seen as a profession which has lost its status. Relevant literature presents evidence of debates on re-professionalisation (Birenbaum, 1982). Some strongly suggest role expansion as a strategy to regain status in society (Gilbert, 1998), and the latest idea is to shift pharmacy's role into patient care, as seen from national policy reforms. Consequently, role boundary encroachment as a result of pharmacists' expanding role into the medical profession's territory has become a hot debate and a research focus for pharmacy (e.g. Eaton and Webb, 1979; Mesler, 1991; Nancarrow and Borthwick, 2005). It is also found in the literature that business orientation, as characterised by pharmacy, is a perceived barrier to role expansion.

Debates from sociological and general practitioners' perspectives on these three areas of research focus (professional status, boundary encroachment, and the professional/business dilemma) are ongoing. Thus, it can be concluded that pharmacy is a profession in transition, with ambiguity in its role, image and status (Denzin and Mettlin, 1968; Harding and Taylor, 1997). This section clearly demonstrates the unsettled status of the pharmacy profession within society.

2.2.6 Research Questions

Evidence has been provided that the role of pharmacy is clearly developing toward the patient care boundary, which has traditionally belonged to the medical

profession. Debates about pharmacy in the existing literature have been identified with regard to status, medical-pharmaceutical boundary conflict, and business image. This review prompts the first research question of this thesis:

How do pharmacists negotiate the establishment of role boundaries in the light of professional transition?

Chapter 5 will examine this question.

2.3   Identity Theory

Identity is a complex subject. Key texts in developing an understanding of the theory include Hatch and Schultz (2004), Linstead (2005), Tajfel (2010), Hogg et al. (2004) and Burke and Stets (2009). Articles on theory and relevant concepts have been searched using terms such as organisational control, identity work, managerial identity, narrative identity and identity construction in order to gain insight into current debates and develop an understanding of this complex concept. A snowballing approach was used to identify further articles from bibliographies.

Recent studies focus on the current issue of identity construction and the problem of scant understanding of the processes of identity construction at the individual level, in particular as a professional. This has led to a narrowing of the focus of the current study to processes of identity construction undertaken by pharmacists.

Before moving to a review of current studies, the next section explores how identity has been defined in the literature.

2.3.1 Identity: Definitions and Characteristics

This section examines definitions of identity in the literature. Identity is commonly described as meanings attached to a person by self and others (Gecas, 1982). From this definition, identities link to self-concept because they contain meanings that form a self-meaning or the definition of an individual's self.

Where do identity or meanings of self come from? Traditionally, identity is conceptualised through a structural symbolic interactionist approach, which proposes that identity is socially constructed. From this perspective, individuals derive their identity from the society in which they live. Self-meanings are derived

from a social role or social category, such as being a teacher or a mother, or being a member of a particular group (Burke and Stets, 2009; Hogg and Reid, 2006). Identities are also derived from holding a uniquely personal, idiosyncratic characteristic (Burke and Stets, 2009; Ashforth and Mael, 1989). According to this approach, since human beings belong to multiple social categories, they have multiple identities derived from a multitude of bases, such as personal, role and social bases (Burke and Stets, 2009).

In addition, most of the earlier research has adopted a functionalist perspective, which views identity as being largely bounded and stable. For example, at the individual level, Stryker (1968) and Stryker and Serpe (1982) conceptualise identity as being derived by performing a social role. They propose the concept of role identity salience, which they explain as role-based identities organised hierarchically in a self-concept. Salient identities are those few identities which are organised at the top the self-concept hierarchy and have greater influence over the definition of self. This concept of role identity has implications for the study of human behaviour in explaining that individuals holding the same role behave differently due to different identity salience. Stryker and Serpe (1982) propose that identity salience may be used to predict individual identity. However, it can be argued that this perspective lacks consideration of changes in identity. Their view of identity is thus largely fixed in the individual and has a pattern of conforming rather than being fluid and discursive.

Another range of literature conceptualises identity as derived through a process of socialisation (e.g. Cooley, 1964; Goffman, 1959). Following Cooley (1964), individuals are made up of histories in the social past or organisations in which they live. Cooley (1964) illustrates this in the fact that individuals learn about communication, language and education from society. In Cooley's sense, an individual is a product of society. He also proposes the concept of "the looking-glass self", suggesting that individuals derive self-idea or identity from perceptions of how others think about them. Thus, based on Cooley's sense, identity is derived from interpersonal interactions with society and the perceptions of others.

Goffman (1959) asserts that identity is derived through social interaction. He explains identity as a performance that everyone delivers to audiences (others) in order to make an impression and maintain successful social interactions.

Identity is also understood as reflexively constructed; that is, the self is reflexively interpreted and understood by the individual. According to Giddens (1991):

> *Self-identity is not a distinctive trait, or even a collection of traits, possessed by the individual. It is the self as reflexively understood by the person ... self-identity is continuity (across time and space) as interpreted reflexively by the agent* (p.53).

Following Giddens (1991), individuals construct self-identity through reflexive narration of their past experiences. Giddens' concept of self-identity indicates that self-narration is a suitable method for use in this thesis. This point will be discussed in Chapter 3.

In summary, this section has explored the concept of identity in general. Identity is the various meanings attached to an individual, and individuals possess multiple identities or meanings of themselves. These meanings are derived from social roles and from individuals' own idiosyncratic characteristics. Through a process of socialisation, people interact with others in society to form their identity and perform their identity to audiences. Besides, identity is also reflexively constructed through self-narration.

2.3.2   Identity in Organisation Studies

Albert and Whetten (1985), who originated the concept of organisational identity, conceptualise it as the central, distinctive and enduring attributes of an organisation. They define organisational identity as "a collective understanding that the members perceive as an enduring characteristic of their organisation and distinct from other organisations". It can be seen that they regard identity as relatively stable over time. This concept of identity is situated in the functionalist perspective, which conceptualises identity as stable and enduring.

Similarly to Albert and Whetten (1985), Dutton et al. (1994) examine relationships between organisational image and member identification, and define the concept of

organisational identification as "the degree to which a member defines him or herself by the same attributes that he or she believes define the organisation" (p.293). This perspective of identity is based on the functionalist approach, which conceptualises identity as fixed and enduring.

The functionalist view of stable identity has attracted criticism from interpretivists and critical scholars, who see identity not as *being* but rather as *becoming*; consequently, identity is dynamic rather than static. Gioia et al. (2000) debate the idea of enduring characteristics of organisational identity, suggesting that organisational identity relates to what organisational members believe about their organisation and that, because its expression is changeable, organisational identity is mutable and potentially precarious and unstable.

Sveningsson and Alvesson (2003) and Alvesson et al. (2008) note that the trend in research has shifted from viewing identity as static to dynamic; that is, moving from a functionalist perspective to an interpretivist and critical scholar perspective. The interpretivist approach, in contrast with the functionalist, does not measure organisational performance but focuses on how individuals construct identity through socialisation, how they narrate the story of self in relation to others, and how they enact a role within their work (Alvesson et al., 2008). The critically-oriented approach highlights contemporary relationships of control and resistance. Research employing this approach is interested in how the organisational script impacts on individual internalisation of worldviews and is reflected in cooperation with or resistance to the organisational regime (Alvesson et al., 2008).

Current research tends to conceptualise identity as a process that occurs in the dynamics and interplay between societal and psychological factors (Alvesson et al., 2008; Linstead, 2005; Sveningsson and Alvesson, 2003; Linstead and Thomas, 2002). Moreover, identity construction is not derived from clear-cut choices but occurs in confusion and conflict within the individual and in context (Linstead, 2005).

This section has presented the background to the development of the concept of identity. It has observed that the current view of identity construction is that it is not merely a straightforward process of an individual constructing an identity within an organisation. Previous literature has identified identity construction as an

individual's struggle to adapt in order to fit into a role within an organisation (Currie et al., 2010; Sveningsson and Alvesson, 2003). This will be expanded on in Section 2.3.4 below.

2.3.3 Current Studies

Recent studies have focused on the process of identity construction rather than identity as a final product. They have viewed identity construction as it occurs through the process of role enactment, socialisation and interaction, and narrative or telling stories about self, and as being prescribed by an organisation and individuals situated within the organisation. These studies can be summarised as focusing on three aspects: 1) role and career/role transitions, 2) socialisation and 3) individuals being engaged in an ongoing process of identity construction or identity work.

2.3.3.1 Identity Construction through Role and During Role Transition

A link between role and identity construction has been noted in the literature in two main respects. Firstly, a role exists in conjunction with a counter-role or complementary role; thus, a role has a meaning in terms of the existence of the counter-role or complementary role (Burke and Tully, 1977). Secondly, role is a boundary object which contains identity. This boundary is not fixed but malleable and expandable; consequently, individuals construct a new identity (Fournier, 2000).

It is commonly accepted that identity exists in relation to others. Role identity is argued to be relational: it only has meaning in the presence of a counter-role. Burke and Tully (1977) propose that role influences identity construction, because in performing a new role one will interact with others who perform the counter-role or complementary role. According to Burke and Tully (1977, p.883), role identities "come to be known and understood through interaction with others in situations in which those others respond to the person as a performer in a particular role".

Similarly, Sluss and Ashforth (2007) propose an identity which is constructed during a role and complementary role interaction as a relational identity. They define relational identity as "the nature of one's role relationship, such as manager-subordinate and co-worker-co-worker. It is how role occupants enact their respective roles vis-à-vis each other" (p.11).

Relational identity, as argued by Sluss and Ashforth (2007), is interactively influenced by role-based identity and person-based identity between the role holder and the complementary role holder. In their view, the pattern of identity, relational identity and identification is arranged in a cognitive hierarchy. They assert that individuals may have a clear sense of what it means to be in a role, but may resist viewing a relational identity as a self-definition if they have low relational identification. Sluss and Ashforth's (2007) hypothesis is difficult to apply in a real situation because at the beginning, when an individual is enacting a new role, he or she may have no idea of what the role is. Thus, this model cannot explain how individuals experience the initial stage of role socialisation. Moreover, the model cannot explain how the personal-based and role-based identities of individuals interact with each other. Thus, the model cannot explain a circumstance in which one has to perform a role which is in conflict with one's personal-based identity. Lastly, according to their argument, identity is conceptualised as a product of a role/counter-role relationship rather than a process of construction. This view is thus aligned with the traditional functionalist approach.

Recent debate on identity has centred on the process of identity construction during role change. A number of studies (Currie et al., 2010; Pottie et al., 2009; Hotho, 2008; Pratt et al., 2006) examine the identity construction process occurring during role transition and socialisation. Ibarra (1999) argues that, when individuals enter a new group, they socialise with other members, and interact and negotiate with them. It is during these processes of socialisation and negotiation that individuals develop a new identity.

How does socialisation influence identity construction? As mentioned earlier, an individual is a product of society. Goffman (1959) compares each individual to an actor who performs an identity to audiences (others) in order to impress. Delivering the right performance or performed identity is noted to be important. This is not only because an inappropriately performed identity may cause embarrassment to the individual, but also, if the performed identity is unacceptable, the individual may lose the role or the job (Ibarra, 1999). However, individuals must not only practise new skills and adopt new sets of rules and social norms, but must also socialise and interact with new others during the macro-transition of their work. According to

Ibarra (1999), during these processes of changing role and socialisation individuals construct new identities.

Ibarra (1999) further argues that, during the process of negotiated adaptation of newcomers, role models provide individuals with ideas about future identities, which she calls "provisional selves". Provisional selves are the future selves that one would like to become or fears becoming. Therefore, provisional selves are identities in the future that exist in one's head. The process of identity construction, as argued by Ibarra (1999), involves observing a role model, deriving provisional selves (future identities), "trying on" those identities, evaluating the results using internal standards (values) and external feedback (reactions from others), and then adjusting them through a negotiated adaptation process in order to fit into the workplace.

Role transition can not only be observed in organisations, but may also occur in professions. Professional boundaries are dynamic (Nancarrow and Borthwick, 2005); thus, allied professions, such as nursing, may take on roles that formerly belonged to medicine, and some professions may extend their role by becoming specialists (Currie et al., 2010). Professionals working in a multidisciplinary team may be forced to adopt a new role and interact with other professionals (Pottie et al., 2009), and individuals may be given organisational control which directs their identity in a different direction (e.g. Doolin, 2001; 2002). Hence, in such situations, professionals are faced with the dynamics of role in their workplace. Previous studies have explored role dynamics as played out in professionals, including Currie et al. (2010), Pottie et al. (2009), Hotho (2008) and Pratt et al. (2006).

Currie et al. (2010) examine how personal identity and role-based identity of genetics nurses interact over time, from moving into a new role, to enacting the role and moving out of the role. Their study finds that the nurses try to maintain their traditional nursing identity (patient care) through new roles, rather than embracing a move across organisational and professional boundaries. Moreover, they even perceive the new role as a constraint on the professional identity of nursing, rather than viewing it as a developmental path for the profession. This finding reveals the tension between expectations of identity by policy makers and by the profession.

The same study also identifies some resistance from doctors regarding the boundaries of clinical tasks. This finding can be explained by Abbott's (1988) concept of inter-competition amongst professions, which proposes that professions compete to claim jurisdiction or to protect their jurisdiction from other occupations. In this case, doctors closely monitor nurses performing clinical tasks on the boundary of medicine, reflecting resistance to nurses intruding on their jurisdiction. Nevertheless, Currie et al. (2010) indicate a lack of evidence to support this finding. This gap therefore suggests a need to integrate the concept of inter-professional competition to explore further the level of resistance, whether it is full or partial, and what strategies the medical profession employs to protect its jurisdiction. It also suggests the need for future studies to determine what strategies allied professions employ to mitigate the tension. These gaps are explored in this thesis in the light of how an allied profession, specifically pharmacy, negotiates to gain acceptance and extend work boundaries.

Pratt et al. (2006) argue that identity is constructed due to identity violation, specifically role and professional identity violation. They examine identity construction in the medical profession during residency, when they believe that identity formation is most pronounced. They find that customised identities are socially validated to achieve work-identity integrity.

Pottie et al. (2009) identify role models as influencers in developing professional identities. According to their study, pharmacists develop professional identity by observing a mentor pharmacist and using the role model as a standard of practice. Although this body of work illustrates the notion of role model in the process of identity construction, it does not explain the processes employed by pharmacists in forming a new identity.

It has been established in this literature review that recent research has focused on the dynamic and malleable characteristics of identity, and that identity construction occurs during the process of role transition and socialisation. The first strand of studies on identity construction focuses on the processes of socialisation and negotiation that are crucial in forming and shaping identity (e.g. Currie et al., 2010; Pratt et al., 2006; Ibarra, 1999). This review also suggests the need to explore further the level of resistance from other professions and the strategies which

professions employ to establish a role boundary in relation to the boundaries of other professions.

2.3.3.2 Occupational Demands and Identity Work

Organisational control is a form of procedure and process established within an organisation. The notion of organisation control relates to identity because it usually states clearly the roles and responsibilities of organisational members. Control within the organisation is exercised in the form of organisational discourse, for example policies, norms, values, missions, induction, orientation and training sessions, with the aim of directing the identities of employees or regulating how it wants its employees to behave. In this sense, organisational control operates through identity management by means of discourse (Alvesson and Willmott, 2002).

One strand of research is interested in examining the process of identity construction in which organisational discourse acts as a mould to form and shape employees' identity into designed or ideal employees. The concept employed to explore the control of organisation is identity work (Alvesson and Willmott, 2002; Sveningsson and Alvesson, 2003), which refers to identity engaged in constructing and reconstructing, forming and repairing, maintaining, strengthening or revising. Identity regulation or discursive practices stimulate identity work; identity work comprising narratives of self then either transforms or reproduces self-identity (Alvesson and Willmott, 2002). Identity regulation is accomplished when self-identity is sustained through identity work. If identity work fails, tension often occurs and individuals may act in resistance to identity regulation. Therefore, identity work is both a medium and an outcome of organisational control (Alvesson and Willmott, 2002).

The existing literature takes different perspectives on capturing identity work. On the one hand, identity work is seen as being embraced: the individual is an active agent who constructs identity to accommodate to organisational control (Alvesson and Willmott, 2002). On the other hand, identity work may be problematic (Thomas and Davies, 2005; Sveningsson and Alvesson, 2003; Linstead and Thomas, 2002), when individuals are stressed due to roles and expectations within their organisation. Individuals experience tensions from conflict between demands from policies.

Watson (2008) explains that, within an organisation, employees are prescribed various corporate personas, which may constrain the self-identity or personas that the individuals have developed in the past, hence causing tension. Thomas and Linstead (2002) further point out that tension experienced by individuals may create fragility of identity and insecurity over their roles and status. Evidence shows constraints between corporate personas and self-identity; thus, the identity construction or identity work of the employee is described as a struggle, and individuals behave in the form of resistance to organisational control (e.g. Ruohotie-Lyhty, 2013; Thomas and Davies, 2005; Sveningsson and Alvesson, 2003; Linstead and Thomas, 2002).

Thomas and Davies (2005) observe tension experienced by four public employees from different sectors of new public management (NPM). The study shows consistent results of resistance by employees to the adoption of NPM. In the case of a head teacher who was prescribed commercial identities to the role, the respondent faced tensions between being a professional and being a leader. Similar evidence of identity work as resistance is found in Thomas and Linstead's (2002) study of middle managers and in Watson's (2008) study of managers.

Although current discussion of identity focuses on identity in the process of construction, there is limited understanding of what situations or processes are involved in identity construction (Pratt et al., 2006; Ibarra, 1999). In addition, few studies focus on identity construction in professionals. The literature review reveals that observation of a role model has been identified by Ibarra (1999), Slay and Smith (2011), and Pottie et al. (2009), whereas Pratt et al. (2006) find that work identity is stimulated by violation of the integrity of work identity, and is constructed through the process of identity customisation. Nonetheless, the literature also suggests that identity construction is not a straightforward process but happens through paradox, fluidity, inconsistency and emergence, rather than changing in a stable way (Linstead and Thomas, 2002). It is also evidenced that influences such as culture, past professional experiences and family background also impact on individuals' identity construction (e.g. Slay and Smith, 2011).

How are these concepts applied in the case of semi-professions? The need for more evidence on identity construction in professions is highlighted by Pratt et al. (2006),

who state that a profession is different from an organisation, and a professional is also different from an employee; that is, an organisation is about where one works, while a profession is about what one does.

Existing studies (e.g. Watson, 2008) often highlight the importance of studies of managerial workers, in whom it is claimed that organisational change is more noticeable than in other workers. Watson (2008) asserts that:

> *managers cannot simply be themselves at work. They have to act as the voice or the face of the corporation. They must be seen as knowledgeable, authoritative and, above all, "in control". Yet at the same time, they must present themselves to others as credible human individuals* (p.122).

This thesis debates whether professionals are also facing new roles and expectations, as well as receiving demands from policy makers and other professions. Thus, this highlights the need for empirical study of the identity construction of professionals.

2.3.3.3 Narrative Identity

In Section 2.3.1 it was established that self-identity is constructed through reflexive narration (Giddens, 1991). It is through our understanding of who we are, and through our interpretation of our experiences that we come to know ourselves, and it is through our self-narration that others come to know us:

> *If you want to know me, then you must know my story, for my story defines who I am. And if I want to know myself, to gain insight into the meaning of my own life, then I, too, must come to know my own story* (McAdams, 1993, p.11).

A self-narrative is a story about self that is told or written by an individual. A narrative is a means of identity construction and it also expresses identity (Georgakopoulou, 2007; Ibarra and Barbulescu, 2010; McAdams, 1993). On the one hand, a life story reveals the emergence of the identity of an individual. According to McAdams (1993, p.5), "identity is a life story". In order to know a person well in terms of meaning, unity and purpose, one needs to know his/her identity; and in order to understand identity, one needs to know his/her life story

(McAdams, 1993). On the other hand, a story not only reveals who a person is to the audience, but also, as McAdams (1993) explains, individuals construct who they are through their stories: "We do not discover ourselves in myth; we make ourselves through myth" (McAdams, 1993, p.13).

How do we construct identity through our stories? Bamberg (2011) explains that through self-narration an individual disassociates "I", a storyteller, from "me", a character who has developed over time. Through self-narration individuals see themselves as different from or the same as others, and through self-narration they view themselves as responsible agents. Hence, self-narration is a process of reflection, and through this reflexive process individuals construct self-identity.

The benefit of using narratives to examine identity construction is that they provide a coherent story, comprising past, present and future. Therefore, a narrative shows how identity develops or is constructed over time.

2.3.4 Defining Professional Identity

Review of the literature reveals the following definitions of professional identity conceptualised in existing studies:

> *Professional identity, as one form of social identity, concerns group interactions in the workplace and relates to how people compare and differentiate themselves from other professional groups* (Adams et al., 2006).

And:

> *It can be described as the attitudes, values, knowledge, beliefs and skills that are shared with others within a professional group and relates to the professional role being undertaken by the individual, and thus is a matter of the subjective self-conceptualisation associated with the work role adopted* (Adams et al., 2006, p.56).

Borrowing from the above definitions, professional identity is defined for the purposes of this thesis as how pharmacists view the attitudes, values, knowledge, skills and beliefs that they share with their pharmacy colleagues, and those that are different from members of other professions.

2.3.5 Summary

This section has reviewed the existing literature on identity. In summary, an individual comprises multiple identities rather than a single identity, and identity is dynamic, highlighting the importance of identity construction rather than identity measurement. The concept of dynamic identity in organisations can be seen in the concept of identity work, which refers to people being engaged in forming, repairing, maintaining, transforming and revising constructions (Sveningsson and Alvesson, 2003). This section has identified that individuals construct identity through role transition, socialisation, identity work and telling stories about self. It has also observed that identity is discursive and is constructed by means of discourse.

A single perspective on identity is insufficient to understand self. Identities, which comprise self, are derived from the negotiation of managerial identities, professional identities, work identities, etcetera. Hence, in order to examine identity construction, this thesis proposes the use of qualitative interviews to generate adequate data.

Rather than viewing identity as static and trying to measure it, this study conceptualises identity as dynamic, mutable, discursive and reflexive. Identity construction is also ambiguous, depending on the context and situation. Individuals construct identity during a process of socialisation in which they negotiate their identity, and either adjust and reconstruct their identity to fit with the work environment, or resist complying with workplace or professional control.

This thesis assumes that pharmacists construct their identity differently depending on their workplace or situation; whereas, being in the same profession, their professional identity has more enduring characteristics through shared meaning from education and norms of practice amongst professionals.

In terms of gaps in previous research, it has been found that current debates focus on the process of identity. However, there is a lack of research focusing on the process of identity construction in depth (Sveningsson and Alvesson, 2003).

More specifically, there is a significant gap in the relevant literature that highlights the need to focus more closely on exploring how differences between the context of

organisation and profession may affect professional identity construction (Pratt et al., 2006; Ibarra, 1999).

Therefore, this thesis aims to contribute to the literature by filling a gap in the debate on identity construction in a profession that has not been fully established, specifically pharmacy.

2.3.6 Research Questions

This research explores how pharmacists construct identity on a day-to-day basis in the light of identity work. The second research question is:

> *How do pharmacists engage with the consequences of the role within the boundaries of pharmacy?*

Consideration of this question is presented in Chapter 6.

2.3.7 Criticisms of Identity Theory

From the above review of literature on identity, identity construction is viewed, based on multiple approaches. These approaches include symbolic interactionist approach, functionalist approach, narrative identity approach, and discourse theory. This thesis argues that using a singular approach to capture individual identity construction is not enough to provide a fully understanding of identity construction.

Specifically, symbolic interactionist, for example, Cooley (1964), and Goffman (1959), views that individuals construct identity through social interactions. Furthermore, this perspective views that individuals construct role identity through interaction with their counter role (Sluss and Ashforth, 2007). However, this view lacks consideration of social structure, power and cultural discourses. On the same ground, a functionalist perspective views identity as being derived by performing a social role (Stryker 1968; Stryker and Serpe, 1982). This approach conceptualises identity and individual as being static rather than being fluid and discursive. Similarly, narrative identity approach theorists (McAdams 1993, Sveningson and Alvesson, 2003). conceptualise identity construction through self-reflection and story telling This approach focuses the role of individuals in constructing identity through reflexivity, yet it neglects social structure and external discourse, which also impact on shaping identity construction.

On the other hand, scholars who view identity from a discourse theorist perspective (for example, Doolin, 2001; Doolin, 2002; Linstead and Thomas, 2002; Thomas and Davies, 2005) focus on how external discourses (that is, values, norms, policies) affect identity construction of individuals. Literature which is based on discourse theory, views individuals as recipients who are subject to external discourses, as well as individuals as active actors, who resist the power of discourses. Subsequently, this approach highlights the role of power and cultural discourses as well as the capacity of individuals in acting upon those discourses.

However, the existing studies (Doolin, 2001; Doolin, 2002; Linstead and Thomas, 2002; Thomas and Davies, 2005) fail to identify what capacity or power that individuals exercise in their identity construction. Those studies often focus more on identity as a form of resistance rather than the power and the processes that individuals exercise their power to resist. According to Max Weber, individual's or group's ability to possess power derives form individual's or group's ability to control various social resources such as capital, land, knowledge, and prestige (Herod, 2006). Within this framework, this thesis defines power as the social resources that pharmacists as the subordinates poses and exercises to win the class power of doctors. Thus, this thesis argues that using identity theory alone, thus does not provide a full understanding of what power the pharmacists have, and what processes they use in exercising these powers.

Therefore, based on the criticisms above, using identity theory alone is not sufficient to understand how pharmacists respond to the new direction of professional policies. Hence, this thesis combines identity approaches with negotiated order theory to analyse how pharmacists are affected by the society, and cultural discourses, as well as, how they exercise their power, which are their social resources, to interpret and act upon discourses.

To better understand the negotiated order theory, section 2.4 offers assumptions of the theory as well as the review of literature.

2.4   Negotiated Order Theory and the Social Arena Concept

Section 2.2 proposed a research question to explore how pharmacists negotiate their role boundaries. This section provides a review of the literature on negotiated order theory and the social arena concept, which are employed in this research to explore the strategies used by pharmacists in attempt to establish their professional boundary, which is regarded as a shared understanding of their roles, values and interaction patterns, and hence of their professional identity (see Chapter 5).

Negotiated order theory was first introduced by Strauss et al. (1963) based on a symbolic interactionist perspective, which explains micro and macro relations, whereas a structuralist perspective argues that behaviour is influenced mainly by structure. Their work was derived from an observational study of two psychiatric hospitals. For Strauss and his colleagues, a hospital is visualised as "a professionalised locale" where different kinds of professions share the same hospital goal, "to turn patients to the outside world in better shape". Such a goal is known as "symbolic cement", which means a symbol that everyone shares and can agree on. It is this goal that holds the organisation together.

Although professional staff share the same goal, Strauss et al. (1963) emphasise dissimilarities between psychiatrists, psychiatric residents, nurses, nursing students, psychologists and social workers in psychiatric hospitals. They see a psychiatric hospital as a "professionalised milieu" comprising different groups of professionals who vary in status and power, specialities, training, skills, knowledge and ideology of care within a profession and across professions. These differences lead to disagreement about how to provide care to patients.

The day-to-day relationships of professionals in the hospital involve negotiations about how individual patients should be treated. For Strauss et al. (1963), negotiation is the main characteristic of organisational life. Strauss's later (1978) work further emphasises that social orders are always to some extent also negotiated orders. Hence, the first argument relating to negotiated order theory is that organisations always involve negotiations.

The second argument relating to negotiated order is that "there is a patterned variability of negotiation in the hospital pertaining to who contracts with whom,

about what, as well as when these agreements are made" Strauss et al. (1963). To clarify, some negotiations are predictable. As Strauss et al. (1963) illustrate, some actions are typically practised in the ward, so these kinds of contract are implicit or tacit and become "the usual things". This pattern is often seen when doctor and nurse know each other well and their actions are routinely practised. On the other hand, when doctor and nurse are unfamiliar with each other, for example when a new resident doctor enters the ward, the nurse may seek help from a higher ranked administrative officer in the process of negotiation. Accordingly, it can be seen that hierarchical position influences variability.

Thirdly, negotiations have temporal limits. Strauss et al. (1963) emphasise that agreements, understandings and rules of the hospital can be changed over time: they are "continually established, renewed, reviewed, revoked, revised". A hospital can be seen as a place in which people engage in a continual negotiation process in order to agree about how to accomplish tasks.

Fourthly, change of structural context also requires new negotiation. This characteristic of ongoing negotiation becomes what Strauss et al. (1963) call "the hospital and its negotiated order". Strauss (1993) also further emphasises the fluidity of interactional patterns:

> *The concept of negotiated order was designed to refer not merely to negotiation and negotiative processes. It also points to the lack of fixity of social order, its temporal, mobile and unstable character, and the flexibility of interactants faced with the need to act through interactional processes in specific localized situations where, although rules and regulations exist, nevertheless they are not necessarily precisely prescriptive or peremptorily constraining* (p.255).

In order to employ a negotiated order framework, it is important to define the structural and negotiation contexts as well as the arena concept. Strauss (1978) highlights the existence of structural contexts in which negotiations take place. For him, the structural context is the societal and organisational properties that shape social action. Depicted in his studies of psychiatric hospitals, the structural context includes features of American medical care, the sub-speciality of psychiatry, specialisation amongst the professions, as well as the division of labour. The

negotiation context, on the other hand, refers to "the structural properties entering very directly as conditions into the course of the negotiation itself" (Strauss, 1978).

An arena refers to all collective actors, including organisations, groups (social worlds), social movements, ideologies and technologies, involved in a commitment to acting within it (Clarke, 1991). For instance, Strauss et al. (1963) studied a psychiatric arena which included all professional groups committed to treating patients. The arena is assumed to have intergroup conflicts because different professional groups hold different ideologies of care, and negotiations are undertaken to find an agreement. Hence, an arena is a boundary setting which contains all the actors and all the groups which are usually in conflict committed to acting within it (Renn, 1992; Jaeger et al., 2001; Clarke, 1991).

Although negotiated theory was first established from the observational study of psychiatric hospitals, the theory has been employed in other types of hospital, as well as other types of organisation. In the existing literature, much research has employed negotiated order theory to study hospital settings. A dominant theme in the existing literature is the micro-political process employed by health professionals to negotiate the professional work boundary (e.g. Mesler, 1989; Svensson, 1996; Allen, 2000).

Svensson (1996) and Mesler (1989) adopt a negotiated order perspective to examine the strategies used by allied professions to negotiate their work boundary with medicine. Svensson (1996) investigates the negotiation strategies used by nurses with doctors to influence doctors' clinical decision making. In the latter study, a nurse's knowledge and the daily negotiation between nurse and doctor resulted in changing the medical/nursing division of labour from a hierarchical system in which medicine held the greatest clinical decision-making power to a system in which nurses had increasing power in decision making.

Mesler (1989) explores strategies used by clinical pharmacists to expand their clinical roles, which were perceived as causing boundary encroachment. He concludes that pharmacists avoid boundary conflict and are able to establish their jurisdiction in clinical roles by employing "tact and diplomacy", "role-taking", and "tactical socialisation".

Arguing that the management arena in healthcare is under-studied, Allen (2000) examines micro-political processes employed by nurse managers to negotiate their work boundary and professional identity with medicine in a district general hospital. This study suggests that nurse managers negotiate to establish their occupational boundary and their professional identity by "taking control", "establishing expertise" and negotiating professional identity to resist the "dirty work" that medical staff delegate to nursing.

Studies by Mesler (1989), Svensson (1996) and Allen (2000) explore the micro-political processes used by professionals to establish their occupational margin and professional identity. In these studies, individuals' negotiations resulted in structural changes; that is, clinical pharmacists expanded their jurisdiction into clinical roles (Mesler, 1989), nurses gained power in decision making through negotiation, even though they were subordinate in the medical hierarchy (Svensson, 1996), and nurse managers successfully established their occupational margin and professional identity (Allen, 2000).

It can also be seen that negotiation by representatives of the group resulted in boundary establishment for the whole profession. In one case, the staff workers not only negotiated for themselves but for their occupational group, as the staff shared the same occupational ideology (Fine, 1984).

Further studies have examined the management arena in the hospital context (Currie, 1998; 1999; Holman and Hall, 1996). These studies examine policies implemented in a single hospital. They regard policy as a driver to change the hospital culture. Holman and Hall (1996) evaluate the use of competence-based management development in a single hospital and its impact on individual ward managers' competence and identity reconstruction. They discuss new managerialism as an attempt to form a new culture in the hospital. To them, culture is a negotiated system of shared symbols and meanings being produced and reproduced through everyday practices. They conclude that cultural change in the organisation may be achieved by redefining individuals' identities. In their study, a policy was successfully implemented when the practitioners developed managerial identity by drawing on managerial discourses.

In contrast to Holman and Hall (1996), Currie (1998; 1999) identifies participants' resistance to policy and organisational changes. These studies examine the management development intervention and its impact on creating cultural change within a single hospital. They examine how the meaning of the programme was negotiated by the participants. The studies conclude that the failure of the programme was caused by a lack of robust understanding of the context. These studies suggest that policy makers should take structural constraints into consideration and that programmes should be tailored to specific professional groups – nurses, doctors or middle managers – rather than being too generic.

The studies of Holman and Hall (1996) and Currie (1998; 1999) highlight the importance of professional identity in prohibiting successful implementation of policy. That is, if individuals experience a new managerial role conflicting with their professional role, they may resist the programme in order to maintain their professional identity. Fine (1984) argues that individuals cannot change the structural context to their liking without being restricted by the organisational structures within which they are situated.

2.4.1 Summary

In conclusion, this section has reviewed the negotiated order perspective and identified four main arguments. Firstly, negotiation occurs when there is organisational change, as well as when there are disagreements or differences in ideology on how to run the service. Hence, it can be said that negotiated order is a typical characteristic of an organisation. Secondly, there is patterned variability of negotiated order. Thirdly, agreement and rules are the outcome of continual negotiation; and fourthly, any structural change requires new negotiation. A sample of negotiated order research has also been reviewed to investigate the use of negotiated order theory in the existing literature. The literature review has helped scope a framework for use in the data analysis of this thesis.

2.5 Strength of Combining Identity theory with Negotiated Order theory

This thesis argues that using identity theory together with negotiated order theory will offer a better understanding on how individuals and social structure interacts

with each other. Existing studies on negotiated order theory (for example Mesler, 1989; Svensson, 1996; Allen, 2000) often demonstrate how the subordinate refuse or bargain to do tasks as assigned by the dominant profession with higher class power. Thus, negotiated order theory is useful to understand how the subordinate exercise their other social resources, which is regarded as their power, in negotiating with class power of dominance profession.

Furthermore, negotiated order theory emphasises fluidity of organisations: that is, rather than viewing organisations as stable and fixed, it explains organisation as continuously changing due to negotiations. As Strauss et al. (1963) emphasise, a hospital is seen as a place in which people engage in a continual negotiation process in order to set agreements. Hence, negotiated order theory provides an understanding of a web of interactions amongst individuals, to agree on how to accomplish the organisational tasks (Day and Day, 1977).

There are advantages of combining identity theory with negotiated order theory. This is as these two theories complement each other. First, previous studies on negotiated order theory often focus on micro politics interactions, for instance, interactions amongst professions in a hospital setting in order to set an agreement on how to treat patients, or how allied professionals negotiate their role boundaries with the medicine profession. These studies (for example Mesler, 1989; Svensson, 1996; Allen, 2000) often put the focus on interactions amongst individuals, thus they lack consideration of the external forces, particularly politics, cultural contexts, health care structure, which further impacts on these interactions. The discourse identity approach is therefore able to capture how external power influences negotiative processes.

Second, symbolic interactionist views that individuals construct identity through social interaction. Meanwhile negotiated order theory emphasises that in different situations and interactions, individuals own a different power, as well as have different processes in mobilising their power. In this regard, integrating negotiated order theory together with identity theory offers an understanding of pharmacists' identity construction in different stations, as well as with different actors with whom they interact.

Lastly, negotiated order theory focuses on the role of social actors in negotiating to change social order, as well as the role of social structures which shape negotiations. More specifically, individuals negotiate to shape society, and society also affects the way individuals negotiate. Meanwhile a range of identity approaches, specifically the discourse identity approach, focuses on how external power impacts on individuals, hence neglecting the power of individuals. Subsequently, by integrating negotiated order theory with identity theory, this thesis offers an insight into the micro and macro level perspectives of identity construction. Therefore, combining negotiated order theory together with identity theory offers further insight into how social structure, cultural discourses, as well as individual agency affect pharmacists identity construction.

2.6   Conclusion

This chapter has provided a review of the literature relevant to this thesis, including three ranges of literature on the pharmacy profession, identity theory, and negotiated order theory and the social arena concept.

The review of the literature on the pharmacy profession has identified that the pharmacy profession is in a transitional stage: its role boundary has been directed away from a product-oriented boundary toward a patient care boundary. Together with this paradigm shift, new concepts of practice have emerged, including pharmaceutical care and clinical pharmacy. Despite evidence that pharmacists' interventions in patient care lead to improved health outcomes, current studies also identify boundary conflict as a major problem to pharmacists in establishing their role in patient care. In addition, debates about the status of pharmacy as an incomplete or semi-profession, and about the business persona have also been discussed. Thus, it has clearly been demonstrated that pharmacy is an unsettled profession.

This review has prompted an examination of how pharmacists negotiate in order to establish their roles in the light of professional transition. Therefore, the first research question is:

> *How do pharmacists negotiate the establishment of their role boundaries in the light of professional transition?*

Review of the literature on identity theory has established that identity has been conceptualised as dynamic and malleable rather than static. It has also identified a lack of research into the processes of identity construction in individuals, and especially in professionals. It has been argued that individuals who are professionals are different from employees. Thus, the scope of this thesis is about the identity construction of professionals.

Having identified the lack of literature on specific processes or situations of identity construction in professionals, the second research question is:

> *How do pharmacists engage with the consequences of the role within the boundaries of pharmacy?*

Individuals' identity construction has been studied from many perspectives. Firstly, individuals construct identity during a role transition through a process of socialisation. Secondly, individuals are viewed as active actors who develop identities corresponding to organisational identities. Thirdly, individuals are also viewed as recipients of organisational identities. In addition, the narrative identity approach views identity as being constructed through telling stories.

Existing literature often employ a singular approach to study identity construction. For example, one range of literature bases their assumption only on symbolic interactionist approach (for example, Ibarra, 1999; Pottie et al., 2009), thus they often focus identity construction through socialisation processes. On the other hand, another range views identity construction based on discourse theory (for example Alvesson and Willmott, 2002; Linstead and Thomas, 2002; Doolin, 2002; Ruohotic-Lyhty, 2013), analyse individuals identity construction as a result of external power. As previously discussed in section 2.3.7, each approach is insufficient to capture how individuals as well as the society, interact in shaping identity. In this regard, it is insufficient to examine only one aspect of identity construction. To fill this gap, this thesis suggests the use of negotiated order theory together with identity approach.

Subsequently, the literature has been reviewed regarding the framework used in the analysis of this thesis: negotiated order theory and the social arena concept. To summarise, negotiation is undertaken to establish an agreement or rule, thus

bringing structural change. Structural change also requires new negotiations. Negotiations are therefore ongoing in any type of organisation. The social arena is the boundary of the conflict. This boundary encompasses all social actors and the resources that they mobilise to influence negotiations.

In conclusion, by using negotiated order theory together with identity theory, this thesis offers a more comprehensive model of identity construction which includes the role of social actor, their power, which is not limited to class power but their social resources, as well as the processes that individuals use in exercising these powers in negotiations. Thus, using negotiated order theory links micro and macro level perspectives of identity construction. That is, using negotiated order theory in combination with identity approaches, this thesis offers an insight into how social structure, cultural discourses, as well as individual agency affects pharmacist identity construction.

Having established the research questions, Chapter 3 will provide information about the research design and methodology employed.

Chapter 3: Data and Methodology

3.1   Introduction

The research questions that this thesis aims to answer are:

1. How do pharmacists negotiate the establishment of role boundaries in the light of professional transition?

2. How do pharmacists engage with the consequences of the role within the boundaries of pharmacy?

This chapter presents the research design and methodology employed in this study which enable the above questions to be explored. It is organised as follows. Section 3.2 explains the qualitative research paradigm and Section 3.3 describes the sample and its context. Section 3.4 presents the data collection methods and analysis, Section 3.5 presents the methods of data analysis and Section 3.6 discusses triangulation for this thesis. The ethical process is presented in Section 3.7, and Section 3.8 summarises this chapter and introduces the next chapter.

3.2   Qualitative Research Paradigm

Justification for the research design of this study depends on the researcher's view of social reality and the ontological position of the research. From an ontological perspective, the social reality for this thesis is pharmacists' professional identity, which is defined as their professional self-concept. Hence, the professional identity of an individual pharmacist is about what it means to be a pharmacist. Perception of self is subjective and varies between pharmacists. Thus, for this researcher social reality does not exist but is based on what people claim, whereas realists believe that reality is out there, waiting to be discovered. Social reality for this research is what the respondents believe, thus it is subjective. The use of a qualitative paradigm is therefore more suitable than a quantitative one.

Chapter 2 established that several approaches have been used to study identity construction in organisations. For example, a social identity approach views identity as being derived from personal identity and group identification, whereas a narrative approach understands that individuals construct their identity through

stories of self, and the discursive approach considers that individuals construct identity through cultural discourses. Existing studies have often employed a single perspective to examine identity construction which, in this researcher's opinion, is insufficient to capture the multifaceted characteristics of identity.

Specifically, identity construction is a complex process: it is constructed from the interplay of social structure, cultural discourses, agency, social interactions and identification. Before conducting this study, the researcher did not know through what process pharmacists construct professional identity. Therefore, the aim of this thesis is to explore the process through which individuals construct identity, rather than using a single existing theory to capture identity construction. In this regard, the nature of this thesis is exploratory, and exploring the complexity of identity construction using grounded theory to discover themes emerging from pharmacists' accounts is appropriate for this study.

Fundamentally, grounded theory is theory generated from data. Glaser (1978, p. 2) posits that:

> *Grounded theory is based on the systematic generation of theory from data, and itself is systematically obtained from social research [and] offers a rigorous orderly guide to theory development that at each stage is closely integrated with a methodology of social research.*

Consequently, grounded theory is regarded as an inductive approach which is used to generate theories or concepts that help to explain a phenomenon.

3.3   Sample and Context

The chosen sample consists of pharmacists in two different work contexts: public hospital and private drugstore. The reason for focusing on these work contexts is that the roles of these pharmacists have been directed towards patient care, whereas pharmacists who work on production lines have retained a traditional production role. This research is interested in those whose roles have shifted to patient care, which is regarded as a strategy of pharmacy professionalisation; hence, this research included pharmacists in drugstores and hospitals and excluded those in production.

3.3.1 Theoretical Sampling

Grounded theory suggests the use of theoretical sampling, which is defined as:

> *the process of data collection for generating theory, whereby the analyst jointly collects codes and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges* (Glaser and Strauss, 1967).

Thus, in this research study, data collection started with the collection of autobiographies from three respondents (P01, P14 and P18). Analysis then began by examining the turning points in their stories, and how these turning points were associated with identity construction. Together with the examination of narrative turns, thematic analysis was also used to discover themes in their stories. The analysis of these three autobiographies allowed the development of themes relating to identity construction. For example, the pharmacists wrote about their educational background, perceptions of the role of pharmacists, decisions to quit their current jobs, and feelings about the role. Thus, from these emerging themes, interview questions were developed for use in the interview phase.

These data collection methods followed a theoretical sampling approach: the analysis was begun after the data had been collected, then decisions were made on what sources of information and data to collect next, until saturation was reached. Justification for saturation followed the methodology of Corbin and Strauss (2014). According to Corbin and Strauss (2014) total saturation is probably impossible to achieve; however, the research justification is that if a category offers depth and breadth of understanding about a phenomenon and its relationships with other categories, then the sample is sufficient for the purposes of the study.

3.3.2 Sample Selection

All participants were recruited by employing network and snowball sampling techniques. An invitation letter was sent with a reply slip (see Appendix B2 &B3) to pharmacists known to the researcher, and they were also asked to recommend others in their network. In the invitation letter, the pharmacists were informed about the background of the research. There were also informed about the methods (autobiography and interview) that would be used for data collection, as well as the

scope of the questions that would be asked (e.g. educational background, what they learned during their pharmacy education, perceptions about the pharmacist's role, and who pharmacists are and what they do).

All pharmacists were given a consent form when they were interviewed. In total, 21 pharmacists were included in this research. Of these, 17 were from public hospitals and four from drugstores. Amongst the 17 hospital pharmacists, eight operated their own drugstore alongside their full-time job; hence, they had a dual role, working full-time in a public hospital and operating a private drugstore part-time.

The original plan was to recruit hospital pharmacists from both public and private sectors, as well as private drugstore pharmacists from large drugstore chains and small privately-owned drugstores, with the aim of discovering possible differences between various types of hospital. However, only pharmacists from public hospitals were willing to participate in this study. In drugstore chains, it was also difficult to interview pharmacists during working hours because they were employees and it was inconvenient for them to provide the data. All respondents preferred to be interviewed in their work context. Although they expressed their eagerness to participate in this study, most did not want to be interviewed after a full day's work.

Therefore, this research contributes to understanding identity construction in the contexts of public hospitals and small, local, private drugstores.

3.4 Data Collection Methods

This research employed multiple data collection methods. In total, it included five autobiographies, 15 semi-structured interviews, six repertory grid interviews, and one focus group interview (three pharmacists from three public hospitals).

3.4.1 Autobiography

Autobiography has been employed in previous research to study identity construction (for example Watson, 2009; Ruohotie-Lyhty, 2013; Slay and Smith, 2011). Autobiography can be used to access internal and external aspects of identity construction (Watson, 2009). It enables the discovery of identity derived through self-reflexivity, as well as identity which has been shaped by external factors (Watson, 2009).

Having defined the gap, proposed the research questions for this study and justified the research design and methodology, the researcher began to examine what emerged from pharmacists' stories about their professional selves. Starting with the collection of autobiographies, autobiographies were derived from three pharmacists (P14, P01, and P18). These were analysed by looking at the narrative turns or turning points in their stories, and by examining how these turning points related to how they constructed their identity.

For the three pharmacists from whom autobiographies were derived, the turning points included role transitions, including stages at which they moved from one role to another, in particular when they changed from being a student to entering the workplace as a pharmacist (P01), when they decided to quit their jobs and change to another job (P14 and P01), and their expressions of difficult periods, such as "My first year of working was like I was facing a tidal wave" (P01).

These turning points in their stories were identified, examining how these turning points were associated with identity construction.

3.4.2 Semi-Structured Interviews

Sixteen semi-structured interviews were conducted. Although an interview guide was prepared prior to the data collection, during the data collection process more questions were developed, depending on themes discovered along the way. In general the interview questions covered the following:

- **Background of respondent and the workplace**

  How long have you been working?

  Have you ever changed workplace or role?

  Please describe your main tasks/job functions at your workplace. Which job function do you consider to be most important?

  To what extent does your work involve a patient care team? Please describe your role within the team.

- **Respondents' perceived professional identity**

  In your view, who is a pharmacist?

What roles/functions do you perform? Which of your roles as a pharmacist would you consider to be the most important?

What are the important skills and training that are specific to your role as a pharmacist?

Would you say that medicines could be dispensed by a non-pharmacist?

- **Perceived/experienced dual identity and conflict**

(When pharmacists change their jobs from a hospital to a drugstore and vice versa, or work in multiple workplaces)

Are there any differences in terms of tasks that you perform in different workplaces? If yes, how and to what extent do they differ?

Is there any difference with regard to expectations of doctors, nurses and patients in different workplaces? If yes, what kind of expectations are they? How do you meet those expectations?

Is there any challenge from customers' demands in your workplace? If yes, what are they and to what extent do those demands constrain your professional values and career goals?

How do you negotiate demands from doctors, nurses and patients?

Do you experience any performance pressures, e.g. workload, time constraints and profits necessary to maintain your business, and how do these affect you?

- **Respondents' professional values and career/personal goals**

How would you describe the professional values of the pharmacy profession? How would you describe your career and personal goals? Is there any conflict? If yes, how would you bring them together?

- **Respondents' concepts of patient care**

(Patient care is the current direction of pharmacy education and training.)

How would you describe your work in patient care?

Based on your experience, to what extent does your role relate to patient care?

- **Respondents' perceptions of multidisciplinary work**

  (Multidisciplinary work is encouraged by the World Health Organization and
    health policies globally to improve patient care.)

  *How would you describe your role in the multidisciplinary team? Have you had
    any issues of trust or interactions with others (doctors and nurses) in the
    team?*

  *What is your relationship with others (pharmacists, doctors and nurses) like,
    and how does the relationship impact on your work performance?*

  What are your perceived barriers to multidisciplinary team working?

- **Respondents' concepts/experiences of ideal pharmacist or role model**

  *Based on your experience, what would an ideal pharmacist look like, and what
    roles does he/she perform? Is this different from what you experience in
    your workplace?*

  Do you have a pharmacist role model and, if so, who is he/she, and why?

  How does your role model affect your work performance?

- **Respondents' views/experiences of training and working**

  *How have your perceptions of being a pharmacist changed since you started
    work?*

  *What training have you had, and has it provided relevant skills that you need to
    perform your work?*

3.4.3 Repertory Grid Interviews

The repertory grid technique was developed from Kelly's (1955) personal construct
theory. It is useful for eliciting individuals' personal perceptions of the topic of
study. Thus, the technique can explore the idiosyncratic nature of an individual's
construct system. Moreover, by employing content analysis of the constructs
elicited from participants, a researcher may also discover shared perceptions

construed by a group of people about the topic. Therefore, the repertory grid technique was useful in this study for eliciting the constructs of individual pharmacists, as well as shared constructs they have in common (Shaw, 1994; Green, 2004).

The aims of using repertory grid interviews were:

1. To gather perceptions that pharmacists have about themselves in the past, present and future, in order to understand how pharmacists construe changes in professional identity.

2. To gather participants' shared constructs in order to redefine individual and focus group interview questions carried out following the repertory grid interviews.

3.4.3.1 The Repertory Grid Form

The elements were designed using pharmacist work types found within the Thai pharmacy profession. The form also included "myself in the past", "myself", and "my ideal self", with the aim of exploring changes in the professional identity of each pharmacist, as well as the direction and level of change. The element "an ideal pharmacist" was introduced, so as to assess how far pharmacists construe themselves in terms of an ideal pharmacist. The elements "an ethical pharmacist" and "a non-ethical pharmacist" were used in order to examine how pharmacists construe the notion of being ethical and non-ethical, and whether they see themselves as being close to or far from an ethical pharmacist. The repertory grid form used in the interviews is presented in Appendix B5.

Repertory grid interviews is useful:

- To explore how Thai pharmacists construe "what it means to be a pharmacist?"

- To draw shared perceptions of "what it means to be a pharmacist" amongst pharmacists.

- To identify the personal values of pharmacists by using the laddering up technique.

In this study, repertory grids were used to explore the personal constructs of pharmacists regarding different types of pharmacists. They were also used to identify the personal values of individuals, which support the findings of the interviews and autobiographies. Lastly, they might also generate shared perceptions by grouping the personal constructs into themes. Emerging themes are useful in a grounded theory method to compare with themes emerging from interviews and autobiographies.

3.4.3.2 How the Repertory Grid Interviews Were Conducted

The repertory grid form was used to elicit constructs from individual participants.

Although the repertory grid may be conducted with a group of participants, one-to-one interviews are more effective because the interviewer has more time in the interview and can elicit more constructs than in a group interview. One-to-one interviews were carried out in this study.

In the interview, each pharmacist was presented with a form (Appendix B5). A triadic method was used (Jankowicz, 2005): three elements were picked from the form, and individual pharmacists were asked to compare two of them with the other element. The question asked of each individual pharmacist was:

> *Amongst these three elements, please pick the two elements that are most similar and tell me why. Tell me why it is different from the other one.*

Each interview was carried out by picking three elements and asking the question until there were no more elements left and the interviewees ran out of constructs. After each individual had completed the grid, they were asked to rate each element on a 1 to 5 scale. Subsequently, a value priority for each individual was elicited by applying a laddering up technique (Jankowicz, 2005). From the constructs derived from the interviews, constructs from both ends (implicit and emergent poles) were laddered upwards. In order to use the laddering up technique, the questions asked included:

> *Which end of the constructs do you prefer?*

and

Why is it important for you?

These questions were asked until the participant ran out of constructs. The end result of applying laddering up was a personal value (core construct).

Figure 1 presents the core value of pharmacist P05 (Hospital T)

Figure 1: Core value of pharmacist P05 (Hospital T)

In order to establish this, two constructs were chosen, derived from the respondent. In this example the constructs are:

Have freedom in decision-making

and

Being controlled about how to practise.

Respondents were then asked

Which end of the constructs do you prefer?

and

Why is it important for you?

The respondent answered with two constructs: "Can do what I like to do" and "Have to do what other people tell me". The laddering up technique was then continued until the respondent ran out of constructs. The final construct was the personal value. In this example, it was important for the respondent to "feel secure". Pharmacist P05 also participated in a semi-structured interview after completing the repertory grid interview. In the interview, she said that she would like to quit in the future, as she felt bored with the organisation. She identified that the problem included a lack of cooperation amongst pharmacists and that the "boss could not manage the problem". Her core value may explain her interview data, as she was concerned about family security; hence, she still maintained her hospital job.

This thesis is able to draw core value of 6 pharmacists. The other five core values can be found in the Appendix A1.

3.4.3.3 Difficulties Encountered in Using Repertory Grid Interviews

Although the repertory grid technique is a powerful means of deriving personal constructs, it has some limitations experienced in this thesis. Initially, the researcher planned to use repertory grid interviews as a primary data gathering method for all pharmacist respondents, followed by semi-structured interviews. However, two main difficulties were encountered during the data collection. Firstly, pharmacists felt that the repertory grid was difficult for them to rate; and secondly, after completing the repertory grid the pharmacists, who were usually busy, ran out of

time to conduct the following interviews. Hence, rather than gaining a professional life history of the pharmacists, the scope of the data was limited to the elements presented in the grid.

In total this thesis gains 6 repertory grids from respondent P02, P12, P05, P03, P04, P13, which some of them are not being rated. Consequently, the data from repertory grids are not used in the main analysis of this thesis. However, the data from laddering interviews which were done following the repertory grid interviews all pharmacists constructs (117 constructs) were used.

3.4.4 Focus Group Interviews

Focus groups are useful to study how views are generated and modified through group interaction (Barbour, 2008). An important characteristic of focus groups is that power is given to the participants rather than the researcher (Howell, 2013). Howell (2013) also argues that the power relations that surface amongst the participants are more authentic than the artificial relationship between interviewer and interviewee; that is, in the environment of a focus group, participants are encouraged to talk amongst themselves and are stimulated to ask questions, exchange anecdotes and comment on each other's experiences and viewpoints (Kitzinger, 1994; Howell, 2013). The role of the interviewer is to facilitate and stimulate the group discussion. If the dynamic of the group discussion works well, a focus group will lead to unexpected discoveries of both complementary (shared and common) and argumentative (challenging or disagreeing) meanings (Kitzinger, 1994). Focus groups are therefore useful for studying professional practices. Furthermore, Wilkinson (1999) suggests that focus groups allow the researcher to examine the process of how collective meaning is negotiated, and how group identities are elaborated.

Consequently, a focus group was employed after gathering interview and autobiographical data. The focus group consisted of three hospital pharmacists from the public sector, following completion of the interviews in the second phase of the research. Themes were gathered from the interviews and autobiographies, and open-ended questions were used to explore the shared agreeing and disagreeing perceptions of pharmacists on issues derived from the interviews. The aim of using a focus group was to identify agreement and disagreement with the findings of the

previous methods. However, the nature of this research is exploratory, so an additional aim was to gain new insights that might emerge from the group interview.

3.5 Methods of Data Analysis

The sources of interview data included 16 semi-structured interviews, six repertory grid interviews, and one focus group interview. The interview transcription process is considered to be a crucial step in interpreting the data accurately. During this process, the researcher listened repeatedly to the recordings, as well as checking and rechecking the transcripts to ensure that they had been transcribed verbatim.

Once the data had been collected, the process of data analysis began. Corbin and Strauss (2014) state that researchers may employ analytic techniques that help them to "make sense of masses of qualitative data" and may construct various interpretations from the data. In this regard, multiple methods of analysis were applied to the data including: 1) analysis of the repertory grid; 2) application of negotiated order theory and the social arena concept; 3) thematic analysis; and 4) narrative turn analysis.

3.5.1 Analysis of the Repertory Grid

The repertory grid data were analysed using Rep 5 V.1.05 software.

Figure 2: Respondent P02's Repertory Grid

Product oriented roles	4 4 5 5 4 4 1 3 4 3 3 2 1	Patient oriented roles
Non-profit interest	2 3 3 2 5 5 5 3 3 3 2 5 3	profit interest
Uncertain in knowledge	2 3 5 5 5 4 2 5 5 5 5 1 3	Confident in knowledge
Cannot get along with colleague	2 4 5 5 4 4 5 5 4 5 5 1 3	Adaptive
Know theory but not practice	1 3 5 5 3 3 1 5 4 5 5 1 3	Experience clinical practice
Take advantage for his own benefit	4 3 3 4 3 3 2 5 3 5 5 1 3	Help others
Less practical experience	1 3 5 5 3 3 1 5 4 5 5 1 1	Well experienced in practice
Know about diseases	3 3 3 3 3 3 5 3 3 3 3 2 5	Know about products
Poor communication skills	2 3 5 5 5 5 5 5 5 5 5 1 5	Good communication skills

Production Pharmacist
A non-ethical pharmacist
An ethical pharmacist
An ideal pharmacist
My colleague
Pharmacy lecturer
Medical representative
Employee pharmacist
Owner pharmacist
Hospital pharmacist
My ideal self
Myself now
Myself when I just graduated

Figure 2 shows a repertory grid of respondent P02 generated by Rep 5 V1.05. Elements are below the grid and the poles of the constructs on either side of the grid. Scale used in this grid is 1 to 5.

The analysis of the repertory grid can be done by various methods. In this thesis, the analyses include 1) eyeball analysis, 2) cluster analysis, 3) cross plot analysis, 4) principal component analysis, and 5) content analysis. In the next section, a discussion of the analysis of respondent P02's repertory grid by these analytical methods, is presented.

3.5.1.1 Eyeball analysis

The primary analytical method used to examine the data was eyeball analysis (Jankowicz, 2005). The aim of eyeball analysis is therefore to identify the element closest to the ideal pharmacist. For example:

> *"Myself where I am now" and "where I want to be (ideal me)", which personal constructs are alike?*

Respondent P02 construed that "an ideal pharmacist" should be the one who has good communication skills (this she rated 5). Her view was that "herself when she was just graduated" as being different from "an ideal pharmacist" because she did not have good communication skills (which she rated 2). Then she perceived that "herself now" has become more similar to an ideal pharmacist as she developed communication skills (which she rated 3). In the future, her ideal self is expected to have good communication skills as the same as an ideal pharmacist (she rated 5 for the elements "my ideal self" and "an ideal pharmacist").

Another example from figure 2 is further given. Respondent P02 viewed that the element "a pharmacy lecturer" is the same as the element "an ideal pharmacist". Based on her repertory grid, respondent P02 rated these two elements exactly the same. Her repertory grid indicates that a pharmacy lecturer is the same as an ideal pharmacist because s(h)e has good communication skills, and is well experienced in practice, in particular in clinical practice . S(h)e also aims to help others (rated 5) rather than being interested in profit (rated 3). Besides, s(h)e is adaptive and confident in knowledge.

3.5.1.2 Cluster Analysis

Figure 3: Cluster Analysis (Respondent P02, Hospital T.)
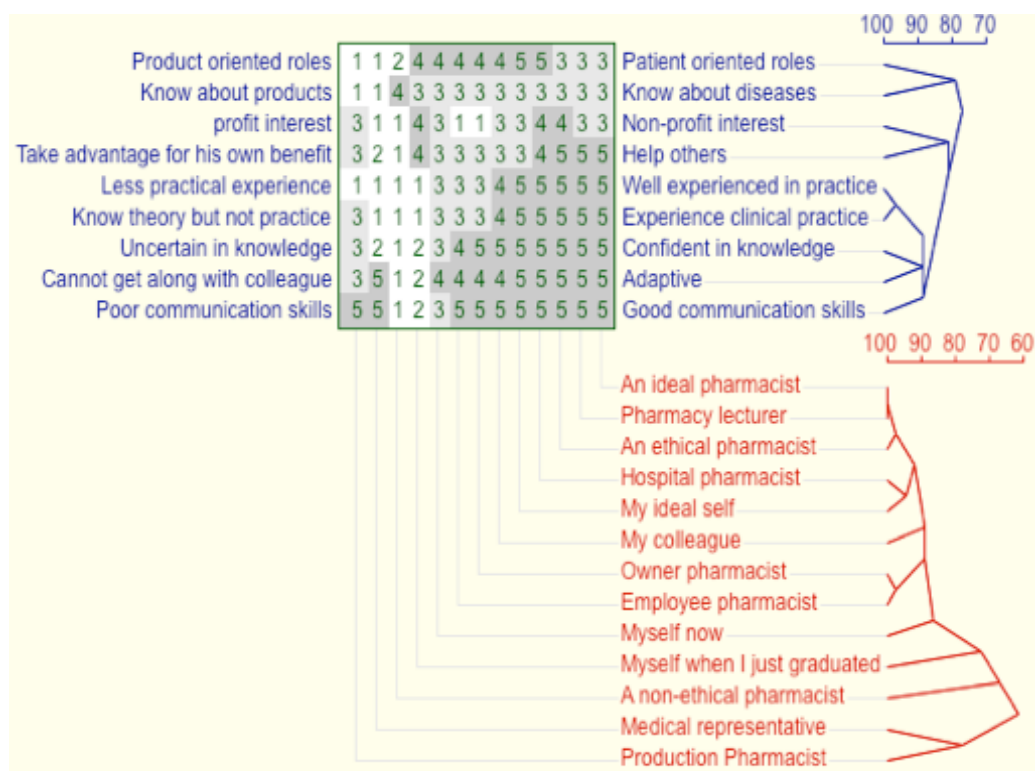
Figure 3 shows a cluster analysis. The order of the elements and the constructs is different compared to that of the original grid (figure 2). A cluster analysis generates clusters of elements and constructs, which reflect how the respondent construe these elements and constructs, as being similar to each other or dissimilar with the others. The blue dendrogram to the right of the grid shows the percentage of similarity in the rating of the constructs. The red dendrogram to the right of the grid shows the percentage of similarity in the rating of the elements. For example, figure 4 indicates that the respondent P02 construed an ideal pharmacist, a pharmacy lecturer and an ethical pharmacist as similar elements. She also construed "a hospital pharmacist" as the same as "her ideal self" which corresponds with her interview that she sees herself as being a hospital pharmacist in the future.

Considering the blue dendrogram which shows the percentage of similarity in the rating of the constructs, this thesis suggests that the respondent perceived "patient-oriented role" as similar to "know about disease". The data indicate that, to the respondent, the role oriented in patient requires the knowledge about disease.

3.5.1.3 Cross Plot Analysis

Cross plot of respondent P02's repertory grid was generated by Rep 5 V1.05. Figure 4 presents cross plot analysis of respondent P02.

Figure 4: Cross plot (Respondent P02, Hospital T.)
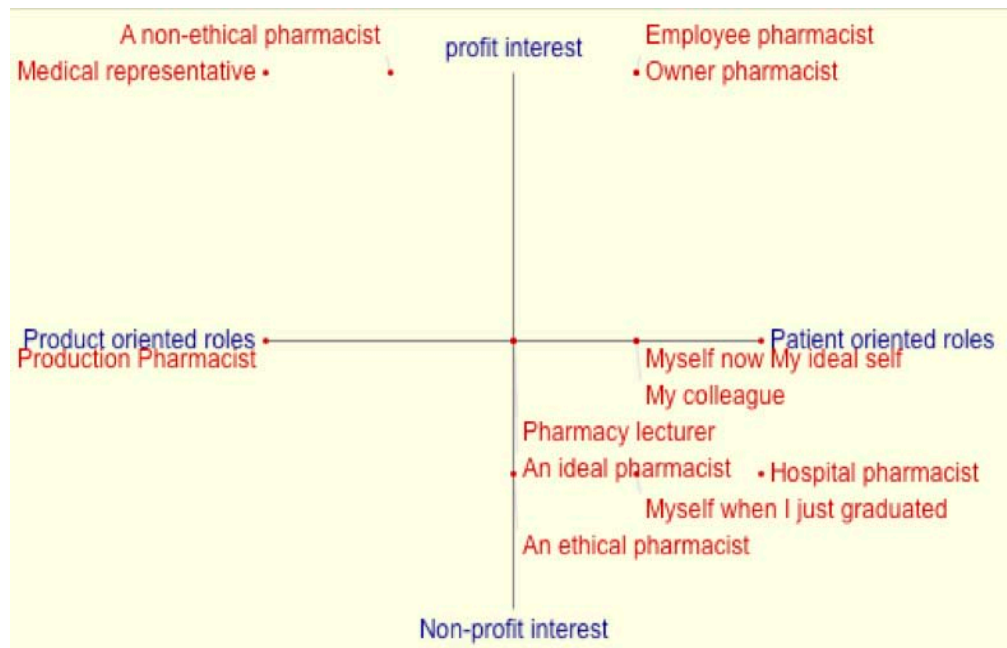
Figure 4 indicates that respondent P02 construed that a non-ethical pharmacist is solely concerned with profit whereas an ethical pharmacist's main focus is not profit-oriented. She also viewed that herself now is close to her ideal self in the way that both have role oriented in patient care.

3.5.1.4 Principal Components Analysis

Figure 5: Principal Component Analysis (Respondent P02, Hospital T.)

Figure 5 shows the principal components analysis graph. The vertical and the horizontal lines show two distinct patterns of the ratings and are called the two principal components. The horizontal line is called component 1 and the vertical line is called a component 2. Elements are the red dots, and the constructs poles are blue lines. The elements and the constructs are placed in relation to the two main components.

Figure 5 shows that construct "Experience clinical practice" versus "Know theory but not practical" is close to component 1. Construct "Know about diseases" versus "Know about product" is close to component 2. The interpretation of principal components is that one is about having clinical practice experience and the other is about having knowledge for the practice.

3.5.1.5 Content Analysis

A content analysis was carried out to group similar constructs. This was done by applying a set of categories to the constructs elicited from the participants.

According to (Jankowicz, 2005), a set of categories can be obtained either from existing categories derived from the literature review or by bootstrapping, which means looking at each construct one at a time, deciding which are the same and grouping them. As the aim was to generate categories, the bootstrapping technique was used to group similar constructs into categories.

A total of 117 constructs was obtained from six pharmacists (Figure 2). Each repertory grid illustrates the idiosyncratic nature of construct systems (Shaw, 1994).

Figure 6: Repertory grid constructs

1. Product-oriented role	61. Lack of ethics at work
2. Patient-oriented role	62. Profit interest
3. Profit motivated practice	63. Patient interest
4. Non-profit motivated practice	64. Have rules, and being an employee in an organisation
5. Confident in knowledge and skills	65. Have freedom, being self-employed.
6. Not confident in knowledge and skills	66. Have financial security
7. Adapted and adjusted to group culture with shared understanding of practice with colleagues	67. Lack of financial security
8. Know how to work	68. Selling products
9. Know the knowledge from the textbook but do not know how to apply to work	69. Providing pharmaceutical care
	70. Being an owner and practising knowledge with patients
10. Gain work experience	71. Being an employee, have to reach sales target
11. Lack of work experience and have never seen a real patient	72. Being myself
12. Job relates to producing products	73. Not being myself
13. Job relates to using products on patients	74. Have experience and knowledge
	75. Lack of experience and knowledge
14. Can apply knowledge in work	76. Have comprehensive knowledge and know everything
15. Cannot apply knowledge in work	77. Have specialist knowledge
16. Have good communication skills and be able to transfer knowledge to others	78. Have ethics
17. Do not have good communication skills and cannot communicate to others	79. Do not have ethics; think of own benefit
	80. Practice ethically
18. Feel enthusiastic about work	81. Malpractice
19. Lack of enthusiasm about work	82. Patient-oriented role
20. Having profit interest	83. Product-oriented role
21. Not having profit interest	84. Patient-oriented role
22. Patient-focused practice	85. Product-oriented role
23. Non-patient-focused practice	86. Profit is the return (have to reach sales target)
24. Gain knowledge and experience	87. The return is not profit because pharmacist has fixed salary
25. Lack of knowledge and experience	
26. Be able to transfer knowledge to others	88. Knowledge confidence
27. Unable to communicate knowledge to others	89. Do not have knowledge confidence
	90. Adjusted to organisational culture and work well with colleagues
28. Have ethics	91. Still exploring and do not know what to do
29. Do not have ethics	
30. Like product-oriented practice	92. Know how to practise
31. Do not like product-oriented practice	93. Know theoretical knowledge but do not know how to practise
32. Have good communication skills	
33. Have bad communication skills	94. Have ethics and help others
34. Being a lifetime learner	95. Take advantage and do for own benefit
35. Not being a lifetime learner	
36. Have comprehensive knowledge	96. Have gained more work experience

37. Have knowledge specifically only about own job	97. Lack of work experience and do not know how to apply to patients
38. Own business job	98. Work relates to new products
39. Being employed	99. Works relates to how to use medicine in patients
40. Have power to make decisions and manage tasks	100. Have comprehensive knowledge
41. Have to follow the rules	101. Cannot apply knowledge in practice
42. Have experience	102. Have good communication skills and can communicate knowledge to others
43. Have theoretical knowledge but lack of experience	103. Do not have good communication skills and cannot explain the knowledge to others
44. Know theory	
45. Know how to apply and practise	104. Patient-oriented practice
46. Take advantage for own benefit	105. Product-oriented practice
47. Do not take advantage	106. Meet other people at work
48. Enthusiastic to make a change	107. Work alone, lack of socialisation with others
49. Feeling bored	108. Think about patient benefit
50. Do for the organisation	109. Think about own benefit
51. Do for own benefit	110. Have freedom in making decisions for patients
52. Have responsibility similar to doctor (diagnosis)	111. Do not have freedom, have to follow the rules
53. Have pharmacy responsibility	
54. Pharmaceutical care practice	112. Have pharmacy knowledge broadly and specifically
55. Product-oriented practice	113. Do not have pharmacy knowledge
56. Profit is the return	114. Practise according to law
57. Benefit for others is the return	115. Do not practise according to law
58. Can practice the same as what I have learned from the university	116. Concern about patient condition
59. Have limitations and conflicts with other professionals. Cannot do like the ideal pharmacist	117. Concern about profit
60. Have professional ethics at work	

Based on a content analysis, these 117 constructs were fitted into themes, including:

- Work content (e.g. product-oriented role, patient-oriented role, pharmaceutical care, knowledge about medicines)

- Motivation (e.g. profit motivated practice, benefit of the patient)

- Autonomy (e.g. being an owner and having autonomy and freedom in decision making, being employed and having to follow employers' rules, having to reach sales targets)

- Ethics (e.g. practise according to law, use professional ethics at work, do not take advantage of others, malpractice, take advantage of others for own benefit)

- Feelings at work (e.g. being enthusiastic, feeling bored)

- Professionalism (e.g. have comprehensive knowledge, have specialist knowledge, product knowledge, pharmaceutical care, have good communication skills, have bad communication skills)

- Sense of security (e.g. have financial security, lack of financial security)

These themes were then used to compare with the final themes derived from the analysis of other interview and autobiography data. Redundant themes were reduced to derive the final themes.

3.5.2 Negotiated Order Theory and the Social Arena Concept

In order to explore how pharmacists negotiate the establishment of their role boundaries, negotiated order theory and the social arena concept were used as frameworks to analyse and interpret the data.

In Chapter 2, it was explained that a social arena is a symbolic location. In a social arena, there are collective actors, who usually have conflicts, and social resources that are mobilised in negotiations to reach agreement on a particular issue (Renn, 1992; Jaeger et al., 2001). Thus, in order to analyse how pharmacists negotiate the establishment of their role boundaries, the social arena with the issue of conflict was first defined. Then the following were defined:

- What social arenas are presented in the pharmacists' accounts?

- Which social actors are involved in those social arenas?

- What social resources do the pharmacists mobilise in negotiations?

- How do pharmacists mobilise their social resources in negotiation processes to establish pharmacy role boundaries as shared meanings of role-role relations with other social actors?

Chapter 5 of this thesis presents the outcomes from the analysis using the negotiated order theory and the social arena concept.

3.5.3 Thematic Analysis

In order to deal with the mass of qualitative data, this thesis follows Miles and Huberman (1994). In doing so, thematic analysis was used for all the data. In doing so, the initial stage was to employ open coding on the data collected from pharmacists. Following open coding, all the codes were then listed after which they were subsequently reduced. The outcomes are the final themes. In addition, the decision to select the final themes was taken by considering how the themes relate to each other and to identity construction. The example of thematic analysis is presented in the Appendix A2.

3.5.4 Narrative Turn Analysis

The use of narrative data offers continuity of pharmacists stories. In this thesis, self-story offers a discovery of identity derived through self-reflexivity, as well as identity which has been shaped by external aspects (Watson, 2009). The analysis of pharmacist stories is conducted by considering the narrative turn (Watson, 2009). In order to do so, this thesis examined the turning points in pharmacists stories and how these events relate to identity construction. The use of stories further offers this thesis the ability to capture macro and micro role transitions as the turning points, which in turn trigger identity construction. In addition, the use of stories helps to identify different processes and factors which play a role in identity construction. The outcomes of narrative turn analysis are presented in chapter 4 as a part of information of the respondents.

3.6 Triangulation

In a broad way, triangulation is defined by Denzin (1978, p.291) as "the combination of methodologies in the study of the same phenomenon". The purpose of triangulation is to provide a rich description for this qualitative research, in order to increase the credibility of this study. This thesis thus employs multiple methods of data collection and analysis in order to adequately examine the data collected and arrive at seasoned conclusion.

For example, interviews are useful for qualitative research but they have limitations. This is due to the fact that an interview is an interaction between an interviewer and interviewee. In an interview, an interviewer is a person aiming to understand a

particular subject. Thus the researcher may ask questions with the aim of discovering what s/he wants to know. Hence, through interview interactions, it is possible to miss some of the "bumps and grinds of everyday life" (Miller, 2000). In contrast, the autobiographical method requires pharmacists to create their personal life stories. This method offers insights into turning points in their lives and how these points relate to identity construction. Thus, the use of multiple data collection methods in this study enabled this research to offer a rich description of the information.

3.7   Ethical Process

Saunders et al. (2012, p.129) define ethics as "the appropriateness of your behaviour in relation to the rights of those who become the subject of your work, or are affected by it". Thus, key issues must be addressed, including invasion of privacy, lack of informed consent, betrayal of participants' confidentiality and anonymity, deception of participants and misuse of data (Saunders et al., 2012; Bryman and Bell, 2007). Ethical issues in this sense are thus not restricted to maintaining physical safety, but also involve ensuring the privacy and confidentiality of respondents (Flick, 2009).

The process of gaining ethical approval began with the submission of ethics documents to the University of York's Humanities and Social Science Ethics Committee (HSSEC). All participants were given a consent form and were assured that their confidentiality and anonymity would be safeguarded. Thus, in following approved ethical practices, this research sought to minimise ethical risks to participants, researcher and institution.

3.8   Conclusion

This chapter has discussed the research design and methods used in this study. It has also presented the data sources and data collection methods employed in this research, and has explained how the data analysis was conducted. Chapter 4 presents a discussion of the respondents' backgrounds and the work contexts in which they were situated.

Chapter 4: The Work Contexts and the Pharmacists

4.1 Introduction

It is important to understand the cultural context, health care structure as well as work contexts in which pharmacists situate their role, because these contexts shape social action. Individuals not only shape social structure, but also social structure impacts on the way individuals interact (Strauss, 1978). This study considers both way of how individuals interacts as well as how the external forces, for example policies, cultural contexts, and health care structure, affect their identity construction and negotiation. This chapter thus aims to provide background information about the health care system in Thailand, and work contexts and the pharmacists who provided data for this study.

This chapter has three main sections. Section 4.2 presents background information about Thailand health care system and the pharmacy profession under this system. Section 4.3 provides the work contexts of public hospitals and private drugstores, as well as general information about pharmacists' roles in public hospitals, how they describe their roles, and the values that guide their roles.

Section 4.4 then presents information about the 21 respondents who provided data for this study, including how they view themselves as pharmacists, as well as narrative turn data which provides rich information about individual pharmacists.

4.2 Overview of Thailand Health Care System

Thailand currently provides universal coverage health care through the pluralistic health care system. In 2002, Thailand implemented universal health coverage scheme nationwide alongside with existing health insurance schemes. Presently, Thailand offers four different health insurance schemes including the national health coverage scheme, the civil servant medical benefit scheme, the social security scheme and insurance from the private sector (Health Insurance System Research Office, 2012).

Although, universal health coverage is based on the ideology that the system would increase equity in accessing health care amongst the population, however there are still differences, including target beneficiaries, percent coverage, sources of funds and payment methods, amongst the schemes. Accordingly, health inequity amongst citizens is still present in Thailand. Nevertheless, the universal coverage scheme has increased accessibility to the poor who were exempted from any insurance before 2002, by extending coverage to 18 million previously uninsured citizens (Limwattananon et al., 2013).

4.2.1 Consequences of the Universal Coverage implementation

The implementation of the universal coverage (UC) scheme has caused several major changes to the health care system. Firstly, the purchaser-provider health care model was introduced to the system. Following the UC implementation, the National Health Security Office (NHSO) was formed and separated from the Ministry of Public Health. The NHSO acts as a new public purchasing agency, which purchases health service on behalf of beneficiaries (Health Insurance System Research Office, 2012). The NHSO spends general tax revenues to purchase health services from hospitals through a system called Contracting Unit for Primary Care (CUP). The providing hospitals (CUPs) act as 'fund holders', which receive monetary budget and use this budget to manage their business to service patients.

Secondly, according to this purchaser-provider split model, the ministry of public health decentralises the management system of health care from top-down management approach, to localisation by using new payment mechanism; capitation to allocate budget from the NHSO to each providing hospital (CUP). Based on the government decentralisation and localisation of health care, the team of policy makers believe that it will improve the efficiency of services due to the decision given to the local hospitals. Besides, they believe that this system will reduce costs via the providing hospitals (CUPs), which also act as gatekeeping/referral points (Nitayarumphong, 2005).

Lastly, the implementation of universal coverage scheme changed the concept of health care from secondary and tertiary to focusing on primary health care in order to control the cost. Under the universal coverage model, the CUPs not only function as fund holders, which have decision power to choose ranges of services for their

local people, but they also act as gatekeepers and referral points to maintain health service costs. Ideally, under this system, health care service should improve equity whilst maintaining health expenditures (Health Insurance System Research Office, 2012).

In summary, Thailand presently provides universal coverage health care together with different schemes. The characteristic of Thailand health care system is thus considered as pluralistic. Currently, health care schemes in Thailand include 1) the universal coverage, 2) the civil servant medical benefit scheme, 3) the social security scheme and 4) insurance from the private sector. The implementation of the universal coverage scheme has led to major changes regarding financial management as well as power decentralisation, from the central government to the providing hospitals. In addition, the primary health care concept is promoted through the contracting unit for primary care (CUP).

Having provided brief information about the Thailand health care system, the thesis offers a background about the pharmacy profession in Thailand under this system in the next section.

4.2.2 Thailand Pharmacy: An Established Profession

Pharmacy in Thailand has been established as a profession since 1914 (Jaiarj, 1998). The profession is regulated under Thailand pharmacy council which has the role of ensuring competency standards of pharmacists. Since its foundation, the pharmacy profession in Thailand has been professionalised through role expansion into patient oriented practices, as well as through setting the licensure examination to restrict the practices to only pharmacists.

At the beginning of the profession foundation, pharmacists focused their roles on drug preparation and dispensing. Their roles were later extended to patient oriented practice. This role development is evident from the change of pharmacy educational programme, starting from a 3-year programme and the graduates receiving a certificate in Compounding Pharmacy, to a 4-year programme, and the graduates receiving a BSc in Pharmacy. Subsequently, the education programme was extended to 5 years. Since 2014, the pharmacy educational programme in Thailand has been further extended to 6 years, and the graduates receive a degree titled

Doctor of Pharmacy (Pongcharoensuk and Prakongpan, 2012). With the global change of the pharmacy profession during the mid 1970s, which put more focus on patient care, the content of pharmacy educational programme in Thailand was also extended to patient oriented practice. However, the education programme still had a duration of 5 years until 2014, when the pharmacy program in Thailand was extended to 6 years, with an increased focus on patient care and extended placement periods. Subsequently other subjects associated with patient care, for instance pharmacokinetics, pathophysiology and pharmacotherapy have been added (Pongcharoensuk and Prakongpan, 2012).

Besides, Thailand pharmacy has become more professionalised through the setting of the licensure examination. In the beginning, all the pharmacy students graduating from public universities automatically received licenses, whereas those who graduated from the private universities were required to take the licensure examination. Since 2004, all pharmacy graduates are required to take the licensure examination in order to be able to practice pharmacy services.

In summary, Thailand pharmacy, as a profession is established. The profession is regulated by the pharmacy council which has roles in ensuring standards of practice. In addition, the profession has been professionalising through role expansion into patient oriented practice, as well as setting up the licensure examination.

4.2.3 The patient oriented role of Thailand pharmacists in the Health care system

Section 4.2.1 mentions that the primary health care concept has been promoted more through the providing hospitals or contracting unit points which act as gatekeeper and referral unit. There are opportunities presented for Thai pharmacists to be integrated into the health care system and expand their roles in the patient care arena. Specifically, with regards to the opportunity in a drugstore setting, pharmacists could serve as a potential primary health care unit, whereas in a hospital setting, pharmacists could extend their role into patient care and work with doctors and nurses. Thus they help improve the quality of care in the hospitals.

In considering the role of Thailand pharmacists in a drugstore setting, empirical studies have demonstrated that pharmacists in drugstore settings have been involved in patient counselling and health screening. For instance, drugstore pharmacists smoking cessation service results in cost savings and life year gains (Thavorn and Chaiyakunapruk, 2008). Further evidence shows that drugstore pharmacists are effective in detecting patients who have hypertension and cardiovascular diseases (Pongwecharak and Treeranurat, 2010). Accordingly, it is apparent that the role of pharmacists in a drugstore setting has shifted from behind the counter role (dispensing) to patient-oriented roles. Further studies have shown the effectiveness of hospital pharmacists in patient care especially in monitoring adverse drug reactions. For example, pharmacists collaborate with doctors in managing patients who use anticoagulant results in reducing adverse drug reactions from drugs (Saokaew et al., 2012).

In summary, there are opportunities for pharmacists from both public hospitals and drugstores to extend their roles into patient care arena. Empirical studies have demonstrated that drugstore pharmacists have been providing services in patient counselling, such as smoking cessation service and patient screening which helps early detection of cardiovascular diseases in patients. Meanwhile hospital pharmacists have worked alongside doctors and nurses in ensuring patient safety from drug use.

Having provided the background information about the Thailand health care system and the pharmacy profession under this system, the following section thus offers information about work contexts, from which the pharmacist respondents were derived.

4.3   Work Contexts

The respondents were derived from two types of work context: seven public hospitals and 11 private drugstores. This section describes typical characteristics of these work contexts. Sub-section 4.2.1 presents the typical characteristics of public hospitals described by the respondents.

4.3.1 Public Hospitals

A total of 17 pharmacists from seven public hospitals in Thailand provided data for this study. These hospitals varied in size, range of services and type. The pharmacists' descriptions of their hospitals reveal similar characteristics, which suggests that they are typical of public hospitals in Thailand. Table 1 presents information about these hospitals.

Table 1: Information about public hospitals in the study

Hospital	Type of Hospital	No. of respondents
S Hospital	Regional (766 beds)	7
T Hospital	Provincial (312 beds)	5
RM Hospital	Medical School	1
LS Hospital	Tertiary (500 beds)	1
RVT Hospital	Tertiary (500 beds)	1
P Hospital	Provincial (500 beds)	1
SK Hospital	Provincial	1
Total		**17**

All the public hospitals in which the 17 pharmacists worked are considered to be medium-sized to large. All have both general practitioner and specialist doctors; thus, the hospitals are able to offer a broad range of patient services, dealing with both common problems and specialist healthcare. However, the two hospitals with a greater variety of specialist doctors are S Hospital, a very large hospital, and RM Hospital, a medical school hospital. Because RM Hospital is a medical school hospital, its doctors include general practitioners, residents and specialists.

In these hospitals, collaborative relationships between health professionals are seen as consisting of complex working interactions within and across professions. Their services comprise inpatient departments (IPD), and outpatient departments (OPD). Outpatient departments service patients who visit for healthcare but do not stay in the hospital, for example patients visiting a doctor for drug replenishment. In inpatient departments, services are provided to patients with unstable conditions who need to be closely monitored by doctors.

4.3.1.2 Role of Pharmacists

In general, the pharmaceutical responsibilities of the pharmacy workforce cover the outpatient department (OPD), the inpatient department (IPD), the production unit, supply and stock management. A head pharmacist has a more senior position than

the other pharmacists, with the role of supervising and managing tasks within the pharmacy department. The head pharmacist also acts as a representative of the department, and the role includes managerial responsibilities rather than practising professional services.

Pharmacists in the outpatient department (OPD) review doctors' prescriptions, dispense medicines and counsel patients, whereas pharmacists in the inpatient department review doctors' prescriptions and dispense medicines to be supplied to patient wards. Production pharmacists formulate and prepare various items, including parenteral nutrition (PN), cytotoxic drugs, intravenous (IV) mixtures, and extemporaneous drugs. Pharmacists' roles in the supply and stock management area include ensuring the quality of the hospital's stock.

This study finds that hospital pharmacists have a great variety of roles, all relating to drugs.

> *A hospital pharmacist does anything that relates to medicines. Pharmacists are responsible for drug management. This responsibility includes everything from knowing about the product and knowing how to use it in the patients. Comprehensive knowledge will lead to the ultimate outcome of our services, which is the benefit of the patients* (P08).

Drawing from respondents' accounts, the broad role content of pharmacists in public hospitals can be grouped into three categories: 1) pharmaceutical care provision, 2) production, and 3) non-pharmaceutical services.

a) Pharmaceutical Care Provision

Pharmaceutical care has been defined as: "The responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life" (Hepler and Strand, 1990). According to this definition, pharmaceutical care includes all activities that aim to improve patient safety and quality of life, as well as ensuring cost-effective care. Nevertheless, this study discovers that the range of roles delivered by pharmacists under pharmaceutical care provision differs between public hospitals. In S Hospital, the role content of pharmacists in pharmaceutical care provision is comprehensive, well established

and well acknowledged by other professions. On the other hand, in the other hospitals it is rather less established, and other professions also fail to acknowledge the pharmacists' role in this provision.

Below is a description of the pharmaceutical care activities practised by pharmacists in S Hospital:

We [pharmacists] *take care of patients, starting before they receive medicine to following up their medication use. There are a lot of activities involved. These include monitoring safety of drug use and medical reconciliation. For example, we review the history of drug use of individual patients, and review problems related to drug use, especially in those who have chronic diseases. Then we have to clarify the problems we find with a doctor, for example whether the patients have taken medicine correctly or whether they have complied with the medication. This is what we call medical reconciliation. For high-alert drug monitoring, we also collaborate with multidisciplinary professionals. We set a standard of practice for drugs with a narrow therapeutic index or serious side effects, and we have a monitoring guideline* (P07).

And:

About how we work, when they [nurses and doctors] *find adverse drug reactions, they will call a pharmacist to evaluate the patients. A pharmacist has a role in evaluating the patients' signs of adverse drug reactions, and reporting the findings in a specific form in order to keep a record* (P07).

The roles of pharmacists in pharmaceutical care provision in S Hospital are well established and well acknowledged amongst nursing and medical professions. Some pharmacy services in S hospital are unique in that the pharmacy department has an ambulatory clinic as a separate unit in which the pharmacists provide pharmaceutical care to patients with chronic diseases. A pharmacist explained the roles of pharmacists in the clinic:

At the ambulatory clinic, we emphasise patients with all chronic diseases, including diabetes, heart disease and patients who are on warfarin, tuberculosis and HIV. We start by screening doctors' prescriptions, checking whether the prescriptions are correct. We also review patients' history of adverse drug reactions, review whether they have taken drugs correctly, or whether they comply with the prescription. We also teach them about how to take care of themselves specifically for individual patients. For example, we teach them how to use inhalers, how to take drugs, how they should cut their medicine when they have to take half a tablet. Some drugs are taken every other day, so we have to help them make a timetable to increase compliance. We do these in order to promote safety of drug use and increase rational use of drugs (P07).

The roles of pharmacists in S Hospital in pharmaceutical care provision are well recognised. It is also found that, amongst the hospital's services, the diabetes clinic has been acknowledged as a successful service. The hospital gained "Distinguished Diabetes Service" awards in 2005 and 2009. Within this service system, the pharmacists play a central role in the ambulatory clinics, as mentioned above.

Unlike pharmacists' services in S Hospital, in the other hospitals there is no established clinic in which the pharmacists review medical histories and counsel patients. When a case needs pharmaceutical counselling, a pharmacist will guide the patient to an unofficial counselling room, which is a space within the OPD dispensary service. A pharmacist explained that:

In my hospital we don't have clinics established because there are not enough pharmacists to be allocated to work in the clinics. Even checking and dispensing alone already take up our time each day (P14).

He continued:

So if there is a patient who we think needs counselling, for example a patient who receives multiple drugs, or patients with noncompliance, we will counsel them. But we can't do counselling for all patients (P14).

The data further demonstrate that medical–pharmaceutical role relations in the public hospital context are structured around the traditional healthcare division of labour. That is, medicine is the dominant profession (Freidson, 1970) and has exclusive power in clinical decision making and prescribing. The pharmaceutical profession is subordinate to medicine. Pharmacists have a role in dispensing doctors' orders. A pharmacist explained medical–pharmaceutical role relations in the hospital:

> *In a hospital, pharmacists don't make decisions about what drugs to use. We have roles in dispensing and counselling but never about making decisions on patient treatment* (P11).

The empirical data from the focus group confirm that the respondents perceive that the roles associated with the patient-oriented practice of pharmacists in the public hospital context are limited to dispensing and counselling, but are never about diagnosing and prescribing.

> *We can contact them if we have concerns about their prescriptions, but in the end it is the doctors' right to prescribe. If we consult and they* [doctors] *don't want to change, then we have to prescribe* (P13).

Thus, the main role of pharmacists in hospitals is checking doctors' prescriptions. A pharmacist described her routine work at her hospital:

> *I am a checker. Every day I check doctors' orders. It is my routine. I check everything. I check whether the medicines they* [doctors] *prescribed are correct and appropriate for individual patients. I check to ensure there is no drug interaction, no repetitive drugs, and make sure of any possible side effects. I check every day and I get used to it. It's so boring* (P01).

Pharmacists check doctors' orders to ensure the "five rights" approach of drug administration: the right patient with the right drug at the right dose, the right route and at the right time (Jones, 2009). The pharmacists' narrative data reveal not only that they must ensure the five rights, but that they also have to check to ensure that the doctors' orders are in line with cost containment.

We [pharmacists] *check the prescriptions to ensure patient safety because patient safety is the most important. But we also check whether doctors use expensive drugs or not. If they order expensive drugs, we have to check whether they have provided their reasons for choosing the drugs* (P14).

Pharmacists' role in the procurement of drugs has been strongly enforced following the implementation of Thailand's universal health coverage scheme in 2002. Since then, Thailand's Ministry of Public Health has prevented escalating drug costs by specifying national lists of essential drug items to be used by public hospitals. Hence, public hospitals must control the cost of drugs and ensure rational use. Therefore, pharmacists check doctors' orders to ensure patient safety, as well as to ensure rational use of drugs in their hospitals.

If the doctor prescribes an expensive drug, s(h)e has to submit a form stating the reason for the drug use. If the doctor doesn't give this form, the hospital can't get the drug expense reimbursed from the government. This means the hospital has to pay for the medicine itself (P14).

Besides the checking role, roles in dispensing and counselling are also mentioned as the other main roles of pharmacists in public hospitals. Dispensing and counselling are delivered together. That is, when pharmacists dispense drugs to their patients, at the same time they advise them about how to use the drugs.

Along with dispensing, pharmacists also provide counselling. For example, in the past pharmacists dispensed insulin injections and the nurses taught patients how to use insulin injections, but now pharmacists are the ones who teach patients at the same time as we dispense the insulin injections (P11).

So far, it has been established that activities of pharmaceutical care provision are perceived as the role content of pharmacists working in public hospitals. These activities are associated with patient care practice, with the aim of promoting patient safety in drug use. Although pharmacists regard pharmaceutical care practices as part of their role, the level of activities delivered by pharmacists varies

between hospitals. Hence, it can be said that there is no central standard of pharmaceutical care practice for pharmacists in public hospitals. In most hospitals, pharmaceutical care activities occur behind the counter, where pharmacists check doctors' orders, dispense and provide counselling.

b)   Production Role

The production role is present only in public hospitals, not in private drugstores. The production role of pharmacists in public hospitals covers mass production which does not require advanced skills, such as producing normal saline in small volumes, as well as highly-skilled production for individual patient use, such as IV mixtures and chemotherapy drugs.

> *There are two types of production jobs. First is the small volume production. This requires precision and it is the pharmacists who do this. The other is the large volume production, such as alum milk, normal saline, etc. I think a pharmacist assistant can do these, but in the past I also had to do this* (P12).

Although the new paradigm of pharmacy has guided the pharmacists' role extensively in the direction of patient-focused practices, this research finds that the production function of pharmacists remains the most important. Pharmacists perceive that product-oriented roles are the areas of responsibility and knowledge which other professions do not know. For example:

> *Doctors want to know whether we* [pharmacists] *can prepare drugs for intravenous injections or not because they want to use them but they are unable to mix them. They have clinical knowledge but they don't know about products and drug compatibility. And I think this is knowledge that pharmacists need to use in a hospital* (P14).

c)   Dirty Work

The term "dirty work" (Hughes, 1962) is used to refer to work that pharmacists do not view as their professional role and yet is delegated to them. Pharmacists in public hospitals also have roles that they do not regard as professional but have been delegated to pharmacy by the medical profession. These include any activities

that relate to drugs but do not require pharmaceutical knowledge, for example keeping the rational drug use record form for reimbursement.

> *For expensive drugs, if doctors order them for patients under the government support scheme, they must provide a reason for the drug use, otherwise the hospital can't get reimbursed from the government. But some doctors don't give any information; pharmacists have to contact the doctors. I don't think this is our job* (P14).

Another pharmacist added:

> *I even have to remember the signatures of doctors, so I can get back to them. Is this my job? But we have to do it, because if the hospital can't get reimbursement, it's the pharmacist who would be blamed* (P13).

The pharmacists stated that doctors delegate this task to the pharmacy because it relates to drugs, even though the task does not require professional knowledge: "*The job is about drugs, so they* [doctors] *give it to us*" (P14).

The pharmacists' view is that this official documentation role causes them inconvenience in performing their professional role, but they have to do it because the ministerial rule also states that this role belongs to the pharmacy profession.

The respondents' data reveal that the role of pharmacists in public hospitals covers a wide range of tasks involving drug preparation, dispensing and counselling, and monitoring patient safety, as well as non-pharmaceutical services such as preparing documents for quality control assessment.

4.3.1.3 Description of Daily Role

This section summarises respondents' descriptions of the pharmacist's role in public hospitals.

a)   Workload

The pharmacists described the characteristics of their role within the hospital as *"always busy"* (P13) and having a huge daily *"workload"* (P13, P10, P05, P16, P14, P03) due to increasing numbers of patients. A respondent stated: "*There is an extensive workload due to increasing numbers of patients*" (P10).

The day-to-day work of the pharmacists is described as being involved in the *"rush hour"* period, which refers to the time during each day when there is the greatest number of patients. High demands from patients require the pharmacists to deliver their services quicker so as to respond to these demands and control waiting times. One pharmacist expressed a view about the rising number of patients that increases workloads and creates a rush hour:

> *Workload is a major problem. There are so many patients in the public hospitals so we have to work faster and faster* (P14).

He added that increasing numbers of patients cause pharmacists to rush to deliver their services:

> *Can you imagine if we needed to spend 15 minutes per patient in dispensing services, how many minutes we would spend for 100 patients? You see? We haven't got enough time to provide the service. In public hospitals, the number of patients is extensive, so the services need to be delivered as quickly as possible* (P14).

It is evident that there is an issue of insufficient pharmacists in public hospitals to respond to growing demands, thus worsening the workloads of pharmacists. A pharmacist mentioned the ratio of patients to pharmacists, which she viewed as imbalanced. She said:

> *I think the problem is the patient per pharmacist ratio. There are many patients but there is a lack of pharmacists to do service in the public hospitals* (P16).

The pharmacists in this study pointed out that the higher number of patients visiting public hospitals in Thailand is a consequence of Thailand's rapid implementation of universal coverage in 2002. This policy implementation has increased the workloads of health professionals in the public sector nationally. Accordingly, health professionals in public hospitals have moved to private hospitals and other private sector businesses. The internal brain drain of professionals from public hospitals to the private sector has thus increased the workloads of remaining pharmacy staff. Issues such as increasing demands, insufficient pharmacists and the

heavy workloads of pharmacists currently working in hospitals were discussed in the focus group conducted as part of this study:

P16:   *There are many graduates but they don't choose to work in a public hospital.*

P14:   *That is the case.*

I: *Why is that so?*

P14:   *The pay is low but the workload is high in public hospitals.*

P16:   *In some hospitals, there are also stresses from bosses and colleagues.*

P13:   *Yes, the pay is not worth the stress and workload. Even to find a part-time pharmacist in my hospital who would receive a higher salary than the full-time pharmacists is difficult.*

I: *So have many people resigned because of the workload, stress and low pay?*

P16:   *Yes, a lot. Only the old employees who are civil servants remain.*

(Focus group of three hospital pharmacists from three public hospitals: Hospitals LS, RVT and RM)

It is evident that high patient demands have caused stress to the pharmacists in this study because they have to deliver their services quickly. For example, one respondent's role is to prepare cytotoxic drugs, which is a highly skilled technique. Because patients want to receive drugs quickly, she felt stressed about having to rush. She said:

It is quite stressful in the hospital because there is a high workload. Patients want to receive drugs quickly. For me, I mix cytotoxic drugs but I can't prepare drugs in advance because we [health professionals] *have to monitor laboratory tests and body temperatures first. But when the patients arrive, they want to receive drugs right away. When the*

outpatients come at the same time as the inpatients, I feel quite stressed (P13).

This section has drawn on pharmacists' accounts to depict characteristics of the pharmacist's role in a typical public hospital in Thailand. These include increasing demands from patients, with insufficient pharmacists to respond to this demand, consequently raising pharmacists' workloads and resulting in stress at work.

b) Hospital Job Provides Sense of Security

Pharmacists also described their public hospital jobs as providing them with a sense of security, and said that this is a reason for them remaining in their jobs. For example, a respondent said:

> *If I didn't have to take care of my family, I would have quit this* [hospital] *job to work alone in my drugstore* (P03).

Other pharmacists reported similarly:

> *I prefer to work in a drugstore because I can manage things myself. But I don't think of quitting my job at the hospital because I am a civil servant, so I will have a pension* (P11).

c) Fixed and Relatively Low Salaries

Although pharmacists in public hospitals have higher workloads, it is found that they receive fixed and much lower salaries than those who work in other types of organisation.

> *We receive salaries four times less than doctors. The salary of pharmacists is low compared to the amount of work we are responsible for* (P07).

In summary, the job of a public hospital pharmacist is described as having a high workload and a fixed and rather low salary, yet offering pharmacists a sense of security.

4.3.1.4 Value Embedded in the Pharmacist's Role

Being patient-centred is demonstrated to be the single core value of pharmacy practice amongst hospital pharmacists. The respondents strongly defined the value of their practice as the safety of patients. For example:

Our ultimate goal is patient safety. I am a pharmacist, I am a professional, and I have knowledge to contribute to others (P08).

The respondents from public hospitals acknowledged that it is their responsibility to ensure patient safety, and emphasised their contribution to patient safety as the value of their practice. For example:

I think our role is to make sure that patients are safe. We check the prescriptions before dispensing and we have to do counselling. If there is a medication error, it is our responsibility not doctors' because we are the people who give the medicine to the patients. We have an opportunity to detect the error and prevent it (P14).

And:

Pharmacists aim for patient benefit first. We ensure that the patients are safe in drug use. I think patient safety is at the heart of pharmacists' practice (P09).

And:

The value of our profession is what we can do for the patients (P12).

Pharmacists practice pharmaceutical care not because it will improve our image but because our roles bring therapeutic outcomes to the patients – when they are safe because they receive correct and good quality drugs (P08).

Pharmacists also believe that working in a hospital context provides them with greater opportunities to contribute to patient safety. One pharmacist explained:

I chose the hospital track because I want to contribute to patient outcomes. Working in other tracks can also contribute to patients; for example, the production line can contribute to producing effective

medicine. But working in a hospital allows me to have direct contact with patients. I think I can do more for them in the hospital (P07).

Another added:

I think the dispensing role at the hospital will reduce harm from drug use because we [pharmacists] *have a chance to review the patients' prescriptions and also we can access their historical treatment data. Then we have an opportunity to consult their doctor, and we also have direct counselling with patients* (P14).

Some of the pharmacists were also of the view that working in a business setting would contradict their professional values. For example:

Being a pharmacist at the public hospital, I don't earn much but I can contribute to the patients' outcomes. Being able to help patients makes me happy and proud to be a pharmacist. I don't think I am suited to working in a private drugstore. I don't like running a business. I used to run a drugstore but I felt that business was not for me because I felt guilty about making a profit from my practice (P08).

Another pharmacist pointed out that there are limitations to delivering an inclusive health service in a private drugstore because pharmacists cannot access patients' laboratory data, nor review their historical treatment background. Consequently, she was concerned that pharmacy services in private drugstores may not be correct.

In a drugstore, we [pharmacists] *diagnose and that's done. But it may not be complete. In some cases, patients need to have a laboratory test, or x-ray or other tests. So, I think we can't provide comprehensive care in a drugstore. I view this as a risk to patients. In the drugstore, we cut that laboratory test process out and just dispense* (P07).

The above excerpts clearly demonstrate that the respondents perceived patient safety as a value of the pharmacy practice of public hospitals. Pharmacists also perceived that the public hospital context allows them to contribute directly to patient outcomes, whereas there is less opportunity to do so in other work contexts.

4.3.2 Private Drugstores

This section presents how pharmacists describe their role in private drugstores. This study included 12 drugstore pharmacists, of whom eight were dual-role pharmacists, working full-time in a public hospital and operating a private drugstore in their spare time.

4.3.2.1 Role of Pharmacists

The role content of pharmacists in the private drugstore context involves two conflicting roles: professional and businessperson roles. Regarding the professional role of pharmacists in private drugstores, the respondents viewed the role of drugstore pharmacists as similar to the role in public hospitals. That is, both roles are oriented to patient care.

> *I think the roles of pharmacists in the hospital and the drugstore are the same, in that both roles are about care of patients' health* (P02).

While the roles of pharmacists in both public hospitals and private drugstores relate to patient care, there are also differences, in that the roles of drugstore pharmacists include both patient diagnosis and a business role. The respondents were of the view that these two roles distinguish the role content of pharmacists in the two work contexts.

> *Pharmacists in a drugstore are different from those in a hospital because the role in a drugstore includes diagnosis. So a pharmacist in a drugstore also evaluates a patient's condition and makes decisions about how to treat patients and what drugs to use. I think these are the key differences between the roles of pharmacists in a hospital and in a drugstore* (P20).

Another pharmacist added:

> *In a drugstore, you have the right to evaluate patients. But in a hospital, the person who diagnoses is the doctor. You can consult doctors about their prescriptions but they are the only people who have the right to prescribe* (P05).

And:

The role of pharmacists in drugstores includes two main functions. First, to sell medicines; and second, to provide health services. The pharmacist role in a drugstore can't be just selling medicines and products alone, but being a pharmacist you have to give health advice too (P11).

In summary, the role content of pharmacists in a private drugstore context is associated with both professional and business roles. With regard to the professional role, they provide patient care, including patient diagnosis, choosing drugs and providing a counselling service to their patients. With regard to the business role, they must ensure that sales provide them with enough profit to maintain the business.

Regarding role relationships in the private drugstore context, pharmacists are the sole professionals providing health services to patients. Thus, their role is separate from other health professions and relates only to service users who visit their drugstores.

4.3.2.2 Description of Daily Role

a)   Lower Workload

Unlike the role in a public hospital, the main characteristics of a pharmacist's role in a private drugstore are described as *"relaxing", "stress free", "having less controls",* and *"less workload"*. For example:

The drugstore is my own business. There are not many patients but I earn extra money after my full-time hospital job. It's better than doing extra hours in the hospital because there is no stress at the drugstore (P10).

Or:

I prefer working in my drugstore to a public hospital because there are fewer managerial controls in the drugstore. For example, in the hospital there are more patients, and I have to quickly dispense drugs. I can't talk to each patient as much as I can do in my drugstore. Besides,

in my drugstore, I can manage the services myself. I don't have to ask
for permission (P11).

It should be noted that all the respondents in this study were derived from small, local drugstores owned by a pharmacist. The characteristics mentioned above might vary if other types of drugstores had been explored, for instance large drugstore chains owned by non-pharmacists. One pharmacist who used to work in a large chain drugstore provided evidence of this:

Before I moved to work in this drugstore, I used to work in a company
which has a chain of five drugstores. It was just a couple of months. I
felt the work was stressed there because the owner set a daily sales
target for the pharmacist employees and the assistants to reach. But in
this drugstore, I don't feel pressured from my work because the owner
doesn't set a sales target for me. She emphasises that I must practice
pharmacy services correctly (P20).

b)   Full Self-Autonomy

Pharmacists described their role as having full power to manage the business by themselves. One respondent described the full autonomy of a pharmacist in the private drugstore context as different from pharmacists' level of autonomy in a public hospital context:

In a drugstore, you have the right to evaluate patients. But in a hospital,
the person who diagnoses is the doctor. You can consult the doctors
about their prescriptions but they are the only people who have the
right to decide whether they want to change their orders or not (P05).

4.3.2.3 Values Embedded in the Role

The value that drugstore pharmacists provide to the public is that they have knowledge of medicines, and what makes them different from non-pharmacist drugstores is being a source of knowledge for the public.

The role of a pharmacist in a drugstore includes two main functions.
First is to sell medicine and second is to provide health advice. The role

cannot be only selling medicine alone. Being a professional pharmacist,
you have to give them knowledge too. This is important (P11).

Similarly to hospital pharmacists, community pharmacists also described themselves as being patient-focused in their professional practices. Although community drugstore pharmacists employ business-oriented practices, they also identify themselves as distinct from non-professional drug sellers because they are concerned about patient safety in drug use. With regard to being health professionals, community pharmacists described their roles in giving advice on health-related issues and drug use in their community:

I think a pharmacist in a drugstore setting is different from non-
professional drug sellers because the pharmacist is concerned about
patient safety too. Pharmacists don't focus on profit and not care
whether a patient would be safe in drug use or not. In terms of making
profit, my supervisors taught me how to make a profit and also provide
health services (P20).

The values that community pharmacists contribute to society are also seen in their professional knowledge in identifying drug misuse within their community. For example:

If a case of drug misuse comes to my drugstore, for example if a
customer requests a medicine to wash kidneys, I will ask them what
symptoms they have. I will tell them that their symptoms are not related
to a kidney problem and there is no such drug to wash and clean
kidneys. I then advise them instead not to lift heavy stuff. Or in some
cases, we can detect problems of drug use in our community. For
example, when some customers came to ask for two tablets of Kana
(antibiotics), I suddenly knew that they had listened to a radio
advertisement. I would advise them about drug misuse and that taking
the medicines is not only unhelpful but could also be harmful (P21).

4.4   The Pharmacists

A total of 21 pharmacists provided data for this study. Sixteen pharmacists in this study worked full-time at a public hospital. Of this number, eight had a single role as a full-time pharmacist in a public hospital, while the other eight performed the dual roles of being a full-time pharmacist in a public hospital and operating a private drugstore outside of the full-time hospital work.

A total of 12 pharmacists worked in a private drugstore. These included four full-time pharmacists who worked only in a private drugstore and eight who performed dual roles. Table 2 lists the respondents and their work contexts.

Table 2: Respondents and their work contexts

Number	Respondent	Public Hospital	Private Drugstore	Dual Role
1	P04			✓
2	P03			✓
3	P21		✓	
4	P18		✓	
5	P15			✓
6	P09	✓		
7	P16	✓		
8	P20		✓	
9	P14	✓		
10	P08	✓		
11	P07	✓		
12	P12	✓		
13	P06	✓		
14	P11			✓
15	P13	✓		
16	P01			✓
17	P05			✓
18	P10			✓
19	P02			✓
20	P19		✓	
21	P17	✓		
Total	**21**	**9**	**4**	**8**

4.4.1   Pharmacists' Perceptions about Self

4.4.1.1 Evidence from Public Hospital Pharmacists

a)   Drug Expert

Pharmacists in public hospitals viewed their role as covering product-oriented and patient-oriented practices. This contributes to the pharmacists' perceptions of self.

According to the pharmacists, their identity is of a *drug expert* with a wide range of knowledge, from production to patient care.

b)   Subordinate

The pharmacists also viewed themselves as being under the power of the medical profession; that is, pharmacists in public hospitals do not have clinical autonomy. Hence, their role relates to anything except diagnosis and making decisions on treatment. Consequently, the pharmacists viewed themselves in the role of *subordinate.*

4.4.1.2 Evidence from Private Drugstores

This study finds that pharmacists in a private drugstore context form mixed identities, being both professionals and businesspeople. This contributes to answering the question of how pharmacists construct their identity in the private drugstore context.

Regarding the services provided in a private drugstore, the pharmacists recognised that their roles include a professional role and a business role. Considering their professional role content, pharmacists indicated that their roles include diagnosis, counselling and advising about products, which distinguish them from non-professional drug sellers. The diagnosis role also differentiates private drugstore pharmacists from public hospital pharmacists.

Table 3: Comparison of work contexts in relation to pharmacists' roles, values and professional identity

Context	Public Hospital	Private Drugstore
Characteristics	Busy, heavy workload, and stressful Fixed and low salary Provides sense of security	Relaxing, freedom Salaries depend on sales Provides sense of freedom
Role content	Comprehensive role (product-oriented to patient-oriented roles)	Professional role (counselling) and business role (making profit)
Values	Patient-oriented value	Patient-oriented value and profit value
Professional Identity	Drug expert Subordinate	Doctor of the community Counsellor

4.4.2   The Narrative Turn of Pharmacists

The interview and autobiography data for each pharmacist provide individual stories. These stories have continuity, from when they were pharmacy students to

the present. Some of their stories revealed why they chose to study pharmacy. Other stories told about why they quit or remained in a job. The autobiographies and interviews enabled an exploration of the "bumps and grinds of everyday life" (Miller, 2000) of the pharmacist respondents. Thus, using narrative turn (Watson, 2009) to observe these "bumps and grinds" enabled a better understanding of individual pharmacists in relation to their work and social contexts.

In this regard, the outcomes of narrative turn analysis are provided in Table 5, which provides rich information about the respondents.

4.5   Conclusion

This chapter has provided background information about the work contexts and the pharmacists who provided data for this research. The next chapter employs negotiated order theory (Strauss et.al., 1963) and the social arena concept (Renn, 1992; Jaeger et al., 2001) to explore how pharmacists establish pharmacy role boundaries in two different work contexts.

Table 4: Narrative turn analysis of 21 pharmacist respondents

No.	Name	Workplace & Position	Summary of the Respondent	Narrative Turn	Consequence of the Narrative Turn	Identity Construction
1	P01	T Hospital (senior in IPD) and drugstore (owner)	She studied Pharmaceutical Administration as a major, but after graduation she returned to work in a public hospital as part of a compulsory contract with the government. She thought the work was different from university. She dislikes the work on the ward as she describes it as stressful. She prefers to work at her drugstore because she has more freedom and less stress. However, she is also afraid to quit the full-time job at the hospital because she is unsure. She is concerned about insecurity and the uncertainty if she quit.	1) Macro role transition *"When I started to work, I felt like I faced with a tidal wave. I thought work would be as fun as university"* 2) Working on the ward *"I was not happy"*; *"It was stressful. Every day I saw people with illness and suffering"* 3) Operating a drugstore *"I thought I could use the knowledge of the hospital job to work in the drugstore but I was wrong"*; *"On the first day, when a patient walked into my drugstore, I was totally blank"* 4) Daily work at the hospital *"I feel uncertain about being self-employed"*	1) Observing how her colleagues and her mentor worked, receiving feedback from her mentor 2) She requested a move back to the OPD. However, later she was also allocated to the ward. She got used to it. 3) Self-study (read more books and discussed patient cases with her friends) 4) Remains in the job at the hospital. Feels stressed at work but also feels that she can contribute to patients.	1) Socialisation 2) Negotiation and identity work 3) Self-study and socialisation 4) Identity work (drawing from professional value, and sense of security value to maintain the hospital job)
2	P14	LS Hospital (OPD pharmacist)	He used to work in the manufacturing department of a drug company. His previous work was quality control of drugs and products. He quit because he thinks that working in a hospital he can do more for patients. In the hospital, he had made several attempts to set up a counselling clinic. However, he hasn't received cooperation from his colleagues. Although he had to run the clinic alone, he continued to provide patient counselling.	1) Quit a job in manufacturing to become a hospital pharmacist *"I think working in the hospital, I can deliver the service direct to the patients"* 2) Setting up a counselling clinic *"I think patient counselling is our role, but many pharmacists don't want to do it. They just want to be behind the counter. I don't care. I think this is my job, so I do it"*	1) Observing how to work in the hospital, but also a lot of self-study, and comparing how pharmacists work internationally. 2) Experienced resistance from his colleagues because they did not want to cooperate in the counselling clinic. However, he committed to the professional value and continued the counselling service. 3) Doctors acknowledge his role.	1) Socialisation 2) Identity work (drawing on professional value) 3) Negotiation

				3) Dealing with doctors He has no problem with doctors because he knows what knowledge to offer. "*If you talk about something that they already know, they won't listen to you*"		(providing pharmaceutical knowledge to doctors, committing to the professional value)
3	P17	P Hospital (OPD)	He used to operate his own drugstore along with his full-time pharmacist job at a public hospital. However, he closed down the drugstore for health reasons. He feels the high workload in the hospital. According to him, the workload includes professional and non-professional tasks (daily patients and document tasks).	1) Closing down the drugstore "*I prefer to work in my drugstore because I like being able to manage things myself. I also like to advise people*"; "*But I closed down because I have health problems, so I remained in my work at the hospital because I am a civil servant. The hospital job gives me more security*" 2) Dealing with daily work "*Preparing for the HA assessment adds more workload to pharmacists. Some of the assessment, we don't need to do*"; "*The pharmacists know this but we don't explain to those lecturers who come to assess us*"	1) He preferred to work in a drugstore, but he had to close that down and has maintained the full-time job. 2) Stress due to workload from professional and non-professional services.	1) Identity work (drawing on sense of security to maintain the work of a hospital pharmacist). 2) Negotiation He thinks that pharmacists fail to negotiate with pharmacy lecturers who come to assess the quality of pharmacy group work.
4	P15	SK Hospital (OPD) and drugstore (owner)	She chose to work in a public hospital in her home town. She feels happy that she can help patients. At her drugstore, she also used business strategies to gain more sales. She mentioned that she gains trust from her customers at her drugstore because she is a full-time pharmacist in the hospital.	1) Daily work at the hospital: dealing with workload "*The work at the hospital is overwhelming. I wish I had 10 hands, 4 eyes, 2 mouths, and 5 brains so I could finish all the work (laughing) ... but although I have just 2 hands, 2 eyes, 1 mouth and 1 brain, I am also doing my best. I feel happy every time when I see that I can help patients to get better*";	1) Overwhelmed by workload at the hospital.	1) Identity work (drawing on professional value to guide her practice)

				"*Although I don't earn much money, I feel happy I could help them*". 2) Daily work at the drugstore: being a business owner "*At my drugstore, I also have to be concerned about sales and also retain professional values.*"	2) Changing work contexts (from hospital to drugstore) Maintaining sense of professional self whilst being a business owner.	2) Identity work (maintaining hybrid identities. Being professional and being a business owner)
5	P18	Drugstore (owner)	She used to work in a cancer centre but she left the job because her boss did not support her work on ward rounds. She is happy to work at her drugstore. At the beginning of her drugstore work, she used to let her mother (non-pharmacist) sell drugs whilst she was absent. However, she later reconciled with the professional value.	1) Quitting job at the cancer centre "*I used to go to the patient ward because I wanted to be involved in patient care, but my boss said that we couldn't do it. I cried, you know. I felt discouraged*" 2) Opening a business drugstore "*I felt quite bored being at the drugstore all day, so at the beginning I let my mother help me*" 3) Reconciliation "*I've been a pharmacist for a long time, and I think if other people sell drugs for pharmacists, patients might not be safe. I think it's the pharmacist's role.*"	1) Quitting Job: She quit the job at the hospital because of lack of cooperation and support from her mentor. 3) Reconciliation: After being a professional pharmacist for a period of time, she reconciled with the professional value and did not let a non-professional seller hand drugs to patients.	1) Identity work (drawing on two conflicting discourses. First, she drew on the professional value to maintain a sense of professionalism in the commercial context. Secondly, she also drew on a business value discourse to gain profit for her business survival.)
6	P13	RM Hospital (cytotoxic production)	She prefers to work on a production line because she does not like talking to people. Luckily, her pharmacy department does not use a rotation policy so she can remain in production. However, she is overwhelmed by the workload due to increasing numbers of patients. She also mentioned non-professional jobs that	1) Entering professional life: At the beginning of her career, she did not know how to interact with doctors: "*I knew that the dose was not right but I didn't know how to explain it to the doctor*" 2) Working during rush hour: "*Stressful because the patients want to get drugs quickly*"	1) To adjust to work, she committed to the professional value, and practised good communications in order to gain trust from doctors. 2) She coped with the workload. She thinks her role contributes to patient safety. She is also unsure about changing jobs because she	1) Negotiation (with doctors to establish her role) 2) Socialisation (observing how her supervisor performed the role, and receiving feedback) 3) Identity work (drew on professional value and sense of security)

			should not be done by pharmacists but are delegated by doctors because doctors do not want to do them. This adds extra workload to pharmacists.		perceives the uncertainty.	
7	P07	S Hospital (ambulatory clinic)	She has a good attitude toward being a hospital pharmacist. She said that there is a lot of work but she is happy that she can help patients. She used to run a drugstore alongside her full-time pharmacist job but she closed it down because she felt guilty about making profits from selling drugs and services. She thought that if the patients came to the hospital, they would receive comprehensive care at lower costs than they would in a drugstore.	1) Closing down her drugstore *"I closed my drugstore because I felt guilty about making profits"* 2) Daily work at the hospital The job at the hospital is suited to her personal self. She can integrate the professional value with her personal value. *"I think I am suited to being a hospital pharmacist because I like doing things for others"*; *"I think it's from my family, personally I believe in morality. My parents also nurtured me to care for others"*	1) She closed down her drugstore even though the business could earn her more money. 2) In the end, she remained in her hospital job because she stated that it was more suited to her personal morality.	1) Identity work (She drew on a professional value discourse to construct her identity. She could not compromise two conflicting values, business and professional. She integrated her professional identity with her personal identity)
8	P06	S Hospital (ambulatory clinic)	Overall she is happy with her work at the hospital. During her pharmacy education, she did pharmaceutical administration. For her work placement, she was trained in the role of medical representative. She felt that she did not use professional knowledge in the work. When she graduated, she started a job at a small public hospital. She enjoyed the work and she felt happy that she could help patients. She also mentioned that relations with pharmacists were very good. She could learn from her supervisor. They also had the	1) During pharmacy education She liked business administration, but she felt that the role of medical representative did not give her a sense of being a pharmacist, so she chose to work in a public hospital instead. 2) At the hospital She learned how to perform roles from her supervisors. She felt motivated because of good cooperation between pharmacists. She also developed a sense of being a professional as she identified	1) She chose to work in a hospital rather than in a drug company as she can contribute to patients. 2) She maintains the job because she can do things for patients and because there is good collaboration within the pharmacy department.	1) Identity work (Identity matching) 2) Socialisation (Learning how to perform the role from her supervisor) 3) Identity work (maintaining role because of sense of belonging and professional value)

			same aim, which is to improve the quality of the hospital pharmacy service. She felt motivated because of good cooperation. Now she has moved to a regional hospital to follow her family. She thinks the workload is greater because the hospital is bigger and there are more patients. Although there is a heavier workload, she also feels happy because everyone in her department helps each other. She feels that she is a part of the team. She also feels happy that she can help patients. She never thought of quitting because she feels that the hospital job suits her best.	herself with the professional value (being patient-oriented)		
9	P12	S Hospital (ambulatory clinic)	She chose to major in pharmaceutical analytics during her pharmacy education. However, as she needed to work in a public hospital because of a compulsory contract, she started work in the production unit of a small public hospital. She didn't enjoy the work there because production at that hospital involved mass production which does not require pharmacy skills. Later, she moved to a regional public hospital to follow her family. She used to run a drugstore alongside her full-time hospital job but she had to it close down because she didn't have time for her children.	1) Macro role transition (from student with pharmaceutical analytics background to pharmacist in a public hospital) 2) Working in the production unit She did not use her pharmacy skills at work. "*The job didn't need a pharmacist to do it*" 3) Closing down a drugstore She liked her role at the drugstore but she didn't have time to take care of her small children. 4) Daily work Happy with cooperation of pharmacists. Identified inter-professional collaboration barrier.	1) Observed how others perform the role and did a lot of self-reading, attending seminars She gained skills in how to perform a patient-role oriented from her master's study. 2) Closing down her drugstore 3) Maintains the job because it provides security.	1) Socialisation 2) Identity work (negotiating conflicting identities – being a mother and a professional) 3) Identity work (drawing on sense of security to maintain the job)

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			She thinks about quitting her hospital job to try something different, for example opening a bakery or a drugstore. However, for now, because her children are still small, she maintains the job.	Future Wants to open a bakery alongside a drugstore: "*A drugstore is every pharmacist's dream*"		
10	P09	S Hospital (ambulatory clinic)	She chose to work in a public hospital because her parents wanted her to work in the public sector for social security reasons. She prefers to work with people rather than production, so she is OK with the work in the ambulatory clinic. However, she also feels stressed due to a heavy workload. This workload took time when she wanted to be with her new-born baby. She hasn't thought of quitting because the job provides security for her and her family.	1) Choosing a job "*Actually I wanted to work in a private hospital because the salary is higher than working in a public hospital but my parents wanted me to work in the public sector*" 2) Maintaining the job "*I feel stressed when there is a heavy workload, especially when we have to prepare documents for the HA assessment*"; "*And for example, like today, I didn't want to work extra hours. I wanted to be with my baby.*"; "*I don't think of quitting because this job provides financial security*"	1) She moved to her home town and started work in a regional hospital because the job there provides more security for her family. 2) She feels stressed due to the workload at the hospital; she also misses her child when she has to work extra hours. However, she remains in the job because it gives her security.	1) Identity work There is conflict between the roles of mother and professional. She drew on a sense of security to maintain the job.
11	P10	S Hospital full-time (Cytotoxic production) and owner of a private drugstore part-time	He chose pharmaceutical analytics during his pharmacy study. However, he worked in a public hospital because his parents wanted him to have a job with more security. At the beginning of his career, he experienced transition shock, when he was afraid to do patient care. Later on he rotated to work in the cytotoxic production unit. At his drugstore, he stated that	1) Macro role transition (from a student who studied pharmaceutical analytics to pharmacist in a public hospital) "*I was afraid of doing clinical pharmacy*" 2) Daily work Adjusting to the role: "*I never thought of quitting*"; "*I am the kind of person who would try to learn*" 3) Changing contexts (from hospital to drugstore)	1) He tried to learn knowledge and skills in clinical pharmacy although he was afraid. In the end, he started to become confident about his knowledge of clinical pharmacy. 2) He traded health risks and using skills, such as aseptic techniques and production in small dosages, with fewer working hours in cytotoxic	1) Socialisation (observing how other people work) 2) Identity work (drawing on sense of security to choose and maintain the job) 3) Identity work (negotiating conflicting roles of pharmacist and business owner)

			there is less work than in the hospital. He prefers to work in his drugstore because there is less stress. He also uses business strategies to increase sales; however, he perceives that the main task is to provide health advice and professional services.	He has adopted both identities (being professional and being a business owner) as he draws on conflicting values, patient benefit and profit, to guide his practices.	production. 3) He balances two conflicting identities at the drugstore.	
12	P11	S Hospital (senior OPD) and owner of a private drugstore	Used to work as a medical representative but would like to work in the public sector because it gives him more security. He prefers to work in his drugstore because there is more freedom. He also likes to talk to people. He thinks he has more time to talk to patients in his drugstore than in the hospital. He also uses business techniques to gain sales. He mentioned that being a hospital pharmacist makes his customers trust him.	1) Changing job (from medical representative to hospital pharmacist) 2) Changing contexts (from hospital to drugstore and vice versa)	1) He learned the job at the hospital by observing how people performed it. He selected good things from many people to apply to his own work. He is quite happy with his job because he is senior and people trust him. He doesn't have a problem with dealing with doctors. His son is also a doctor in the hospital. 2) Maintains both identities at his drugstore but states that the professional value is the priority.	1) Socialisation (observing how others performed role) 2) Negotiation with other professional members (using seniority as his power to gain trust) 3) Identity work (negotiating conflicting identities at his drugstore)
13	P03	T Hospital and owner of a drugstore	He wanted to quit because of lack of cooperation amongst pharmacists but he has to maintain hospital work for family security. He prefers to work at his private drugstore because he can manage tasks.	1) Daily work at the hospital He felt bored and wanted to quit. 2) Changing contexts (from hospital to drugstore)	1) He remains in his job at the hospital as it provides security for his family. 2) At his drugstore, he balances two conflicting values. He focuses on patient safety but also emphasises profit as it relates to survival of business.	1) Identity work (draws on sense of security as a reason for keeping the hospital job) 2) Identity work (negotiating conflicting identities)
14	P04	T Hospital and owner of a drugstore	He used to work as a medical representative and liked the job. He quit the medical representative job to become a hospital pharmacist in his home town because it has more	1) Changing job (from medical representative to hospital pharmacist) 2) Changing contexts (from	1) Preferred his previous job but he drew on sense of security to maintain his role at the hospital.	1) Identity work (drew on sense of security to maintain role in public hospital) 2) Identity work

			security. His parents are pharmacists and they would also like him to work in the public sector. He runs his drugstore and likes his work there because he likes to talk to people. He mentioned that the hospital job is mainly checking prescriptions behind the counter, whereas at the drugstore he has more chance to talk to and advise people.	hospital to drugstore)	2) At his drugstore, he balances both roles. He mentioned being a professional pharmacist as well as survival of business.	(negotiating conflicting identities)
15	P02	T Hospital and owner of a private drugstore	She doesn't like the work at the hospital because there is poor cooperation between pharmacists. She is bored with the job but she maintains it for family security reasons.	1) Macro role transition (from student to pharmacist) 2) Daily work Bored because of poor cooperation 3) Changing context (from hospital to drugstore)	1) She observed how others performed work. She also received feedback from her mentors 2) She maintains her hospital job because it provides her with security for her family 3) She mentioned the importance of profit in the drugstore.	1) Socialisation (observing role model, receiving feedback) 2) Identity work (drew on sense of security to maintain hospital role) 3) Identity work (negotiating conflicting identities, drew on professional value and business value)
16	P05	T Hospital and owner of a private drugstore	She mentioned a lack of cooperation in the pharmacy group. She also thought about quitting the pharmacist job to open a café selling cakes and coffee. She would like to do something more relaxing. However, she is currently a hospital pharmacist because she is unsure about quitting. She thinks it is necessary for a pharmacist rather than a non-pharmacist to run a drugstore.	1) Daily work She feels lack of motivation at work due to poor cooperation between pharmacists 2) Changing contexts (from hospital to drugstore)	1) Although she would like to do a more relaxing job, she is unsure about the road ahead. She maintains her job at the hospital because it provides security. 2) She provides professional services at her drugstore but she also mentioned profit which is necessary for the survival of the business. She learned how to work in the	1) Identity work (drew on sense of security to maintain hospital job) 2) Identity work (negotiating conflicting identities, drew on conflicting values – professional and business)

			She also mentioned using business techniques to increase sales.		drugstore using knowledge from the hospital but also read more.	
17	P20	Drugstore (employee)	Just graduated. She is interested in opening her own drugstore in the future but she would like to gain more experience before starting a business. She has never changed job. She is an employee; hence, she does not focus too much on making profit because the owner (also a pharmacist) prioritises professional service.	1) Macro role transition (from student to pharmacist) 2) Daily work (maintains professionalism but also uses business techniques to gain sales)	1) Observing how the owner of the private drugstore performed the job. Self-study (read more) 2) She also learned business techniques from her supervisor pharmacist. She practises professional roles (advising).	1) Socialisation (observing how her supervisor performed the role, receiving feedback) 2) Identity work (negotiating conflicting identities)
18	P21	Drugstore (owner)	She has never changed job. She likes working in a drugstore and likes to sell stuff and talk to people. She thinks that pharmacists are different from other businesspeople because they are also advisors and counsellors.	Daily work (maintaining professional service but also using business techniques to gain sales)	She also gives health advice to people even if they don't buy products from her drugstore. She opens her drugstore all day as there is a competitor drugstore on the opposite side of the road.	Identity work (negotiating conflicting identities, drew on conflicting values)
19	P19	Drugstore (owner)	She used to work in a private hospital and drug company (medical representative). She did not like the hospital job because of a lack of cooperation with other pharmacy colleagues. She did not like working in a drug company because she did not like the customers (doctors) who did not acknowledge her as a professional. She felt that doctors perceived her as a seller. She likes to work in a drugstore because she is in control.	1) Changing job (prefers to be in control) 2) Daily work Focuses on business but also maintains professional services, including advising and counselling.	1) She quit her previous jobs because she prefers the job at her private drugstore as it gives her freedom to manage and control her business and practice. 2) She employs business strategies, such as adding more products for patients to increase sales.	Identity work (negotiating personal identity with role identity, negotiating conflicting identity)
20	P16	RVT Hospital	She mentioned the workload at the hospital. She also mentioned	1) Daily work She mentioned dealing with	1) She maintains the job because she can do things for	1) Identity work (drew on sense of security and

			a lack of pharmacists who want to work in public hospitals because of high workloads yet low salaries compared with other types of pharmacy job.	doctors.	patients. She also believes the job provides security.	professional value to maintain the job)
21	P08	S Hospital (cytotoxic production)	She strongly identifies *"doing for other people"* as her own morality. She believes working in the public hospital allows her to do things for others. She used to run a drugstore of her own, yet she felt guilty about making profit so she closed it down. During the interview, she cried when she was talking about working for the patients. She said that she loves her profession and is proud to be a pharmacist.	1) Macro role transition (from student to pharmacist) At the beginning of her career she had to learn how to perform the role. 2) Closing down a drugstore She felt guilty about making profit out of her professional service. 3) Daily work at the hospital She feels she is suited to hospital work because she can do things for others.	Remains in the hospital and closed down her drugstore business	1) Socialisation (observing how others perform the role, and receiving feedback from her supervisor) 2) Identity work She drew on the professional value discourse to construct her identity

Chapter 5: Establishing Pharmacy Role Boundaries across Work Contexts – Negotiated Order Perspective

5.1 Introduction

In Chapter 2, the first research question was formulated as:

How do pharmacists negotiate to establish their role boundaries in the light of professional transition?

The aim of this chapter is to provide an understanding of how the pharmacists in this study negotiated their role boundaries so as to establish their professional role boundaries.

In this thesis, role boundaries are conceptualised as shared understandings of the roles of pharmacists and how these roles relate to the roles of others (for example doctors, patients). How pharmacists establish role boundaries through meaning negotiation is explored in two different work contexts: public hospital and private drugstore.

In order to investigate the first research question, the social arena concept (Renn, 1992; Jaeger et al., 2001) and negotiated order theory (Strauss et al., 1963) were employed as frameworks for analysis. In Chapter 2, it was explained that a social arena is a symbolic location of actions that impact on collective actions or policies. In a social arena, there are collective actors, that usually have conflicts, and social resources that are mobilised in negotiations to reach agreement on a particular issue (Renn, 1992; Jaeger et al., 2001). Using the social arena concept enables identification of the social arenas within which pharmacists mobilise their social resources in the negotiation of their professional identity, as well as the arena rules that facilitate or restrict pharmacists' negotiations. Together with the social arena concept, using negotiated order theory (Strauss et al., 1963) offers an understanding of how pharmacists mobilise their social resources in negotiation strategies in the social arena to constitute pharmacist–doctor relationships as well as pharmacist–patient relationships.

To accomplish the aim, this chapter provides answers to the following questions:

1. What social arenas are presented in the pharmacists' accounts?

2. Which social actors are involved in these social arenas?

3. What social resources do pharmacists mobilise in negotiations?

4. How do pharmacists mobilise their social resources in negotiation processes to establish pharmacy role boundaries as shared meanings of role–role relations with other social actors?

The chapter is presented as follows. Section 5.2 presents pharmacy role establishment in the public hospital context, which involves three social arenas. Sub-section 5.2.1 presents the first arena, in which pharmacists negotiate with doctors to establish a patient-oriented role boundary. This section identifies pharmacists and doctors as the social actors, and presents the social resources mobilised in the negotiations. Sub-section 5.2.2 then presents the second social arena, which involves pharmacists negotiating with other pharmacists to set a role boundary for the pharmacy department. This section identifies pharmacists as the social actors, and discusses the social resources mobilised in these negotiations. Lastly, sub-section 5.2.3 presents the third social arena, which involves pharmacists negotiating with nurses to claim from nursing a pharmacy role in cytotoxic production and a counselling role. This section identifies pharmacists and nurses as the social actors, and presents the social resources mobilised by pharmacists in their negotiations with nurses. The rules within these social arenas which facilitate the negotiations are also presented in these sections.

Section 5.3 provides evidence of the social arena found in the private drugstore context. This section identifies one social arena, which involves pharmacists negotiating with service users (patients and customers) to establish their role in a drugstore context. This section also discusses the social resources and the arena rule which influence negotiations.

Section 5.4 offers a comparative analysis of pharmacists' negotiations across the two different work contexts (public hospital and private drugstore). This section highlights a shift in the pharmacists' role and social resources, as well as how these determine different pharmacists' identities across contexts. Finally, Section 5.5 provides a discussion and concluding remarks.

5.2   Pharmacy Role Establishment in the Public Hospital Context

There is evidence that pharmacists successfully establish roles oriented to patient care and production in the public hospital context. Role establishment involves pharmacists negotiating with doctors and nurses. By looking at the social actors involved in the negotiations and the social resources employed by the pharmacists in negotiation processes, this section considers how the pharmacists in this study effectively established pharmacy roles within the public hospital context. It also considers the rules within the social arena which facilitated or prohibited the success of the pharmacists' negotiations.

5.2.1   Establishing a Pharmacist–Doctor Role Boundary in the Patient-Care Arena

5.2.1.1 Purpose of Negotiations

Pharmacists' establishment of a patient-oriented role has emerged as a controversial issue in healthcare services in public hospitals. In the patient-care arena, the social actors include pharmacists and doctors negotiating to reach agreement on how to treat individual patients. For example, doctors use their medical knowledge and ideology of care to decide on a treatment regimen for individual patients, while pharmacists have a role in dispensing for those regimens and counselling patients on how to apply them. However, this role–role relationship between the two professions is not straightforward. Pharmacists also get involved in negotiations with doctors when they disagree with doctors' treatment regimens. Based on the pharmaceutical ideology of care, pharmacists in public hospitals negotiate with doctors with the aim of altering doctors' regimens to ensure patient safety. It is within this patient-care arena that pharmacists negotiate with doctors to establish pharmacy's patient-oriented role boundary, which includes all the clinical activities of the pharmacy department serviced in the public hospital context.

5.2.1.2 Social Actors: Doctors and Pharmacists

In the public hospital context, doctors and pharmacists are the main social actors who negotiate to establish role–role relations in the patient-care arena. Although in any type of hospital, such as the psychiatric hospitals investigated by Strauss et al.

(1963), the social actors involved include many parties, such as nurses, patients and their families, who take part in negotiations to decide on treatment, this study finds that nurses and patients themselves do not play a crucial role in the negotiation of treatment. According to the pharmacists' accounts, nurses do not play a significant role in influencing patient treatment. Instead, they only do their part, which is to administer prescribed drugs to patients. A pharmacist described the role of nurses in the inpatient ward:

> *When it comes to drugs, nurses think that it's not their responsibility, it's the pharmacists' responsibility. They will not question the choice of drugs or doses. Once drugs arrive on the ward, they think pharmacists have already checked those drugs so they only have to administer drugs to patients* (P14).

Similarly to nurses, patients in the public hospital context also do not play a role in influencing doctors' treatment decisions. With regard to the role of patients in public hospitals, the pharmacists in this study perceived their patients as passive recipients of treatment decisions; that is, patients are not involved in the negotiation of their own treatment. It is arguable that, on some occasions, patients may play an active role in negotiating with doctors over their treatment choices because they may try to alter doctors' decisions based on their beliefs or word-of-mouth information. Nevertheless, in this study, patients and their families acted as passive recipients who received and accepted the decisions of doctors. A pharmacist explained that:

> *In Thailand, many patients I found in the hospital do not have knowledge about their diseases and drugs* (P14).

Another pharmacist who works full-time in a public hospital and operates a private drugstore in her spare time also clarified this point:

> *Patients in different work contexts are dissimilar. Patients who visit public hospitals will accept and receive the decisions of doctors' treatment, whereas those who come to my drugstore sometimes have decided on the drugs they want* (P01).

She further explained that:

This is because patients who visit public hospitals are funded for their drug costs and doctors' fees, so they can't request the drugs they want. But patients at the drugstore buy drugs with their own money, so they request the drugs they want. I think patients in private hospitals are also different from patients in a public hospital. Patients who visit private hospitals also have money to spend on drugs and they pay for their drugs with their own money (P01).

The pharmacists' accounts explain the different roles of patients in different types of work context, including public hospitals, private hospitals and private drugstores. The roles of patients in different contexts are differentiated due to differences in spending power (and possibly also knowledge power) in the extent to which they can influence treatment decisions themselves. In private work contexts, including private hospitals and private drugstores, patients have spending power and possibly better knowledge of drugs and diseases, thus their role becomes that of a customer buying healthcare services and drugs.

On the other hand, the drug choices of patients in a public hospital context, whose healthcare costs are government-funded, are restricted to those on the national drugs list, so they become passive recipients of treatment decisions. This clearly distinguishes the roles of patients in different contexts and demonstrates that the role of patients in a public hospital is passive and hence they do not influence treatment decisions. Thus, doctors and pharmacists are the only two social actors involved in negotiations to specify roles in patient-oriented care.

5.2.1.3 Social Resources and Mobilisation

The next task is to identify the social resources that doctors and pharmacists mobilise to reach agreement on patient treatment in the patient-care arena.

In the previous chapter, it was seen that doctors are the dominant professional group, with the greatest power to decide on patient treatment, while pharmacists are subordinate to this power. Doctors thus have exclusive clinical autonomy to make treatment decisions for their patients.

Nevertheless, although pharmacists do not have the same clinical autonomy as doctors, they are still able to influence doctors' treatment decisions and to offer

alternative treatments by mobilising social resources that are available in negotiation processes. Using the social arena concept, this chapter categorises these social resources as: a) pharmaceutical knowledge and skills, b) communication skills, c) power, d) trust, and e) professional values.

a) Pharmaceutical Knowledge and Skills

The exclusive knowledge and skills attributable to the pharmacy profession are regarded as powerful social resources that result in successful negotiation. The respondents reported that successful negotiation by pharmacists to establish a role in patient treatment occurs when pharmacists are able to draw on an area of knowledge that doctors do not know about. Accordingly, pharmacists also gain acceptance and acknowledgement from doctors of their role and contribution vis-à-vis patient treatment. A pharmacist explained that:

> *When pharmacists go to the ward, they are keen to use clinical knowledge about diseases and drugs of choice to check whether or not patients are receiving drugs according to treatment guidelines. But that is the doctors' role. If we talk with doctors about diseases and drugs of choice, doctors won't listen to us because we are doing the same thing as them. So we have to talk about knowledge they don't have. If they see that we can help them in treating patients, they will accept our role* (P14).

Knowledge and skills in drugs preparation are necessary for pharmacists' work in public hospitals. This knowledge includes drug compatibility and stability, dosages and routes of administration. For example, the respondents explained that doctors want pharmacists to be able to prepare drugs in a form specific to individual patients. For example:

> *Doctors want to know whether we* [pharmacists] *can prepare drugs for intravenous injections or not because they want to use them but they are unable to mix them. They have clinical knowledge but they don't know about products and drug compatibility. And I think this is knowledge that pharmacists need to use in a hospital* (P14).

Another pharmacist commented:

What doctors don't know are routes of drug administration, or the pharmacokinetics of drugs. For example, a doctor wants to order Dilantin but he does not know whether Dilantin can be administered through a feeding tube or not, or if it can be administered by intravenous injection. We [pharmacists] *have knowledge of routes of drug administration but we don't use this knowledge at work* (P12).

And:

Pharmacists' knowledge of dosage forms and about the stability of medicines is better than anyone else's. This knowledge is one of the areas that we cover which doctors and nurses don't. This is an area of pharmaceutical knowledge. Doctors and nurses don't know about this (P12).

The above excerpts indicate that product-oriented knowledge, including knowledge about chemical substances, drug compatibility and stability and drug administration, is viewed as mysterious and exclusive to the pharmacy profession.

Although the role of the pharmacy profession in the hospital context is moving towards patient-oriented practice, the respondents pointed out that product-based knowledge and skills remain an important area of knowledge that other professions expect the pharmacy profession to have. Being able to offer this product-oriented knowledge and these skills at work results in pharmacists gaining acceptance by doctors for being involved in the patient care team and acknowledgement of their professional identity.

The above example covers a role established by employing product-oriented knowledge of the pharmacy profession. The next example illustrates pharmacists' role establishment using clinical pharmacy knowledge. The establishment of a role in clinical-oriented practice is evidenced as being more difficult for pharmacists. This is because the medical profession has traditionally occupied clinical boundaries, and clinical autonomy is exclusive to the medical profession. Pharmacists' expansion of their role into a clinical setting often leads to boundary conflicts (Eaton and Webb, 1979; Mesler, 1991; Hughes and McCann, 2003).

In this study, it is evidenced that pharmacists are able to establish their role in patient-oriented practice if they offer areas of clinical pharmaceutical knowledge which the medical profession does not have. These areas of knowledge include knowledge of pharmacokinetics, adverse drug reactions and drug interactions. By providing doctors with knowledge about pharmacokinetics, pharmacists become involved in patients' treatment by monitoring and adjusting doses for individual patients, monitoring adverse drug reactions and recommending alternative drugs for specific patients. Hence, pharmacists can make claims for a role in patient treatment. One respondent stated:

> *Pharmacists can help doctors in total drug monitoring (TDM); we know how to adjust drug dosage for specific patients. This is what doctors don't know* (P12).

There is also evidence that pharmacists gain acceptance for their role in patient care when they detect adverse drug reactions. A respondent explained:

> *Once there was a case where a patient was diagnosed as having Sweet's syndrome. Pharmacists in the ward reviewed medical papers indicating that Sweet's syndrome could be caused by the disease itself as well as from the side-effects of the medicine. Then we informed the doctor about the side-effects of the medicine. The doctor stopped the medicine and the patient recovered. So, from that point on, the doctors complimented us as pharmacists who can detect adverse drug reactions, and they acknowledged that we can help in patient treatment* (P12).

Using their knowledge of drug pharmacokinetics, adverse drug reactions and drug interactions, pharmacists can help doctors when it comes to adjusting dosages or changing to alternative drugs for specific patients. Consequently, pharmacists can establish their role in clinical-oriented practice.

In summary, in order to establish a role for pharmacy in a public hospital context, pharmacists should employ their unique knowledge of product-oriented practice to help doctors in preparing or adjusting drug dosage forms for individual patient treatment. Knowledge associated with a product orientation includes knowledge about drugs, their compatibility and stability and routes of drug administration.

Regarding role establishment using clinical knowledge, this study finds that pharmacists can use their knowledge of pharmacokinetics, adverse drug reactions and drug interactions to help doctors choose alternative drugs, monitor adverse drug reactions and adjust doses of drugs for individual patients. By offering these areas of product-oriented and clinical knowledge, pharmacists gain acceptance of their role from doctors. Consequently, they successfully establish the pharmacy role in the patient care arena.

b) Communication Skills

Pharmacists' role in checking prescriptions often causes conflict between the medical and pharmaceutical professions because doctors may perceive that pharmacists are impinging on their role. Such conflict was confirmed by respondents in this study. This is because diagnosis is the role of and autonomous to the medical profession; hence, pharmacists adopting a medical role and impinging on autonomy results in boundary encroachment. For example:

> *When I first contacted one doctor, she was not happy. She asked me why she can't order this drug when it is in use in Western countries* (P13).

Or:

> *Sometimes doctors say to us, when we make contact, "So I can't order anything?"* (P14)

Despite the perceived conflict from undertaking the checking role, the respondents viewed the pharmacist's role of checking as necessary to reduce prescription errors, which in turn increases patient safety. A respondent explained the valuable contribution of the checking role of pharmacists in hospitals:

> *Some doctors think that they can use an auto-dispensing machine instead of pharmacists. Well, I wonder if the machine can detect prescription errors? If it can, then please order the machine quickly because we* [pharmacists] *have already got a big workload, so I would be happy to have a machine to reduce my work. But I have been working in the hospital since the beginning, and I have seen there are*

prescription errors. That is why pharmacists need to check doctors' orders (P12*).*

All respondents regarded communication skills as key to avoiding conflict between the medical and pharmaceutical professions. Communication skills were seen as a crucial social resource that the respondents used when they wanted to suggest replacements for drugs that doctors had already prescribed.

As already discussed, pharmacists position themselves lower in the hierarchy than doctors because they do not have clinical autonomy in prescribing; but pharmacists can still win in negotiations and alter doctors' prescriptions by exercising good communication in the negotiation process. As a pharmacist explained:

We need good communication skills. We should know how to consult doctors and not to make them feel angry. For me, I would rather have a face-to-face discussion than write a note because anybody can see a written note. It seems like I'm pointing out their mistakes in public. And also, when you speak face to face, the other person knows the tone of your voice (P06).

Another pharmacist commented:

Communication is the key. Working as a team, we have to start by building a good relationship with them. When there is an error, we are not going to blame or make a judgement about their profession [medicine]*; rather, we should discuss and find out how to prevent mistakes. We should respect each other's professions. We should communicate with them politely. We have to find a nice way to talk to them, and listen to them as well* (P07).

The respondents mentioned that exercising good communication skills will avoid conflict and save the face of doctors. By doing so, they are able not only to alter doctors' prescriptions but also to create working relationships between the medical and pharmaceutical professions. Accordingly, the role–role relationship whereby doctors prescribe and pharmacists check prescriptions and dispense them can be agreed between doctors and pharmacists.

The respondents saw it as necessary that pharmacists communicate to make doctors aware that the checking role of pharmacists exists, not because pharmacists wish to challenge doctors' knowledge, but in order to help doctors reduce errors and increase patient safety. A pharmacist stated:

> *We* [pharmacists] *are not going to make them* [doctors] *feel that we are watching them attentively for mistakes. We are not going to make them feel they are being challenged about their knowledge* (P11).

Communication skills are therefore a resource that pharmacists deploy in delivering pharmaceutical knowledge, in their checking prescriptions role, in a polite and respectful way in order to avoid boundary conflicts with doctors, who have greater power in clinical autonomy. Mobilising good communication skills leads to successful negotiations and creates good collaboration. Consequently, pharmacists are able to build role–role relations with doctors, which results in successful role establishment for the pharmacy profession in the patient-care arena.

c) Power

Power comes with status or seniority. Power is demonstrated and seen as a useful social resource that pharmacists use to influence negotiations in a relatively large hospital, such as a medical school or a regional hospital where there are many doctors with different specialities and skills. A pharmacist said:

> *Conflict occurs when we* [pharmacists] *contact the residents. They are doctors, and if we advise them about their prescriptions they think we are interfering in their job* (P13).

In this case, a pharmacist who does not know a resident doctor well will contact a senior doctor who supervises the resident. The senior doctor will know the pharmacist, having previous worked together, and will know the intention of the pharmacist's intervention. The senior doctor will also have built up trust with the pharmacist through previous work relationships, and hence will advise the resident to change the regimen.

Pharmacists may not only use a senior doctor as a medium or person to contact; they may also use a senior pharmacist to confront doctors. An interview with the head of the outpatient department demonstrated this:

> *Doctors know me well because I am the head of pharmacy, so they see me in meetings. As a senior pharmacist, I have to contact doctors often. Sometimes I contact them not because of drug interactions or mistakes in their regimens but about using expensive medicines. Controlling medicine costs is important: if a doctor prescribes expensive medicine for a patient on a universal coverage scheme, we have to inform the doctor that the hospital will have to pay for it. Normally they* [doctors] *listen to me because I am old.* (laughing) *I mean, I am the senior one* (P11).

Therefore, it can be summarised that power is an influential resource that pharmacists exercise in negotiation processes. Pharmacists may contact a senior doctor with a supervisory role over junior doctors, or they may ask a senior pharmacist to contact the doctor. This social resource and strategy were also observed in a study by Strauss et al. (1963), in which nurses made contact with higher-ranked administrative staff to help in negotiations with newcomer residents.

d) Trust

Trust is identified as a dominant social resource that influences the success of negotiations. The respondents stated the need for trust between the medical and pharmaceutical professions. For example, a pharmacist pointed out a problem of lack of trust at her hospital, which had led to a situation in which doctors did not trust pharmacists and their knowledge, and gave less acknowledgement to the pharmacist's role. The senior pharmacist explained this situation:

> *In this hospital, we have a problem of trust between doctors and pharmacists. I think there have been errors by the pharmacy department. Most of them were mistakes by newly-graduated pharmacists. So the doctors lack trust in us* (P01).

On the other hand, a respondent from another hospital demonstrated that having trust leads to good collaboration between the two professions. For example:

I think, in this hospital, we have trust. Doctors know why we do our job, and we also understand the doctors. We have the same aim, which is to help patients. So when there is an error, everyone knows that we try to find out why the error occurred so that we can prevent it, not because we want to blame the person or the profession (P08).

As previously demonstrated, there is evidence that pharmacists gain trust from doctors when doctors acknowledge pharmacists' pharmaceutical knowledge and its contribution to patient care. This leads to the successful establishment of the pharmacist's role. Hence, trust is achieved through multiple means, including pharmaceutical knowledge, power through status and seniority, and politeness and good communication when making contact with a doctor.

Offering pharmaceutical knowledge to help doctors in areas with which they are unfamiliar, such as helping them adjust drug doses or monitor adverse drug reactions of individual patients, also creates a good reputation for pharmacists because doctors then acknowledge pharmacists' knowledge and contribution. The status of pharmacists also helps pharmacists to gain trust, because being in a senior position with many years of experience also leads to being respected and trusted. Trust is also built if pharmacists conduct themselves in an appropriate way. Communicating knowledge and counselling in a polite way thus also generates trust.

In conclusion, trust acts as a social resource in pharmacists' negotiations. However, trust is generated by mobilising other social resources, including pharmaceutical knowledge, power (seniority) and communication skills.

e) Professional Values: Being Patient-Centred

Pharmacists in the public hospital context strongly identified their professional goal or ultimate outcome as *patient safety*. For example:

Our ultimate goal is patient welfare. I am a pharmacist, I have knowledge and I can contribute my knowledge to others (P08).

Another emphasised patient safety as the key outcome of pharmaceutical practice:

Pharmacists aim for patient welfare first. We ensure that patients are safe in drugs use. I think patient safety is at the heart of pharmacy practice (P09).

Or:

The value of our profession is what we can do for the patients (P12).

Another added:

The value of our profession is to ensure that patients are safe in drugs use. I think we [pharmacists] *should care for our patients, and use our knowledge to ensure their safety. Patients are at the centre of our practice* (P06).

Their practices are guided by this professional value of being patient-centred. For example, the respondents are concerned about patient safety, hence they carefully check doctors' prescriptions with the aim of reducing prescription errors, consequently promoting patient safety.

Committing to a professional value – being patient-oriented – is the key reason that pharmacists undertake their role carefully and make several attempts to negotiate with doctors when they find prescription errors. The respondents also acknowledged that patients' safety in drugs use is their responsibility, because they are the ones who hand the drugs to patients. They have an opportunity to prevent harm from drugs use. For instance, two respondents stated:

I think our role is to make sure that patients are safe. We check the prescriptions before dispensing and we also have to provide counselling to patients to ensure they know how to use their medicine. If the patients are harmed because of medication errors, it is our responsibility, not the doctors', because we are the people who give the medicine to the patients (P14).

And:

I think pharmacists should pay a lot of attention to patient safety. If we are not sure about a prescription, we should consult the doctor. We

can't let patients go home if we see a possible risk from drugs use. Patients should be safe with the drugs that we dispense (P13).

... if we are not sure about the prescription we have to consult the doctor. We can't let the patient go home if we see a risk from drugs use (P13).

Thus far, it has clearly been demonstrated that pharmacists view patient safety as their main goal of practice, and their professional value as being patient-centred. With commitment to this professional value, pharmacists always deliver their services and make continued efforts to negotiate with doctors in order to ensure that patients are safe in drugs use. This professional value is thus a social resource to which pharmacists commit when performing the role of pharmacist.

To recap, this section has identified the social resources mobilised by pharmacists in negotiations in a public hospital setting to establish their role boundaries regarding patient treatment. A summary of social resources and how pharmacists use them in negotiations is provided in Table 5, below.

Table 5: Pharmacists' social resources and negotiation strategies in public hospitals

No.	Social Resource	Negotiation Strategies
a	Pharmaceutical Knowledge: Product-oriented knowledge and skills (knowledge about drugs compatibility, stability, dosages and forms, routes of drug administration), knowledge of pharmacokinetics, adverse drug reactions and drug interactions.	• Offering pharmaceutical knowledge, meaning doctors do not have to help them mix drugs for individual cases. • Performing total drug monitoring (TDM) and adjusting drug doses for individual cases. • Recommending alternative drugs when needed (e.g. when there is an adverse drug reaction or interaction).
b	Communication Skills	Contacting doctors with politeness and appropriateness (being aware of face-saving).
c	Power	Using a person with more power (supervisor or senior) as a medium to contact doctors.
d	Trust	Building trust with doctors in order to gain acknowledgement of pharmacists' role and role contributions.
e	Professional Value (being patient-centred)	Committing to professional values.

It is also worth noting that, occasionally, a single strategy leads to gaining trust and role acknowledgement, as in the previously-mentioned Sweet's syndrome case when a group of pharmacists was able to detect the adverse side-effects of a drug, following which doctors acknowledged the knowledge and role of pharmacists and their contribution to patient treatment. However, in most cases evidenced in this study, successful role establishment occurs through the use of multiple strategies and continuous negotiations by various pharmacists to produce a synergistic effect.

5.2.1.4 Arena Rule: Hospital Accreditation Programme

The Hospital Accreditation (HA) Programme is found to be a rule which facilitates pharmacists in pharmacist–doctor role negotiations in the patient care arena. The HA programme, first introduced in the United States over 70 years ago, is a policy that aims to standardise the quality of hospitals. Thailand began a pilot phase of policy implementation in 1997 in some hospitals. It has now become a compulsory programme that applies nationally at all levels. All hospitals in the public and private sectors are required to register with the Healthcare Accreditation Institute, the public organisation responsible for accreditation and quality control.

The respondents identified two reasons why the HA programme facilitates their role establishment in the hospital context. Firstly, it clearly states the roles of all professions, including medicine, nursing and pharmacy. Secondly, the policy specifies a multidisciplinary teamwork concept for patient treatment, in which pharmacists are also responsible for delivering patient-focused practice. Thus, doctors have started to become aware of pharmacists' role in hospitals. A respondent explained how HA implementation in her hospital led to the formal establishment of a counselling clinic. She said:

> *Around 2003, my hospital started to implement HA, so pharmacy services became more formalised. Following HA implementation, we* [the pharmacy department] *started a counselling clinic to counsel HIV patients and patients who received inhalers* (P06).

She continued:

We have also become involved in patient care. Our role is within the medication management system. We have created management systems for high alert drugs and one-day dose drugs (P06).

It is seen that within this pharmacist's hospital doctors became aware of the pharmacists' role as specified by the HA programme. Thus, the HA programme has played an important role in setting a boundary for pharmacists' roles within this hospital. Nevertheless, it is evident that, in most hospitals, the HA programme alone has not been effective. It requires pharmacists to mobilise their social resources through negotiations in order to gain acceptance from doctors, consequently establishing the pharmacy role boundary.

5.2.2 Establishing a Pharmacy Role: Pharmacist–Pharmacist Role Negotiation

The data show that pharmacists must not only negotiate with other professions to stake a claim for and establish their role boundaries; they must also negotiate successfully with groups of pharmacy members to obtain cooperation.

The pharmacists' accounts reveal that pharmacists' roles in the hospital context are wide-ranging and span both product-oriented and patient-oriented practice. Most pharmacists prefer to play a particular role rather than take on another role. For example, some pharmacists stated their preference for a product-oriented rather than a patient-oriented role. One pharmacist mentioned that she prefers to have a product-oriented role and does not like to do patient counselling because she does not like personal interactions:

Personally, I like to have a product-oriented role because I don't like talking to people (P13).

Since there are many roles for pharmacists in the hospital context, some pharmacists do not cooperate to provide services for some tasks, especially tasks that they dislike or where they are uncertain about the skills required. Moreover, some pharmacists do not want to take on a role which they perceive as carrying a high risk to their health, such as tuberculosis and HIV patient counselling and

cytotoxic drugs preparation. A pharmacist who works in the cytotoxic drugs preparation unit explained:

> *Not many pharmacists want to do cytotoxic production because they are scared of drugs contamination. Actually, some of them don't even want to step into this room* (P13).

Another pharmacist mentioned the counselling role as something that his colleagues often refuse to do:

> *I think TB and HIV clinics are the two clinics that pharmacists do not want to work in. This is perhaps because of their attitudes towards the diseases and they may perceive there is a risk to their health* (P03).

In addition, the respondents revealed that some pharmacists refuse to work in counselling clinics because of the workload since they receive a fixed salary:

> *Counselling is definitely a pharmacist's role. But some pharmacists don't want to do it because they think a counselling clinic adds to their workload. They just want to be behind the counter and check prescriptions* (P14).

Thus, this section highlights pharmacist–pharmacist role negotiations in defining the pharmacy role as the second social arena, or area of conflict, in the public hospital context.

5.2.2.1 Purpose of Negotiations

The purpose of pharmacist–pharmacist negotiations is to reach agreement on activities within the pharmacy department, as well as to divide tasks between and allocate them to staff members. Consequently, successful negotiations between pharmacists lead to smooth service delivery by the pharmacy.

5.2.2.2 Social Actors

The pharmacists are the social actors involved in deciding roles in the pharmacy department. Two occasions for negotiations are found in the empirical data: firstly, when pharmacists negotiate with a pharmaceutical supervisor; and secondly, when pharmacists negotiate with their pharmaceutical colleagues.

a)   Power

Power is demonstrated most powerfully in negotiations to reach agreements on task allocation. Pharmacists can determine a task in a pharmacy department if they can influence the pharmacy supervisor's decision. Pharmacy supervisors are those with the greatest power among pharmacists. They can mobilise this power, in their role as head of department, to allocate supervisees to deliver certain tasks.

There is evidence that a pharmacist may influence a supervisor to allocate other pharmacists to provide counselling services in patient clinics. According to one pharmacist, there was poor cooperation between other pharmacists regarding the provision of a counselling service at the clinic in his hospital due to the workload and fixed salary. For him, counselling is a pharmacy role. Hence, he started to offer counselling to patients himself. However, when he moved to work in the inpatient department where he did not have to dispense prescriptions to patients, he stopped this role because he did not have direct contact with patients. Thus, the counselling clinic also stopped.

However, his supervisor saw the counselling service as evidence of good performance for the pharmacy department. Hence, he wanted the respondent to restart the counselling clinic. The respondent then negotiated with his supervisor and asked him to allocate some pharmacists to help in that clinic. In the end, the pharmacist was able to establish a counselling clinic because his supervisor set up a formal clinic using his power as head of the pharmacy department. Hence, the counselling clinic was run within the pharmacy's boundaries. The head of department used a rotation rule to allocate pharmacists to providing the service in the clinic:

> *I was the only one who counselled patients. Other pharmacists did not want to do that because they thought running the clinic would add extra workload, while they only get paid the same. But as I said, this* [counselling] *is our responsibility or we have not fulfilled our role. I didn't care that other pharmacists were against me. I just did my job* (P14).

And as he further explained:

When I moved from the outpatient department to work in the inpatient department, the counselling clinic also stopped because no one took it over. But after a couple of years I came back to work in the outpatient department, and so I started the clinic again. And again, when I moved back to the inpatient department, the clinic stopped again. Later, when I rotated back to the outpatient department, my boss told me that the clinic was good because we [pharmacy department] *could identify medication errors in prescriptions, so this time he wanted me to run the clinic again. I told him that if the clinic had to stop again because there was no one to offer the service, I wouldn't do it. So the boss started to establish a clinic and use rotation to allocate other pharmacists to provide service in the clinic* (P14).

From his narrative, we can see that he could not force other pharmacists to work because he had the same positional status and the same power as the other pharmacists. However, he was able to set the rule and practice of his group by proving that his service brought good outcomes, and then negotiating with his supervisor, a person with more power. The supervisor then used his power to set a rule and force group members to rotate and work in the clinic. In the end, this pharmacy department succeeded in establishing a counselling clinic. This case also illustrates that negotiations brought about a big impact in the arena, because they led to establishing a new arena rule.

b) Professional Values

Commitment to professional values is viewed as a factor which leads to pharmacists' success in negotiations. In the above example, the pharmacist focused on patient benefits and safety; hence, he continued to offer counselling, even though he did not receive an increase in salary for this service or cooperation from his colleagues at the beginning. His commitment to professional values brought good outcomes to the pharmacy department, as evidenced by reduced cases of adverse drug reactions.

In summary, within pharmacist–pharmacist negotiations, it is found that pharmacists use resources including the power of a supervisor and professional values to win negotiations.

Table 6: Summary of social resources and negotiation strategies in pharmacist–pharmacist negotiations

No.	Social Resource	Negotiation Strategies
1	Power	Negotiating with pharmacist supervisor and influencing supervisor to use his power in setting a rule.
2	Value	Committing to the professional value.

5.2.2.4 Arena Rule: Rotation Policy

A rotation policy is seen as an arena rule. It is a rule which a pharmacy department uses to operate its own services, and is considered to be a formal rule within the pharmacy departments of many hospitals in this study. The head of the pharmacy department is the ultimate decision maker who sets this rule, and the pharmacists, as members of the group, abide by it.

A rotation policy is used to allocate pharmacists to different tasks within pharmacy role boundaries, including the inpatient department, outpatient department and production unit. The underlying reason for this policy implementation is the shortage of pharmacy staff in most public hospitals in Thailand. Consequently, it is not always possible for pharmacists to be assigned to the unit that they prefer. Instead, some pharmacists are sent to work in a unit that they do not like, or for which they are uncertain about the adequacy of their skills. Hence, the pharmacy department has to use a rule to make every pharmacist rotate through every unit every two to three years. For example, one pharmacist (P14) was allocated to work in the outpatient unit for three years, after which he was allocated to work in the inpatient department.

The use of rotation also produces pharmacists who can replace each other in case of staff absences.

It was found that a rotation policy is employed by the pharmacy departments of most public hospitals in this study, except for two hospitals (Hospital R and Hospital S), a medical school and a regional hospital respectively. The common

characteristics of these two hospitals are that they are relatively large hospitals with high demands from services users.

A respondent from one of these hospitals explained that the reason why they do not employ a rotation policy is that they have more pharmacists for each service than other hospitals, although the respondent's view was that pharmacists still have a considerable workload because service-user requirements are extensive. Therefore, the pharmacy departments in both hospitals are able to assign pharmacists more permanently to each service unit. She also felt that leaving pharmacists in a particular unit may help provide effective services because there are fixed pharmacists who become experts in their job:

> *The thing is, we need to have someone who has expertise in the task.*
> *For example, in cytotoxic preparation, we need to have senior*
> *pharmacists who can prepare drugs for patients as well as train new*
> *pharmacists to help in the unit* (P13).

5.2.3 Establishing a Cytotoxic Production Role and a Counselling Role: Pharmacist–Nurse Negotiations

5.2.3.1 Purpose of Negotiations

Negotiations between pharmacists and nurses were evident in a public hospital (Hospital S). A respondent explained how the pharmacy department at her hospital successfully claimed cytotoxic production and counselling roles from the nursing profession, which resulted in successful role expansion.

She said that originally nurses prepared cytotoxic drugs for patients, until 2003 when the HA policy began. The HA policy states that dosage preparation, especially of dangerous substances, is the pharmacists' responsibility. However, the problem was that nurses and doctors did not acknowledge pharmacists' knowledge and skills; hence, the pharmacists employed a strategy to gain trust from other professions.

Negotiations were also conducted between nurses and pharmacists in order for pharmacists to expand their role into patient counselling and gain recognition for

their expertise from nurses and doctors. Similarly to cytotoxic preparation, counselling was delivered by nurses in the past. However, nowadays counselling is regarded as a role of the pharmacy department.

The purpose of negotiations between nurses and pharmacists was to establish a role in cytotoxic production as well as to gain recognition of pharmacy knowledge.

5.2.3.2 Social Actors

Social actors include pharmacists and nurses. In the past, nurses provided counselling and prepared cytotoxic drugs for patients, while pharmacists mainly worked behind the counter, just checking drugs and dispensing them to patients.

5.2.3.3 Social Resources and Mobilisation

a)   Product-Oriented Knowledge and Aseptic Techniques

A respondent explained that the strategy of the pharmacy department to gain acknowledgement of pharmacists' value in cytotoxic production was to make nurses aware of the risks to health if drugs were prepared by unskilled persons.

> *I think that in order to make other professions realise that we* [pharmacists] *are needed to fulfil this role, we needed to make them aware of the risks if they didn't have the necessary skills. We did this by inviting a professor from a pharmacy university to talk about good practice in manufacturing, and we invited doctors and nurses to attend this seminar too. Then they* [doctors and nurses] *started to see that the production side should be handled only by pharmacists* (P07).

This strategy led to a successful request for a production room to be established for the pharmacy department to handle production services as well:

> *They* [doctors who are administrators] *see the importance of why our hospital needs a room specifically for drugs production. They do not want to risk their lives from drugs contamination. They also have a better attitude to us because they think that we help them reduce such risk. This is one of the tricks. We needed to make them realise and see*

our value first. So after that seminar, they asked us: "When will you
start a production line? Please open one soon!" (P07)

5.2.3.4 Arena Rule: Hospital-Accredited Programme

In nurse and pharmacy negotiations, the arena rule also concerns the HA
programme, because it defines the role of pharmacists as being associated with
drugs preparation. Hence, HA policy is seen as a supporting factor for role
expansion into production.

5.2.3.5 Structural Context: Workload as a Supporting Factor in Pharmacy Role Establishment

It is also evidenced that the workload within public hospitals contributes to nurses
giving up the role of counselling to pharmacists. This is evidenced in the
pharmacists making a claim for a counselling role:

> *The role of pharmacists now includes counselling. This is a change. In*
> *the past, pharmacists only checked prescriptions and the people who*
> *dispensed to patients were our assistants* (P11).

This pharmacist explained that the work of pharmacists at that time typically
involved working behind the counter and having less contact with patients. The
pharmacists mainly worked on checking prescriptions. He explained that this was
because there were not enough pharmacists in the past, and because there has been
a shift in the paradigm of pharmacy practice towards patient-oriented practice:

> *In the past, there was only one pharmacist, so it was just my assistants*
> *and I. Now we can do more work because we have more pharmacists in*
> *our hospital. And yes, there is also a trend for pharmacists to do*
> *counselling and focus our practice on patients* (P11).

It was also found that nurses were willing to hand over the counselling service to
pharmacists:

> *In the past, nurses were the people who counselled patients in how to*
> *use drugs, dosage forms, e.g. insulin injections and the use of inhalers.*
> *So patients came to receive their drugs at the pharmacy department, but*
> *they went to see nurses. Nurses then counselled the patients about their*

drugs. Now, it's our role. And nurses were also willing to give this task
to us because it can reduce the weight on their shoulders (P11).

In summary, pharmacists' claims for roles in cytotoxic preparation and patient counselling involved two main social actors: pharmacists and nurses. In the past, these roles were played by nurses, until 2005 when the HA policy defined pharmacists' role as including drugs preparation and being associated with patient-oriented practice, such as patient counselling. Hence, HA policy is an arena rule which controls the actions of social actors. HA policy is also seen as a facilitating factor which has assisted pharmacists in successful role expansion. However, the pharmacists' negotiations were conducted in order to gain recognition of their knowledge and role contribution from other professions. To do this, pharmacists used their knowledge of production and aseptic techniques in their negotiation strategies.

The heavy workloads of public hospitals are also seen as a supporting factor which facilitated the role expansion of pharmacists, as nurses were willing to hand over that work to pharmacists.

Figure 7 illustrates the establishment of a pharmacy role boundary within the public hospital context

Figure 7:   *Establishment of a pharmacy role boundary in the Public Hospital*
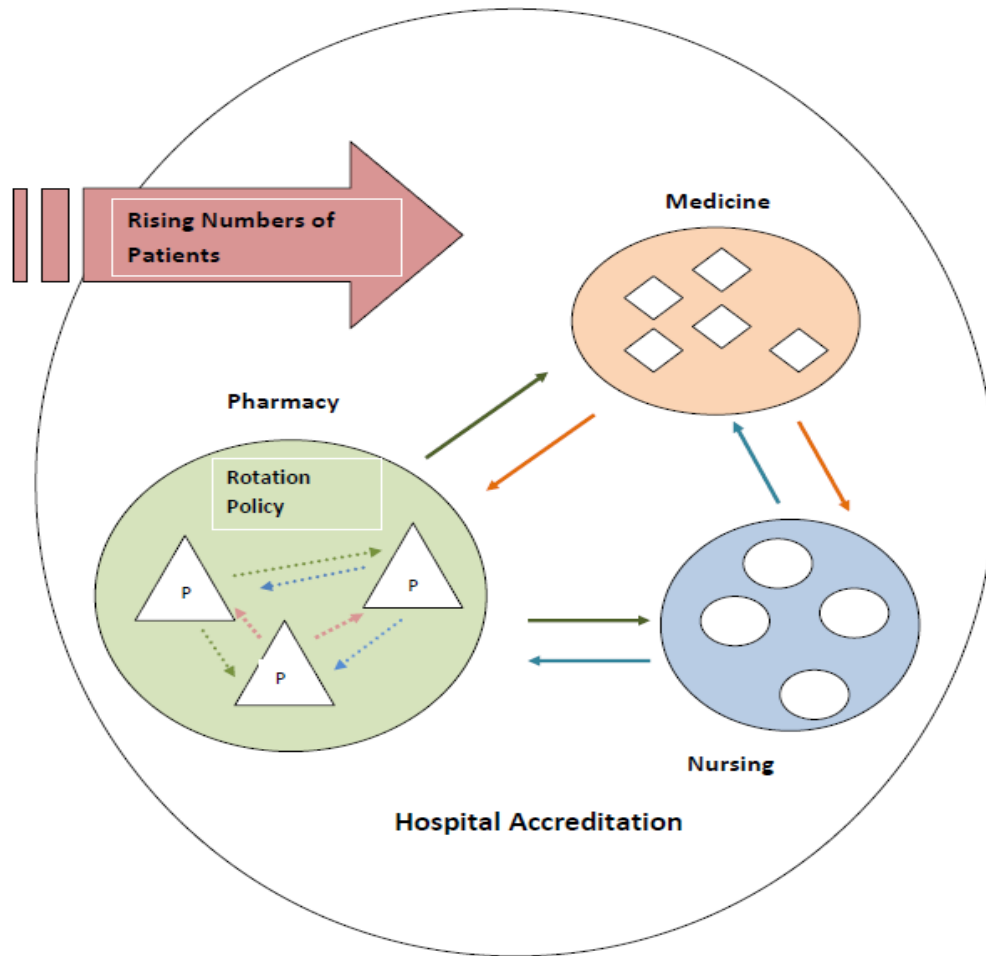
According to figure 7, in the public hospital context, pharmacists negotiate with doctors and nurses, as well as amongst themselves to find an agreement on setting a role boundary of their profession. Hospital accreditation is seen as the arena rule which facilitates pharmacists negotiations. Rising numbers of patients is also viewed as a supporting factor which helps pharmacists expanding role boundary, as nurses also willing to give up counselling role and preparation role to pharmacists.

This section has provided the social arenas as presented in the public hospital context. Subsequently, section 5.3 offers the social arena as evidenced in the private drugstore context.

5.3 Patient Care Arena in a Private Drugstore Context

5.3.1 Pharmacist–Service User Negotiations

This section presents the findings from a negotiated order perspective (Strauss et al., 1963) within a social arena framework (Renn, 1992; Jaeger et al., 2001) to examine how pharmacists who work in the commercial environment of private drugstores establish a role in the patient care arena.

Like those who work in public hospitals, pharmacists in private drugstores have to negotiate to reach an agreement on how to provide patient care for individual patients. However, the elements in the patient care arena are different from those of public hospitals regarding social actors, power and the social resources which social actors mobilise in the process of negotiations. As a result, these have led to the construction of a different identity for pharmacists in this commercial context.

This section identifies patients in private drugstores as *customers* who use their purchasing power to request the drugs they want. Drug misuse and abuse are common problems in the commercial environment, especially in Thailand, where drugstores are privately owned and separate from the healthcare system.

It is found that pharmacists have two conflicting values that guide pharmacy practice in this commercial environment: patient safety and profit. The findings demonstrate how pharmacists negotiate their dual role boundaries in terms of professional and business personas. It is concluded that pharmacists' identity construction shifts in different situations. When pharmacists perceive a high risk to patient health, they draw on the value of patient safety, construct their identity as a professional, and deliver their service in an ethical manner. On the other hand, in a situation where potential risk to patient health is low or absent, pharmacists employ a profit value to construct their identity, their work is guided by their practice as a businessperson, and they use business techniques to increase sales.

The patient care arena in private drugstores is different from that found in public hospitals. The patient treatment arena in a private drugstore setting involves two main actors when negotiating treatment: firstly, the pharmacist as the sole professional who delivers a professional service; and secondly, service users who can also influence decisions about their own treatment.

While in public hospitals pharmacists' challenge is to negotiate with doctors who have exclusive power over prescribing, the challenge for pharmacists in private drugstores is to negotiate with patients who do not have professional knowledge but do have purchasing power to influence pharmacists' decisions. The term "patients" is used to refer to service users in public hospitals, whereas pharmacists in drugstores perceive their service users as "customers". Pharmacists in private drugstores commonly find that consumers with greater purchasing power request drugs or substances for abusive purposes. A pharmacist described a situation in which she would not sell drugs to her customers because she assumed that they would use them for abusive purposes:

> *When I won't sell the drugs they* [customers] *want, they tell me that they*
> *can buy the drugs from other drugstores* (P12).

Her account reflects the competitive nature of the drugstore business. When a pharmacist refuses to sell drugs, customers can turn to another drugstore which may not be owned by a pharmacist.

Another challenge experienced by pharmacists in private drugstores is changing patients' beliefs. A number of patients who come to community drugstores have their own beliefs about diseases and how to cure them. Some patients have listened to radio advertisements for drugs, or have heard things by word of mouth and believe the exaggerated properties of drugs. These patients use a layperson's knowledge and beliefs to negotiate for the drugs they want. It is a challenge for pharmacists to transfer their professional knowledge into a form of knowledge that laypeople can understand, as well as changing their beliefs. The following describes the main actors in more detail: pharmacists and patients/customers.

5.3.1.1 Purpose of Negotiations

Pharmacists in private drugstores aim to provide services which offer professional value and to make profits from drug sales in order to maintain their business, while service users negotiate in order to obtain the drugs they want. Consequently, the purpose of pharmacist–service user negotiations is to reach an agreement on the treatment regimen.

Two social actors in the private drugstore arena are identified. One is the pharmacist who provides a professional service and the other is a group of passive patients and customers who visit private drugstores.

This study includes two kinds of pharmacists: owner pharmacists and employee pharmacists. Within the private drugstore context, pharmacists are the sole professionals who provide a pharmacy service.

a) The Pharmacist

Unlike pharmacists in public hospitals, pharmacists who work in private drugstores are the only professionals delivering healthcare services to patients. They have clinical autonomy when deciding on regimens to treat their patients, as well as managing the business of their drugstores.

This study includes two types of pharmacist working in private drugstores: community drugstore owners and community drugstore employees. Of a total of 12 drugstore pharmacists in this study, eight work full-time in a public hospital and run drugstores outside their full-time job (dual-role pharmacists), while four work full-time in drugstores. Eleven are owner pharmacists and one is an employee pharmacist.

Owner pharmacists and employee pharmacists are viewed as having different levels of freedom in choosing regimens. This was illustrated by the use of repertory grid interviews in which the respondents were asked to recount the differences and similarities of different work types of pharmacists. The data from these repertory grids indicate that pharmacists construe that being an owner pharmacist offers greater freedom in deciding regimens than being an employee pharmacist. The latter have less freedom because their practice may be controlled by the owner.

Pharmacists also perceive a difference between being an employee pharmacist in a large chain drugstore or in a small drugstore. The employee pharmacists of large chain drugstores are construed as having the least freedom because they are forced to pursue the sales targets of drug companies. A pharmacist described this difference thus:

I think being an employee pharmacist in a chain drugstore offers less freedom when deciding than being an owner, because you have to try to reach a target (P04).

Considering the different levels of autonomy associated with being an owner and an employee, which may influence pharmacists' identity and practice, this study finds that the only employee in this study has a similar level of professional decision-making power to that of an owner. This employee pharmacist said that she has power in choosing regimens for patients. She explained that:

My supervisor doesn't push me to reach a sales target. She said that the most important thing is to make sure that I dispense the right drug to patients (P20).

To summarise, pharmacists in private drugstores are different from those in public hospitals because they have greater clinical autonomy, which allows them to decide how to service their patients and how to manage their drugstore businesses. Although this study includes two types of pharmacists – owners and one employee – their level of clinical autonomy is not significantly different because the drugstores examined are small and, typically, the last pharmacist mentioned that her supervisor does not force her to reach a sales target.

b) Passive Patients and Customers

Not only did respondent pharmacists describe different perceptions of pharmacists in hospitals and private drugstores, they also noted differences between patients in a public hospital setting compared with those who visit community drugstores. One pharmacist described the customers in her drugstore thus:

About 70-80 per cent of patients who visit my drugstore walk in and tell me their symptoms and the rest come with the names of drugs or products they already know (P01).

Most patients who visit this drugstore want to know the pharmacist's opinion about their treatment regimen, whereas others already have in mind the drugs they want to purchase. The characteristics of these two types of patients are different. That is to say, patients in a private drugstore setting can be categorised into two types: the

first comprises those who want to be given the pharmacist's regimen and healthcare advice, while the other refers to those who request drugs or products from pharmacists. The term "passive patients" is used here to refer to those who want to receive the pharmacist's regimen and healthcare advice, and the term "customers" is used for those who do not rely on the pharmacist's diagnosis but request drugs or products they want to buy.

It is found that the pharmacist respondents in this study used the terms "patient" and "customer" interchangeably to describe their service users. The different terms they used are important as they explain the relationship; how pharmacists describe service users reflects how they perceive the identity of service users as well as how they recognise their own identity in different situations. As McDonald (2006) explains:

> *The words we use to describe those who use our services are, at one level, metaphors that indicate how we conceive them. At another level such labels operate discursively, constructing both the relationship and attendant identities of people participating in the relationships, inducing very practical and material outcomes* (McDonald, 2006, p. 115).

Thus far, this thesis has categorised two types of service user who visit private drugstores. The first is passive patients who want to receive pharmacists' decisions about treatment and the other is customers who request and negotiate for the drugs they want.

6.3.1.3 Social Resources and Mobilisation

Success in the arena depends on how well social actors mobilise social resources (Renn, 1992; Jaeger et al., 2001). In the private drugstore context, the social resources that pharmacists use to negotiate with their patients include power, clinical and product knowledge, communication skills, trust and values (professional and profit values).

For successful negotiations, this study finds that pharmacists employ multiple resources, rather than a single resource, and multiple negotiating strategies to create

a synergistic effect. The next sections present the resources and strategies that pharmacists employ in negotiation processes.

a) Power: Clinical Autonomy

Clinical autonomy is power to decide how to treat individual patients. Unlike pharmacists in public hospitals, pharmacists in private drugstores have clinical autonomy comparable to doctors when deciding regimens for their patients. This means that pharmacists in a drugstore context can use their clinical power to decide on regimens for their patients. Pharmacists also acknowledge the power differences in the two contexts of public hospitals and private drugstores. They use this resource to distinguish perceptions about professional identities between hospital pharmacists and private drugstore pharmacists. Examples of pharmacists' perceptions of having power to decide patient regimens are demonstrated as follows:

> *Pharmacists in private drugstores are different from those in hospitals because the roles of pharmacists in drugstores also cover diagnoses. Pharmacists in drugstores play a role in evaluating patients' conditions and making decisions about regimens, whereas pharmacists in hospitals do not have power over decision making. They only dispense the drugs that doctors order* (P20).

Having power to decide how to treat patients, a pharmacist who works full-time in a hospital and runs his own drugstore outside his main job described himself as comparable to a doctor, saying:

> *The pharmacist at the drugstore is like the doctor of the community* (P11).

Another pharmacist who works full-time as a hospital pharmacist and part-time in her own drugstore commented:

> *In a drugstore you have the right to evaluate patients, whereas in a hospital it's the doctor's job. In a hospital, you can consult doctors about their prescriptions, but they are the only people who have the*

right to decide whether they want to change their prescription or not (P05).

Another pharmacist described having full power to make decisions in his own drugstore as a freedom which he does not have at the hospital. He expressed his thoughts thus:

In the hospital, if I want to initiate something, I have to ask permission from my supervisor. This is why I prefer to work in my drugstore, because I have more freedom. I can decide how to do my work (P03).

Thus far, it can be seen that having clinical autonomy or power to decide on patients' treatments distinguishes pharmacists in private drugstores from those in public hospitals. This results in different perceptions about who they are as pharmacists, i.e. their professional identity, in the two different types of work context. This study shows that pharmacists in public hospitals see themselves as subordinate to the medical profession, whereas those in private drugstores view themselves as comparable to doctors.

Although pharmacists in private drugstores have exclusive power to choose drugs for their patients, they stated that they are challenged by customers' demands, especially in situations in which the drugs being requested may be abused or misused by patients.

The respondents described many situations when they are asked for drugs. This study categorises these situations into two types. The first is when patients have the wrong information about a drug's effectiveness because they have received incorrect information from radio advertisements and/or word of mouth. In this case, patients trust the exaggerated information they have heard. The second is when customers request drugs for abusive purposes. A pharmacist explained these two types of situation in her community thus:

Working at a drugstore, I can detect a drug use problem in this area. Sometimes customers come and request a drug to wash and clean their kidneys. In this case, I will ask them what symptoms they have and I will tell them that there is no drug to wash and clean kidneys. I then advise them not to lift heavy stuff. Or sometimes, patients request two tablets of

Kanamycin,[2] *I can tell that those patients have listened to a radio advertisement.*[3] *I advise them about drug misuse and tell them that the drug is not going to cure their symptoms but it may be harmful to their body* (P21).

Hence, to conclude this point regarding pharmacists in a private drugstore context, although they have the greatest clinical autonomy, they can be challenged by patients/consumers who have the wrong information about a drug's properties, and by those who have spending power to request abusive drugs. It is found that pharmacists in private drugstores employ other social resources, in addition to their clinical autonomy, in the process of negotiation in order to make patients accept their treatment choices. The next section explains how pharmacists mobilise clinical knowledge in negotiations to change patients' beliefs and gain their trust, and as a result to succeed in negotiations.

b) Clinical Knowledge and Product Knowledge

Clinical knowledge is recognised as a required social resource in the patient care arena in a private drugstore context. The respondents who work in private drugstores explained that they must have good clinical knowledge about diseases to be able to work in a drugstore and make diagnoses from patients' symptoms. In contrast to the clinical knowledge of hospital pharmacists, these pharmacists view the use of clinical knowledge as essential to diagnosing patients' diseases and deciding on patient treatments because they have direct contact with patients. They are the only people who play a role in observing and evaluating patients' symptoms. Hence, pharmacists in private drugstores perform a role comparable to that of doctors in public hospitals.

In contrast, pharmacists in public hospitals work mainly in the dispensary. Their main role is to check doctors' prescriptions before dispensing to patients. Hence, pharmacists in hospitals do not see a patient's condition or make a diagnosis themselves. Although some hospital pharmacists have a role on patient wards, they

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[2] Kanamycin is an antibiotic which is used to treat bacterial infections.
[3] In rural areas in many developing countries, as well as in Thailand, some drugs, including antibiotics, are illegally advertised on the radio. This situation is a public health problem because it results in the misuse of antibiotics, which leads to a serious drug resistance problem.

do not make diagnoses but use their clinical knowledge to monitor adverse drug reactions and adjust dosages for specific patients.

A pharmacist working full-time in a public hospital and operating a drugstore outside her full-time job expressed her perceptions about the levels of clinical knowledge mobilised in the two different work contexts:

> *At first I thought that opening a drugstore would be easy because I have been working in a hospital for nearly ten years, but I was totally wrong. My job in the hospital didn't teach me how to make decisions. On the first day in my drugstore, when a patient turned up with his symptoms, I went blank* (P01).

From her explanation, pharmacists in the hospital context also identified that having clinical knowledge is crucial for their work there, in order to check doctors' prescriptions and thus reduce errors. On the other hand, in the private drugstore context pharmacists use their clinical knowledge to make diagnoses and choose treatment regimens for their patients. Therefore, it is concluded that pharmacists require clinical knowledge, yet that knowledge is used to perform different functions. In public hospitals, pharmacists require clinical knowledge to evaluate doctors' prescriptions and reduce prescription errors; whereas in private drugstores, pharmacists require clinical knowledge to make diagnoses and choose drug regimens.

It is found that clinical knowledge is crucial in negotiations between pharmacists and patients/customers who request drugs for misuse or abusive purposes. Whilst pharmacists have professional knowledge of the clinical area, patients/customers also receive information from the Internet, radio advertisements and word of mouth. Patients/customers use media information and their networks as social resources to negotiate with pharmacists and get the drugs they want. In many cases patients misuse drugs.

Drug misuse is not only harmful to patients but has also resulted in a broader public health problem. For example, the misuse of antibiotics has led to widespread drug resistance in developing countries (Okeke et al., 1999; Levy and Marshall, 2004). Antibacterial drug resistance has long been a public health problem in Thailand, the

main cause of which is misuse and malpractice in business settings which allow non-professional sellers to own and sell drugs (Thamlikitkul, 1988; Sumpradit et al., 2012). Thai pharmacists have an opportunity to reduce this misuse problem by integrating their clinical knowledge to convince patients to accept their decisions.

An example was given earlier of a pharmacist who was asked, in her drugstore, for a drug that cleans and washes kidneys. In that case, she used her clinical knowledge to suppose that the patient might have back pain for other reasons. She also knew that there is no drug that can wash kidneys; hence, she counselled her patient by explaining that there is no such drug and also advised the patient to modify their behaviour to prevent future back pain.

In another case, a patient requested an antibiotic they had heard about in a radio advertisement. The pharmacist knew about the indications and the right dose for the drug. She was also able spot when patients had heard something on the radio and believed the exaggerated properties claimed for a drug. Thus, she employed her clinical knowledge to explain the possible harm from the drugs in order to change patients' beliefs resulting from radio advertisements.

Other examples of drug misuse that pharmacists detect from patients in their private drugstores are evidenced. For instance:

> *There are some cases where teenagers come and ask for contraceptive pills. They will request the drug by describing a drug that is used to "promote menstrual flow". If they describe a drug like that I can tell when they want to pills for an abortion. In that case, I will not prescribe. I will suggest they have a proper pregnancy test and tell them that they risk their life if they are pregnant and take those pills* (P18).

In a case like the above, the pharmacist perceives that there is a high risk to the patient's health, hence she refuses to sell the drug and provides the correct information to the patient about the possible harm from drugs that may impact a patient's life.

To recap, clinical knowledge is necessary in negotiations. Firstly, pharmacists in private drugstores perceive that they need good clinical knowledge to be able to make diagnoses. Secondly, this knowledge is transferred by advising about the

harm that may result from drug misuse in order to influence negotiations with patients/customers who request drugs for misuse or abuse. This finding also highlights that having clinical knowledge differentiates pharmacists from non-professional sellers. Pharmacists are acknowledged as professionals because they are able to integrate their professional knowledge when assessing the risk of drug misuse and provide the correct information to patients/customers. It is found that in running a clinical pharmacy for patients/customers, pharmacists are able to gain their trust. Pharmacists perceive that patients/customers will trust them if they give advice and information, rather than just selling drugs.

Regarding product knowledge, pharmacists in private drugstores also need to know about products in order to choose drugs which suit the socioeconomic status of their customers/patients. The respondents explained that they use their product knowledge to make decisions about what drugs to sell in order to give them the highest profit, for example:

> *If I see that customers seem to be able to afford the expense, then I will*
> *choose the products which give me the highest profit* (P03).

The respondents also use their product knowledge to recommend supplements which are suitable for a customer/patient's condition and will not interfere with the treatment regimen, e.g. by causing product interaction.

c) Communication Skills

Pharmacists in private drugstores regard communication and counselling skills as necessary if they are to transfer their professional knowledge into knowledge that laypeople can understand. For example, one pharmacist employs a counselling technique to produce drug compliance in elderly patients. She uses pictures to help counsel her patients, which seems to make it easier for them:

> *For some elderly patients, I have to draw pictures to explain to them in*
> *an easy way* (P15).

Another example occurs when patients request drugs for likely misuse. Pharmacists are aware of the risks of drugs to patients' health. If, after giving information about

harm, a patient persists in wanting to buy, pharmacists will use other ways to insist on their advice being heeded. For example:

> *This drug does not help you and it is dangerous to take. I would not give this drug to my family members* (P18).

This pharmacist's reference to family members, for whom she loves and cares, implies that her practice vis-à-vis patients is the same as towards people who are close to her, like her family.

Alternatively, if patients request drugs for abuse, pharmacists will give advice as well as telling patients that it is unlawful to use those drugs, in order to scare customers who make such requests.

> *If I suspect that they want to buy drugs for abusive purposes, such as pills for abortion, I will not sell them to them, and I will tell them that it is against the law to use those drugs* (P12).

In conclusion, communication skills are used to transfer professional knowledge into knowledge that laypeople can understand, as evidenced in the pharmacist who draws diagrams for her elderly patients. The pharmacists also exercise communication skills to change patients/customers decisions on drug regimens to maintain professional services.

d) Trust

Trust is important in negotiations because it helps pharmacists to persuade patients to accept their treatment choices and comply with regimens and counselling. Trust is also important in maintaining a business. If pharmacists can win the trust of their patients/customers, then they will visit the drugstore again. There is evidence of a link between professionalism and trust in the private drugstore context. Firstly, trust can be built through engaging with professional practice. Secondly, pharmacists gain trust by building a good professional image so as to differentiate themselves from non-pharmacist retailers.

In the first case, trust is built by delivering professional practice. The data show that pharmacists gain trust from their patients if they provide counselling and professional services, rather than just selling drugs. For example:

If patients become well after receiving my regimens and taking my advice, they will trust me and return to my drugstore (P10).

In the example above, the pharmacist employs clinical knowledge to determine appropriate regimens for his patients. He not only prescribes drugs but also provides the professional service of health advice to his patients. He sees his professional practice as contributing to being trusted by his patients, hence customers will return to his private drugstore.

Another example of the relationship between professionalism and trust is seen in the following example:

Some patients come to me but not to buy drugs. They seek some advice and I am willing to help them. I don't want them to use drugs incorrectly. For example, some patients may receive multiple drugs from the hospital and be confused about how to take them. What I do is I write down for them about the indications and how to take the drugs. I don't make money from doing so but I think it is part of my role. Apart from that, the patients also trust me. I think if they only want to buy drugs, they can buy them anywhere, but if they come to my drugstore, they also receive health advice (P21).

In this case, the pharmacist not only sells drugs but also delivers the professional service of free health counselling to her patients. She views this practice as being professional and acknowledges this is part of her professional role. By being professional she gains the trust of her patients. Consequently, engaging in professional practice is linked with being trustworthy.

Secondly, trust is gained through having the image of a professional. Those pharmacists who work full-time as hospital pharmacists and run their own drugstore outside their full-time job mentioned that being a pharmacist in a public hospital gives them the image of being a good professional. For example:

People who visit my drugstore trust me because they see that I am a pharmacist in a hospital, so they believe my knowledge and advice (P11).

Another pharmacist added:

> *The customers who visit my drugstore trust me because they know that I also work as a pharmacist at the public hospital* (P15).

A professional image can also be created even if pharmacists do not work in a hospital. Pharmacists who only work full-time in their own drugstore added that wearing a white gown allows their patients to notice that they are a pharmacist and not a layperson. For example:

> *Now it is encouraged by the pharmacy council that we wear a white gown during practice hours. I think this is good because it can distinguish me from laypersons. Patients, once they see the white gown, can tell that I am a pharmacist* (P18).

In summary, trust is an influential resource in negotiations and for maintaining customers for a drugstore business. Pharmacists can create trust through engaging in professional practice and having a professional image which differentiates them from non-professional sellers.

e) Values: Professional Value and Profit

Two values are presented in the private drugstore context: professional value and business value. The pharmacists identified patient safety as a professional value that guides ethical practice. However, they also regard business value (profit) as necessary for maintaining their business. These two values play a role in guiding pharmacists' practice. While providing patient care services, pharmacists also use business techniques to sell products and drugs. For instance:

> *Pharmacists who work in a drugstore setting are different from non-professional sellers because pharmacists are concerned about patient safety. Pharmacists don't focus only on profit; they also care whether patients will be safe in their drug use or not* (P20).

A pharmacist compared her full-time job at the public hospital and the drugstore thus:

I think the focus of work at the hospital and in the drugstore is the same in that both focus on patient care. But what differentiates pharmacists in a community drugstore from those in a hospital is that, whether you are an owner or an employee, you have to think about how to make a profit. If you work in a hospital you don't have to care about profit because you have a fixed salary (P02).

Another pharmacist added:

It is impossible for pharmacists in private drugstores not to think about profit because we have to maintain our business. As the owner of a drugstore, I think a pharmacist in a private drugstore will choose the products to sell that will give them the highest profit. But in hospitals, the drugs of choice will be the ones that are the most cost-effective (P03).

The practice of a drugstore is therefore guided by both professional and business values (patient benefit versus profit):

A drugstore is a business, so it is necessary to use business techniques; but it is also necessary to focus on patient benefits. In my drugstore, I choose the drugs for patients but they also have their right to choose. I won't force them, I can only advise them. I focus more on giving advice than making a profit because I want the patients to have a good impression of the service as well so that they will return to my drugstore (P10).

Professional value is perceived as a core attribute that differentiates pharmacists from non-professional sellers, and this value guides pharmacists in how to provide a professional service. A pharmacist explained the differences between pharmacist and non-pharmacist sellers thus:

I think it is important to have a pharmacist in a drugstore. Lay sellers do not care about patient safety. They only want to sell drugs. But as a pharmacist, I will ask the patients about their symptoms, I will be concerned about reviewing their drug allergy history, because I want to make sure they will be safe with the drugs I prescribe (P20).

Another pharmacist added:

In a drugstore it is important to manage the risk of business failure and balance professional and business goals. Pharmacists have to dispense drugs that are right for patients' diseases. This is for the patients' benefit (P19).

The pharmacists' views illustrate that they think that, as pharmacists, they must use their clinical knowledge to review patients' symptoms and deliver a service by maintaining safety. They perceive themselves as different from lay sellers. This view reflects pharmacists' perceptions of professional identity, explaining how they view themselves as pharmacists and how they are different from non-professional sellers.

The drug misuse found in private drugstores was also mentioned earlier in this chapter. Using contraceptive pills to stimulate menstruation is one of the drug misuse cases that pharmacists identified. In such cases, all of the pharmacists refused to sell drugs to their patients. One of them said:

Although, in a drugstore, we [pharmacists] *need to think about sales, we are also concerned about ethics. I will not do anything that is unethical, such as agreeing to customers' requests for contraceptive pills that might cause haemorrhage* (P12).

This pharmacist mentioned that ethics guide her practice. The data from the repertory grid analysis generated perceptions of pharmacists being either ethical or unethical. According to the pharmacists, being an ethical pharmacist means that one is "trustworthy and does not take advantage of patients" (P02). One is also "more concerned about the benefit to patients than profit" (P04). An ethical pharmacist also "complies with the law and employs professional values to guide their practice" (P03).

Professional values are considered to be a discursive resource that pharmacists draw on to make sense of their individual and collective selves. It gives them an understanding of what it means to be a pharmacist. This perception of self influences their behaviours. Where pharmacists recognise drug misuse or abuse,

professional values are a dominant discursive resource on which they draw to construct their identity.

On the other hand, when pharmacists are guided by profit, their practice involves using multiple business techniques to increase sales. There is evidence that some pharmacists in this study employ business techniques to increase sales. The first technique found from the data is advertising non-drug products and food supplements. For instance:

> *The strategy that I use to sell is to ask customers whether they would like other products. For example, we have beauty products here, so I recommend those products to them. Some of them are interested and will buy* (P20).

Another pharmacist added:

> *To maintain the drugstore business, I also add some products that may not be necessary but which, at the same time, are not harmful and do not have a bad effect on their conditions; for example, I add throat sprays, lozenges or syrups to soothe throats in cases with a sore throat. This is to add to my income* (P19).

A second business strategy used in private drugstores is to open for longer hours and stock more products to prevent customers turning away.

> *There is another drugstore in this area, but I open my drugstore all day whilst the other one only opens in the morning and evening. But now they open all day* (laughing). *So, what I do is I stock enough essential drugs in my drugstore. This is to prevent customers turning away to go to the other drugstore. The profit in my drugstore comes from food supplements, so I stock more of those products* (P21).

Therefore, it can be seen that pharmacists in private drugstores draw on a professional value (patient safety) and profit to construct different identities, depending on the situation. To be an ethical pharmacist is to be concerned with patient safety. Situations in which a professional value (being patient-centred) is the dominant discourse are those in which pharmacists perceive high risk to patients'

health. In such cases, pharmacists put the health and safety of patients first. They perceive that high risk relates to cases of drug misuse and abuse. Pharmacists are aware of the possible harm of drug misuse and abuse, possibly leading to physical damage or death; hence, where they perceive such a risk to a patient's life, professional value is the dominant discursive resource that they use to guide their professional behaviour.

On the other hand, in situations in which pharmacists do not perceive such risk to patients, they use profit to construct the identity of a businessperson which guides their practice in a business way, as evidenced from using sales strategies.

So far, the empirical findings have clearly demonstrated that pharmacists in private drugstores have hybrid identities, being both professionals and businesspeople. This can be seen from how they identify both values – professional value (being patient-centred) and business value (profit) – as social resources that guide their behaviour in the private drugstore context. Their identity is constructed differently in different situations. Where the risk to health is high, pharmacists draw on a professional value to construct their identity and engage in professional practice; in contrast, in situations where the risk to health is low, pharmacists use profit to construct an identity as a businessperson and employ business techniques to increase their income.

Table 7 summarises the social resources and negotiation strategies in pharmacist–service user negotiation in the private drugstore context.

Table 7: Social resources and negotiation strategies in pharmacist–service user negotiation in the private drugstore context

No.	Social Resource	Negotiation Strategies
a	Clinical Power	• Deciding regimens for service users • Deciding what to service in the business
b	Clinical knowledge and product knowledge	• Using clinical knowledge to make diagnoses and provide counselling. • Using product knowledge to choose products which do not interfere with the treatment regimens of service users, and using product knowledge to choose products which give the highest profit for the business.
c	Communication skills	• Using good communication skills

		and techniques to deliver professional services such as patient counselling. • Using good communication skills to impress customers, thus maintaining the business.
d	Trust	• Using trust to persuade customers/patients to accept the regimens chosen by the pharmacist. • Using trust to maintain the business. Note: Trust is built through being professional (delivering professional service, practising good communication) and having an image of a professional (wearing a white gown, and being employed as a pharmacist in a public hospital).
e	Values (patient centred versus profit)	• Using professional value to deliver professional service by being concerned about patient safety. • Using business value to gain profit in a situation which is low risk to patient health.

5.3.1.4 Arena Rule: Drugs Act, 1967

Drugstore registration is regulated under the Thai Food and Drug Administration (FDA), which is governed by the Thai Ministry of Health, whereas practising pharmacists are licensed and regulated by the Pharmacy Council. With regard to who is qualified to handle medicines, the Thai Drugs Act, 1967 classifies medicines into four categories: controlled drugs, dangerous drugs, over-the-counter (OTC) drugs, and drugs that are not classified under the first or second categories. The Drugs Act, 1967, section 32 states, "No other person is permitted to sell controlled drugs and dangerous drugs where there is no qualified pharmacist to give service", and section 39(6) declares: "A qualified pharmacist must control the act of dispensing controlled, dangerous and prescription drugs to patients." This means that the law reserves selling and dispensing power for controlled and dangerous drugs to registered pharmacists only, whilst non-professional retailers can only handle OTC medicines.

Ideally, the Drug Act should facilitate pharmacists' negotiations with service users because it specifies the role of registered pharmacists in prescribing in the

commercial context. Nevertheless, this study finds that law enforcement is ineffective, which is viewed as having a negative impact on the pharmacy profession by blurring the image of a professional with that of a lay seller. Hence, in a commercial setting, specifically private drugstores, there are many business competitors, including drugstores owned by laypeople. Therefore, customers/patients cannot distinguish professionals from laypeople. The business image of pharmacists in private drugstores often leads to their being challenged by customers. A pharmacist explained about weak law enforcement, which has caused difficulty to pharmacists in private drugstores in negotiations with customers:

> *I think there are many reasons why there are problems of malpractice in drugstores. I think those who enforce the law do not do so strictly. They are afraid of some power. You may have heard that there was a case of a drugstore pharmacist who was assessed as being physically harmful because of making unlawful sales in a drugstore. That drugstore was type one but the owner was not a pharmacist. During opening hours there was no pharmacist on duty. So you can see that not only do some outsiders not comply with the law but some pharmacists also misbehave* (P03).

Non-pharmacists can run a type one drugstore, but during opening hours the business owner has to have a pharmacist on duty to deliver the service and dispense drugs. Non-pharmacist owners are only business owners; they do not have the right to sell drugs. This is because a type one drugstore can stock pharmacy-only medicines (POM), and the right to dispense those is restricted to pharmacists. Hence, during opening hours, there must be a pharmacist present, otherwise:

> *There was another case where a pharmacist went to assess a drugstore and the owner (a non-pharmacist) invited him to check, but then he opened a drawer which had a gun in it* (P03).

Hence, weak law enforcement provides opportunities for non-professional sellers to handle drugs which should be dispensed by professional pharmacists. Consequently, drugs are treated as goods which can be handled by laypeople. This creates tough business competition in the private drugstore context.

It has become difficult for pharmacists to distinguish themselves from non-professional sellers. Weak law enforcement thus leads to difficulties for pharmacists in the business context in mobilising their resources in negotiations, and in establishing their identities as professionals, as their image is often confused with that of laypeople. Figure 8 presents the establishment of pharmacy role boundary in the private drugstore context.

Figure 8:   Establishment of a pharmacy role boundary in the Private Drugstore Context
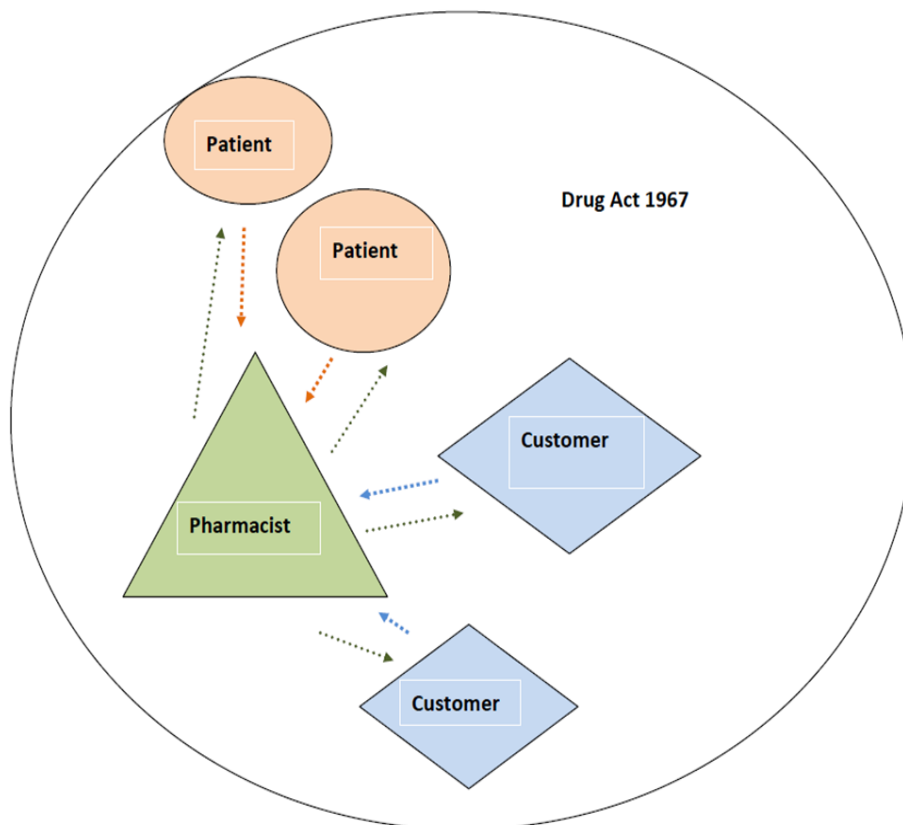
Figure 8. shows that pharmacist is the sole professional who negotiates with patients or customers to set his/her role boundary. Drug Act 1967 is seen as facilitating factor of pharmacist role establishment as it restricts sales of controlled and prescription drugs to pharmacist only. Nevertheless, weak law enforcement may cause difficulties to pharmacist in successful negotiation, and achieving the

status of a profession, because layperson could also handle those drugs and illegally sell drugs to people.

This section has provided the social arena in the private drugstore context. The next section presents a comparison of negotiating pharmacy role boundaries between the public hospital and the private drugstore contexts.

5.4 Negotiating Pharmacy Role Boundaries across Work Contexts: Shift in Pharmacists' Role and Identities

The different types of work context – public hospitals and private drugstores – in this study provide an excellent opportunity for a comparative analysis of identity construction. This chapter addresses three social resources that differentiate the identities of pharmacists between public hospital and private drugstore settings. These resources include knowledge, clinical autonomy and values (patient safety and profit), while communication skills and trust are necessary in both contexts. This section discusses in more detail differences in pharmaceutical knowledge, clinical autonomy and the values of pharmacists, and how they relate to different identities of pharmacists in the two work contexts.

5.4.1 Pharmaceutical Knowledge and Roles

The findings suggest that pharmacists in public hospitals are required to have knowledge and skills covering patient-oriented and product-oriented practices. The patient-oriented knowledge required in public hospitals includes pharmacokinetics and knowledge about adverse drug reactions and/or interactions. Regarding the knowledge associated with product-oriented practice, the respondents identified knowledge covering drug compatibility, stability and aseptic techniques. This wide-ranging knowledge is found to be necessary for the role of pharmacists in public hospitals. Pharmacists' ability to employ this knowledge in role negotiation leads to successful role establishment. In contrast, if pharmacists fail to mobilise knowledge and skills in negotiation, this leads to unsuccessful role establishment or lack of acknowledgement of role contribution in hospitals.

It is evidenced that the knowledge of pharmacists in public hospitals influences how pharmacists see themselves. Having a broad knowledge of drugs, from producing to

administering, the respondents perceive that a pharmacist is *a drugs expert* who has broad knowledge ranging from production to patient care.

As one respondent stated:

> *A pharmacist is a drugs expert, because we know everything about drugs. We know how to produce them and use them on patients. Compared to other professions, we have more knowledge about drugs* (P08).

On the other hand, pharmacists in private drugstores are required to have knowledge of clinical pharmacy in order to diagnose and make decisions about treatment regimens. They must also know about products in order to be able to choose products, such as food supplements, which are safe for patients as well as make them more profit. The pharmacists use this knowledge to deliver their role in health advice in the private drugstore context. The pharmacists in private drugstores view themselves as *health advisors* or *counsellors*. For example, one pharmacist said:

> *At the drugstore, I am the primary unit that people in my community can access for health advice. I provide support in terms of health advising and counselling* (P10).

5.4.2 Power

Regarding clinical autonomy, pharmacists in public hospitals see themselves as being under the power of the medical profession; that is, pharmacists in public hospitals do not have clinical autonomy, hence they view their profession as subordinate. In contrast, pharmacists in private drugstores are sole professionals who have full autonomy when deciding about their own services and business. Therefore, their identity is viewed as being comparable to that of a doctor (*a doctor in the community*). A pharmacist compared his role at his private drugstore thus:

> *My role in the drugstore is like a doctor but a general doctor* (P11).

5.4.3 Values

With regard to values, the pharmacists in public hospitals strongly identified being patient-centred, by focusing on patient benefit, as the only value that guides their practice in an ethical way, whereas pharmacists in private drugstores identified two conflicting values that guide their practice: being patient-centred and making a profit. Hence, this chapter has identified the hybrid role and identities of pharmacists in the private drugstore context. Table 8 compares the social resources and pharmacists' identities between public hospital and private drugstore contexts.

Table 8: Comparison of social resources and pharmacists' identities in two contexts

Context	Public Hospital	Private Drugstore

Pharmacy knowledge	1) Production knowledge
	  • Drugs compatibility & stability
	  • Drugs preparation & aseptic techniques
	2) Patient-care knowledge
	  • Pharmacokinetics and Total Drug Monitoring
	  • Checking prescriptions, dispensing & counselling skills
		1) Patient-care knowledge
		  • Clinical pharmacy
		2) Product knowledge
		  • Dispensing and counselling Skills

Communication skills	1) Good communication skills, politeness, face-saving (with doctors and nurses) 2) Counselling skills (translating professional knowledge into layperson knowledge)	1) Good communication skills to retain customers and gain their trust 2) Translating professional knowledge into layperson knowledge
Trust	Built through offering pharmaceutical knowledge, practising good communication skills, power and value commitment	Built through being professional, offering professional knowledge, good communication, the image of a hospital pharmacist, seniority
Value(s)	Being patient-oriented	Being patient-oriented and profit
Power	Seniority, position	Clinical autonomy
Professional identity	Drugs expert, Subordinate	Hybrid identity (counsellor, doctor in the community, business owner)

5.5 Discussion and Conclusion

This chapter has presented data showing how pharmacists negotiate to establish pharmacy role boundaries in two different contexts: public hospitals and private drugstores. Role boundary establishment for pharmacists is an area of conflict because the role expansion of one profession always affects the boundaries of others (Nancarrow and Borthwick, 2005). Hence, role establishment involves pharmacists and other social actors in negotiation processes in order to try to set

work boundaries. In order to understand how pharmacists negotiate with other social actors to expand their role, and what social resources they mobilise in those negotiations, the social arena concept has been employed (Jaeger et al., 2001; Renn, 1992) together with negotiated order theory (Strauss et al., 1963).

This chapter has identified many social arenas in the public hospital context, including: 1) pharmacy role establishment in the patient care arena involving pharmacist–doctor negotiations; 2) pharmacy role establishment involving pharmacist–pharmacist negotiations; and 3) pharmacy role establishment in cytotoxic production and patient counselling involving pharmacist–nurse negotiations.

Despite growing public interest in promoting the role of the pharmacy profession to involve patient-oriented practice (e.g.The World Health Organisation, 2006), this study has demonstrated that the product-oriented role of pharmacists remains necessary in the hospital context. By being able to offer doctors product-oriented knowledge, including drugs compatibility and stability, routes of drug administration and cytotoxic production, pharmacists in public hospitals gain acceptance of the contribution of their role to patient care. Regarding clinical knowledge, this study has found that knowledge of pharmacokinetics, total drug monitoring, adverse drug reactions and drug interactions is necessary for pharmacists to establish the role. The role of pharmacists in checking doctors' prescriptions has been identified as leading to boundary encroachment because doctors perceive this as a challenge by pharmacists. Nevertheless, pharmacists can mitigate this conflict by employing good communication skills.

There is evidence that power is derived through being older. This is illustrated by a pharmacist who laughingly said that people, including doctors, trust him because he is old: "Normally they [doctors] listen to me because I am old" (P11). This outcome may best be explained by a cultural aspect of Thailand regarding the power distance dimension which gives respect to the elderly. Thus, in case of conflict, the elderly often step in to resolve the problem (Neuliep, 2012).

With regard to the social arena and negotiation strategies in the private drugstore context, this study has identified pharmacists' role negotiation with patients/customers, which determine their identities as different from those in the

public hospital context. In particular, it has identified the role of service users in the private drugstore context as being different from those in public hospitals. This influences how pharmacists construct their identities in the drugstore to interact with the different identities of service users.

Regarding pharmacists' identities, this chapter concludes that patients in public hospitals in Thailand have the role of passive recipient; thus, they have no role in negotiations about their treatment. Pharmacists in public hospitals therefore negotiate mainly with doctors in order to alter treatment regimens. The identity of a pharmacist in a public hospital is that of *a drug expert* and *a subordinate*, since they have wide-ranging knowledge, from production to patient care, but have lower status than doctors. In contrast, this study has characterised the identity of a pharmacist in a private drugstore as *a health adviser* and *a doctor of the community*, due to their diagnostic role for people within their business community and their full clinical autonomy comparable with doctors.

Thus, this chapter has identified the shifting role of pharmacists and their identities, social resources, arena rules and negotiation strategies across two different work contexts. By employing the social arena concept (Jaeger et al., 2001; Renn, 1992) to examine an area of conflict in the healthcare context, this study has been able to define a shift in the social actors' roles and their resources in different work contexts, and offer an understanding of how these impact on the different identities of pharmacists in public hospitals and private drugstores.

With regard to the contribution to the theory, this thesis has shed light on using negotiated order theory and the social arena concept in a commercial context such as a private drugstore. In particular, although negotiated order theory was first developed to examine negotiations in a hospital context that involves multidisciplinary health professionals in negotiations for role boundaries (e.g.Strauss et al., 1963; Svensson, 1996; Allen, 2000), this thesis has demonstrated that the concept can also be used to examine negotiations in the private drugstore context.

The social arena concept has also been popular in studies about risk debates (e.g.Renn, 1992). This concept is often mentioned in other fields of study, including healthcare organisations (e.g.Currie, 1999). Nevertheless, the existing literature

lacks a clear examination of who the social actors are and the social resources they mobilise in negotiations. This study has provided empirical evidence of the use of the social arena concept in studies of role establishment in a work context characterised by division of labour, such as a public hospital. Moreover, use of the social arena concept has also been extrapolated to examine the social actors and their resources in the commercial context of private drugstores.

This thesis has found that previous studies lack empirical evidence with regard to pharmacy employing negotiated order theory (e.g.Eaton and Webb, 1979; Mesler, 1989; Mesler, 1991). Moreover, most studies have examined the negotiation strategies of pharmacists in establishing the role at the clinical boundary. Thus, their presumption is often based on boundary encroachment between doctors and pharmacists. Having this presumption in mind may have guided their research to examine a particular boundary, specifically the clinical boundary. This thesis identifies other role boundaries within the hospital context which pharmacists negotiate with other professions, including medicine, nursing and pharmacy itself. Thus, this thesis offers a richer description regarding pharmacists' negotiations. Furthermore, no previous studies of pharmacy have employed negotiated order theory and the social arena concept in a commercial setting. This study has shed light on the use of negotiated order theory and the social arena concept in private drugstores.

Having established the contributions of this chapter, the next chapter will examine pharmacists' identity construction more closely.

Chapter 6: Identity Reconstruction

6.1   Introduction

Chapter 5 offered insights into the active role of pharmacists as social actors in constructing professional identity through negotiation in order to establish the professional role boundaries of pharmacy in different social arenas. The aim of this chapter is to answer the second research question of this thesis:

> *How do pharmacists engage with the consequences of the role within the boundary of pharmacy?*

This chapter identifies that pharmacists' engagement with the role occurs during transitions at both the macro level, as in the transition from student to pharmacist, and the micro level, as in day-to-day transitions such as from being a mother at home to being a professional at work.

Each role has an identity which defines activities, goals, values and patterns of interaction (Ashforth, 2001). Consequently, pharmacists' moves from one role to another require them to acquire a new identity which contains the new patterns of behaviours, interaction styles and values of the new role. Therefore, pharmacists are engaged in a process of identity reconstruction during the role transition stage.

In order to examine identity reconstruction during role transitions, the *identity work* concept was employed. This involves "people being engaged in forming, repairing maintaining, strengthening or revising the constructions that are productive of a sense of coherence and distinctiveness" (Sveningsson and Alvesson, 2003, p. 1165).

This chapter is structured in two parts. Part One provides an understanding of how respondents reconstructed a new identity for a new role during a macro role transitional stage; that is, the stage of transfer from being a student to a pharmacist. The aim of this part is to identify the specific means, as well as supporting/inhibiting factors, involved in identity reconstruction during the passage from being a newcomer to a professional pharmacist. In this part, the processes of identity construction will be identified as including anticipatory socialisation (during the educational programme) and role relations.

Part Two provides an understanding of how the respondents constructed identities during a micro or day-to-day role transition, specifically when they changed from one role to another (for example, from being a mother at home to being a pharmacist at work, and from being a pharmacist at a drugstore to a pharmacist at a hospital). This part will also identify significant discourses on which the respondents drew to adjust their identity to their daily work, and the processes of identity construction with which the respondents engaged. The discourses available in the respondents' work contexts include professional value (being patient-centred), business value (profit), sense of security, and sense of belonging. Business value (profit) is identified as the discourse that distinguishes the public hospital context from the private drugstore context.

The findings highlight that identity constructions occur through the negotiation of conflicting identities. The findings suggest that the results of respondents' identity negotiations are of two types. Firstly, a group of pharmacists who were able to maintain a role at a private drugstore constructed hybrid identities through a process called compartmentalisation, in which they maintained conflicting identities and constructed different identities in different situations. Secondly, a group of pharmacists who were not able to maintain a role at a private drugstore because they felt guilty constructed identities through dis-identification from the business persona and identified themselves with the role of hospital pharmacist, which was more congruent with their personal identity.

At the end of this chapter, challenges will be highlighted for the pharmaceutical educational programme in reducing the discrepancy between the pharmacy graduate's identity and the identity demanded by the role. These challenges include a lack of standards for the programme, a lack of multidisciplinary learning in pharmaceutical education, and a failure to integrate pharmacy lectures into real patient treatment.

Part One: Macro Role Transition and Identity Reconstruction

6.2 Macro Role Transition: From Student to Pharmacist

6.2.1 Initial Stage of Role Transition: Transition Shock

In the existing literature, role transitions are often categorised into two major groups: macro role transition and micro role transition. For example, (Ashforth, 2001) defines role transitions as follows:

> *Role transitions are about how one disengages from one role (role exit) and engages in another (role entry) – whether the roles are held sequentially (the macro transitions of, say, a promotion) or simultaneously (the micro transition of, say, a commute between home and work).*

Macro role transition refers to infrequent and permanent change, such as transition from work to retirement, whereas micro role transition refers to day-to-day transitions that recur frequently, such as from home to work (Ashforth, 2001).

All pharmacists in this study had experienced a macro role transition at least once in their professional career. This occurs when pharmacists change their role from pharmacy student to professional pharmacist. During the early stages, a number said they had felt eagerness and excitement at becoming a professional pharmacist. For example:

> *As I remember, I felt very excited the first time I counselled patients about drug use because I got a chance to practise with real patients (P15).*

Despite this eagerness, such feelings were replaced with stress during the initial period of the role transition; many were frustrated, as they stated that they were "terrified", and "scared" to deliver their pharmacy services. The factor contributing to this fear is identified as role ambiguity, which can be seen from the circumstances in which the pharmacists did not know exactly what they had to do as a pharmacist.

Many of the pharmacists stated that they did not know how to perform the role. This ambiguity included uncertainty about the knowledge and skills required for the role, role relationship patterns, and the organisational hierarchy and multidisciplinary culture specific to the role of hospital pharmacist. For example, one respondent explained her feelings when she started working at the hospital thus:

When I started to work, I felt faced with a tidal wave (P01).

She continued:

At the beginning, I didn't feel that I contributed that much to the pharmacy department. It was because I had nothing in my head. I did a pharmacy administration programme in my undergrad, no idea of working in a hospital (P01).

Some respondents expressed their feelings at the beginning of their career as a more traumatic experience; they felt "terrified" (P10) because they were unsure about how to apply theoretical knowledge in practice. This respondent said that he was unsure about how his practice would impact on real patients:

When I started to work in this hospital, I was terrified to do clinical pharmacy. I thought clinical pharmacy knowledge is broad and difficult to understand compared to science-based subjects (P10).

He further explained that:

Clinical knowledge is not straightforward: you need to apply the knowledge to individual patients. Whilst science is straightforward: you know straight away whether your action was right or wrong (P10).

His interview revealed that this respondent had done a pharmaceutical analytics programme and would have liked to work in a drug industry in which he could apply his knowledge in the research and development sector; yet after graduation he returned to his home town to work in a public hospital because the job provided him with a greater sense of security than jobs in the private sector. He described his feelings as "being terrified": he lacked confidence in his clinical pharmaceutical knowledge and how to apply that knowledge to real patients, as he had never had work experience with patients during his pharmacy education.

Not only did the newcomer pharmacists not know how they should act in their role, but they also perceived, early in their careers, that doctors did not acknowledge the role of pharmacist. A respondent described her role on a ward as being "invisible for several days", as she expressed:

> *On the first day I introduced myself to the doctor who was routinely in the ward. He only nodded but he didn't talk to me, nor discussed the patients with me. I was invisible for several days* (P18).

As a consequence of role ambiguity, there is evidence that the respondents also experienced boundary encroachment with doctors during the early stage of role transition. A respondent described her first experience when she made contact with a doctor as "a conflict" (P13):

> *I contacted a doctor who had just graduated from abroad. She was self-confident and I was also a new pharmacist. She was confident about the concentration of the IV mixture. She was angry when I disagreed with her. I think I knew the dose was not right but I didn't know how to explain it to the doctor* (P13).

Her interview implies that she did not know how to perform her role and convey her knowledge to bring about a successful negotiation with the doctor.

Another pharmacist thought that boundary encroachment between the medical and pharmaceutical professions is often created by newcomer pharmacists because they are not aware of their role as subordinates; hence, they often perform the role of doctors when they apply clinical knowledge on the patient ward. She said:

> *The new pharmacists want to do a clinical role on the ward, so they often give clinical information that doctors already know. So doctors do not want to listen to them. They sometimes try to make decisions for patient treatment themselves. This confuses the doctor about what we do on the ward* (P12).

Besides ambiguity regarding the knowledge and skills required for the role, many respondents faced difficulties in adapting to the organisational culture, especially in hospitals that operated with a hierarchical culture and a multidisciplinary

environment. Therefore, many pharmacists reported that they were "scared of doctors". Many stated that they were "frightened" about meeting doctors on the patient ward, and some even felt scared to death. For example, one pharmacist said:

> *... if the doctor asked me about the drugs and I couldn't answer? Oh I must die!* (P01)

Or:

> *There was a doctor of whom many pharmacists were scared. So they avoided having contact with this doctor. I was also nervous at the beginning* (P18).

In addition to this, a number of pharmacists found that it was difficult to find a balance between home and work life. For example, some pharmacists stated that they had to continue their hospital work at home because there was not enough time to finish the work; meanwhile, during work they felt that they did not have enough time for their children. For example:

> *I also feel stressed when it comes to the quality assessment because there is not enough time at work to prepare the document. So I have to bring the document work back home, when at home I want to spend time with my children* (P09).

A similar experience in balancing work and life was seen in a pharmacist who works at a private drugstore:

> *I like the drugstore work actually, but I had to close down because my children are still small. When I opened my drugstore, my kids also stayed at the drugstore, but I had to work and I didn't have time to take care of them* (P12).

This section has clearly demonstrated that there is a period of transition shock, in which the pharmacists experience role ambiguity that leads to feelings of anxiety, frustration, fear and stress. As a result of role ambiguity, newcomer pharmacists also often experience boundary encroachment with doctors because they do not know about the expected knowledge and skills, nor how to perform the role and interact with doctors who have greater clinical autonomy. Therefore, during this

initial period of macro role transition, pharmacists often perform a role that clashes with doctors, or do not perform the role appropriately.

6.2.2   Factors Contributing to Transition Shock: Educational and Expected Identity Discrepancy

6.2.2.1 Compulsory Government Contracts

One major theme from the respondents' accounts is a discrepancy between the identity of a pharmacy graduate and the expected identity of a pharmacist. The pharmacists in this study provided stories about their educational background; that is, they discussed what they had learned from their pharmacy education. This indicates the identity that pharmacy students were nurtured to adopt for their future role by the pharmaceutical education institutions.

It is found that the pharmaceutical education institutions that the respondents attended offered different specialised programmes in the final year for students to select based on their interests. This final year included work placements specifically for the selected programme.

It is evident that the respondents had a vast variety of educational backgrounds. For instance, a number of pharmacists took a pharmaceutical analytics programme during their education (for example, P10, P13, P14, P12, P08 and P11), others learned about pharmaceutical administration (P01, and P06), some learned about hospital and clinical pharmacy (P07), and one respondent did not have a specialised programme but learned all the subjects of the pharmacy programme (P09).

Pharmacist P10 stated that he chose to take the pharmaceutical analytics programme during his final year, in which he was trained to do scientifically-based research.

> *In the final year, the pharmacy programme in my university was divided into different tracks, including analytics, clinics and administration. For me, I chose analytics as my major.*

He further explained what he had learned from the programme:

During the programme, I learned the skills of chemistry and pharmaceutics... umm, most of the time I was in the lab, doing experiments, researching and there were a lot of calculations. For example, I tested finished products in mice to observe drug reactions. I measured drug levels, and analysed DNA extractions. Most of all, I learned about drug reactions at the cell level, and I also learned about pharmaceutics as well (P10).

On the other hand, other respondents selected different programmes. For example, in the final year pharmacist P01 chose a pharmaceutical administration programme as her major as she wanted to learn a new subject such as marketing. She would have liked to work in a company in which she could apply pharmaceutical administration, yet she ended up working in a hospital. She stated:

I chose to study drugs marketing and pharmaceutical administration during the final year. The subject was interesting. But when I graduated, I started to work at a hospital in my home town (P01).

Thus, when they were newly graduated, the respondents were diverse in terms of background knowledge, skills and specialist practices during work placements, as well as the values of practice of their major programme. Thus, the first key point is that the newly graduated pharmacists took on a variety of identities due to different educational programmes.

6.2.2.2 Lack of a Pharmacy Educational Standard in Universities

Moreover, there is lack of a standard for university educational programmes that leads to differences in pharmacy graduates. As found in this study, respondents who attended a public university had many options for specialist programmes and were trained specifically for each programme. For instance, those who studied pharmaceutical analytics as their specialist programme were trained in a manufacturing setting, and those who studied hospital and clinical pharmacy were trained in a hospital. In contrast to these, the pharmaceutical education programme of a private university offered the same course to all students. For example, one respondent explained that there was no specialist programme at her university. She said:

In my university, there was no pharmacy specialist programme. We all studied the same and were trained in every type of business, including manufacturing, drugstore and hospital. Each training placement lasted a month (P09).

Drawing from Sections 6.2.2.1 and 6.2.2.2, the findings suggest two points. Firstly, the respondents studied different specialist programmes and were trained differently; and secondly, there is lack of a standard for educational programmes in universities. As a result, it can clearly be concluded that the respondents were dissimilar regarding the identities that their educational programme prepared them to adopt for a pharmacist role.

Having pharmacists with different specialities would not be a problem if they could choose to work in an area relating to their educational background. Nevertheless, this thesis highlights that respondents who graduate from public universities typically end up working in a public hospital. One reason for this is that every pharmacy student from a public university has to sign a compulsory contract with the government stating that they will work for two years in the public sector before being free to work in other businesses.[4] Those who do not work for the government must pay a sufficient amount of money in compensation. Hence, many respondents appeared to be working in a public hospital even though they neither liked the hospital job, nor were equipped with the required knowledge and skills for the role of hospital pharmacist.

For example, the respondent P12 completed a pharmaceutical analytics programme during her pharmacy education; however, she never worked in the research and development department which she dreamed of due to having to be placed in a public hospital in Thailand as a consequence of the compulsory contract she had signed with the government:

I had to work for the government, but actually I wanted to work in the pharmaceutical industry. I like R&D (P12).

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4 The government compulsory contract has been used as a means to allocate health professionals to work in different areas throughout the country to ensure that the workforce is allocated equally.

There is evidence of discrepancies in identity between those that pharmacists developed during pharmacy school and those that they were expected to adopt in real work. The consequences of identity discrepancy are evident in that respondents experienced role ambiguity when did not know exactly what they had to do. In addition, they often experienced boundary encroachment with doctors during the early stages of their career. These experiences were explained earlier in this chapter as a transition shock which occurred during the initial stage of role transition from student to pharmacist.

6.2.2.3 Lack of Multidisciplinary Learning in Pharmacy Education

A number of respondents stated that there was lack of a multidisciplinary learning in pharmacy education which resulted in pharmacists experiencing transition shock when they entered a real organisation in which there were hierarchical and multidisciplinary cultures. For example, one respondent identified that newly graduated pharmacists had little knowledge of the work and they often performed the role of doctors, thus their actions led to confusion and conflict. She identified that multidisciplinary learning might ameliorate the boundary encroachment problem because pharmacists would better understand doctors' ideology of care:

> *They* [newcomer pharmacists] *don't know that doctors learned about clinical diseases deeper than us. They* [doctors] *have their rational use of the regimens that we have never learned in our school. If we had learned with them and had trained together with them, we might have understood better why doctors ordered a particular drug* (P12).

Thus, the respondent perceived that the conflict which occurred during the initial stage of macro role transition was due to a lack of multidisciplinary learning in pharmacy education.

6.2.2.4 Pharmacy Lecturers Never Work in Hospitals

Earlier, it was observed that there is evidence of a lack of multidisciplinary learning in pharmacy education which contributes to pharmacists being unaware of the hierarchical culture of real organisations. There is further evidence of the pharmacy profession as a profession being separate from other professions and patients.

The respondents pointed out that pharmacy lecturers are different from lecturers in other professions because they do not work in real organisations. Hence, pharmacy lecturers may be unaware of aspects of organisational culture, such as hierarchical and multidisciplinary cultures.

> *Pharmacy lecturers know theories but never work in a real organisation. So their expectation about the ideal role of a hospital pharmacist is different from reality. They want us to be an ideal pharmacist which cannot be real. Lecturers thought that we* [pharmacists] *can control the organisational system, but in an organisation there are so many factors* (P12*).*

She continued:

> *The pharmacy lecturers believe that we can always consult doctors to change their orders. But in reality, if doctors don't want to change, then we can't change their orders. What they teach in the pharmacy school is only theoretical knowledge, but for real work life we need other skills, for example communication* (P12).

Another pharmacist suggested that pharmacists who work in real organisations should be more involved in teaching pharmacy students. She said:

> *I think it is important to involve pharmacists who work in the workplace to teach and train the students* (P16).

According to the respondents' accounts, pharmacy lecturers know the theoretical knowledge well, yet they lack knowledge of organisational culture. Thus, pharmacy lecturers may not be aware of the hierarchical culture in which the medical profession has the highest clinical autonomy.

So far in this chapter, transition shock has been identified during the initial stage of the macro role transition from student to pharmacist. It has been pointed out that, during this stage, the respondents experience anxiety, frustration and fear due to role ambiguity, lack of awareness of organisational culture and the multidisciplinary environment, and being unable to achieve a work–life balance. Role ambiguity has often led to boundary conflict between doctors and pharmacists

because the pharmacists have neither known how to perform the role, nor interacted with doctors appropriately.

Figure 9 provides a summary of factors contributing to transition shock.

Figure 9: Factors contributing to transition shock
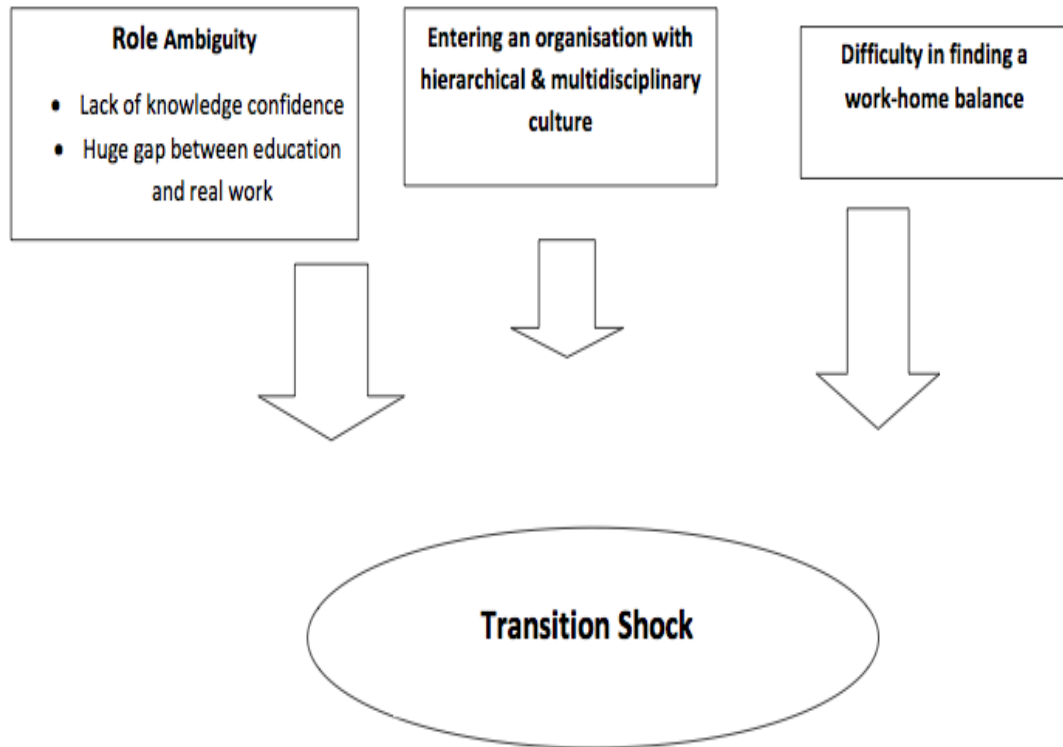
6.3   Coping with Transition Shock: Identity Reconstruction

According to Ashforth (2001), different roles have different identities. Each identity contains different practices, values, goals and interaction patterns. It is clear that there is a huge discrepancy between the identities of pharmacy graduates and the identity of the pharmacist role; nevertheless, there is evidence that the transition shock had been resolved in many respondents in this study, as they had been able to adapt to the new role, acquire knowledge and learn about the organisational culture.

Evidence of the pharmacists' acquiring knowledge and adapting to the organisational culture can be seen from repertory grid interviews in which the respondents were asked to compare and contrast three elements: "myself when I had just graduated", "myself now", and "my future self".

One respondent reported that she had acquired the knowledge and skills required for the role, and had learned to adapt to the organisational culture, so she could communicate with her pharmacy colleagues and doctors effectively. Hence, her perception of self had altered through the process of the role transition, as she stated that she saw herself as a different person now compared to back then. She described herself when she had just graduated thus:

> *When I had just graduated, I couldn't apply the knowledge to my work. I knew where it said in the book but I didn't know how to use it in real patients. I also think my communication skills were not so good* (P02).

She described herself now:

> *I think now I know my colleagues and doctors better. I know what kind of people they are and I know how I should talk with each of them. So I have learned to communicate with them effectively* (P02).

From her accounts, it can be seen that the respondent had learned skills in communicating with other people. There is similar evidence that other respondents were able to acquire work knowledge and skills for their role; hence, they felt more confident and were able to deliver their services more effectively. Consequently, transition shock was resolved in these respondents. Having provided evidence of the mitigation of transition shock, the next sections (6.3.1 and 6.3.2) will discuss the processes which the respondents used to resolve it.

6.3.1   Anticipatory Socialisation: The Role of Educational Background

Anticipatory socialisation refers to the first stage of the socialisation process that occurs before individuals enter an organisation (Van Maanen, 1975). In this study, anticipatory socialisation occurred before the respondents became pharmacists. Pharmacy school was where the respondents initially socialised, learning pharmacy knowledge and internalising professional values, as well as observing the traits of pharmacy lecturers and using them as role models.

The data highlight that the anticipatory socialisation which occurred in pharmacy education was a crucial phase in which pharmacy students gained a broad knowledge of the pharmacy profession, as well as internalising the professional

value of being patient-oriented. The respondents stated that they learned the theoretical fundamentals of esoteric pharmacy knowledge and the skills of the pharmacy profession in their pharmacy education, as well as being nurtured in professional values by their lecturers, who were also pharmacists. One respondent mentioned the role of pharmacy school in equipping pharmacy students with theoretical knowledge and skills. She said:

At university we learned a broad range of theoretical knowledge about pharmacy. I think we have a basic knowledge from production to patient care. But the university did not teach us how to work. So at the school we learned the theory, but at the hospital we learned how to apply the knowledge to work (P08).

The findings show that pharmacy education appears to be influential in nurturing respondents' professional values.

Regarding professional values, the pharmacists reported that they had been nurtured to deliver their practice by being concerned about patient benefits rather than their own benefits. A respondent stated:

The goal of pharmacists' practice, no matter what role they perform, is to contribute to patient outcomes (P08).

She continued:

For example, pharmacists who provide dispensing and counselling services aim to reduce adverse side effects and enhance medication compliance, whereas those who provide production services aim for safe and effective drug use, which in the end also brings about the safety of patients (P08).

Respondents had various perceptions of the role of work placements during pharmacy education. Whilst a few respondents found the work placement useful in preparing them for taking on the role of pharmacist, some felt that they did not receive training specifically for hospital work because they did not study a hospital and clinical pharmacy programme during their education.

For example, a respondent who chose to study a hospital and clinical pharmacy programme viewed the work placement during her pharmacy education as helpful in preparing her for real work. She said:

> *I was trained in a small hospital in a remote district. The hospital was small and there were not many staff. Everyone knew each other. I got a chance to practise all areas of the hospital pharmacist role. I found that period very useful* (P08).

In contrast, a number of pharmacists did not find their work placement useful for their current hospital pharmacist role because they did programmes other than the hospital and clinical pharmacy programme. Examples were given earlier of pharmacists (P10 and P12) who had studied pharmaceutical analytics, yet ended up working in a public hospital rather than in a research and development field.

There is evidence that respondents who took up a professional role in the same field as their educational background seem to have had a smoother role transition than those who changed major. For example, two respondents had a compulsory contract with the government. Both studied a pharmaceutical administration programme during their pharmacy education and both were trained in a private drugstore during their work placement. They reported that they could apply the knowledge and work experience of the work placement to their jobs in private drugstores. For example, one respondent reported that she could apply skills from the work placement to her role in a private drugstore. She said:

> *During the programme, I learned how to design a drugstore. Imagine if we opened a drugstore, what would we need to do? For example, we discussed how to find a location, how to place items on the shelves. I also learned accounting, for example how to do a balance sheet* (P20).

She continued:

> *I learned from the drugstore where I had my work placement. For example, I learned how to diagnose if a patient walked into my drugstore with this condition, what drugs I should be dispensing. I think the experience from the placement gave me confidence when I started my job* (P20).

Some respondents also identified their pharmacy lecturer as a role model who nurtured their professional values and their concept of pharmaceutical practice. The respondents selected some of the lecturers' traits and applied these to their work. For example:

> *When I studied, the concept of pharmaceutical care was just being promoted in Thailand. At that time my lecturer, Ajarn Chalermsri, was the one who taught us about the pharmaceutical care concept and the pharmaceutical value of patient safety. So I learned the professional value from her* (P07).

She continued:

> *I also have another role model, Ajarn Chutamart. She taught pharmacology. I liked how she delivered lectures in the class. She taught clearly. I have her as my role model. When I have to teach newcomers, I apply the way Ajarn Chutamart did in the class* (P07).

In summary, the anticipatory socialisation evidenced by the respondents refers to their pharmaceutical education background. The respondents viewed the role of the pharmaceutical education programme as providing students with broad pharmaceutical knowledge and skills, as well as nurturing the professional value of being patient-oriented. The respondents also observed their pharmacy lecturers and selected some good traits to use when they started work.

The findings also highlight that many respondents had difficulties during the macro role transition because they did not receive education and training specific to their real job.

6.3.2 Learning-by-Doing: Learning through Performing the Role

The study identifies that there was no formal internship period for training newcomer pharmacists before starting the role. One respondent (P12) stated that they learned how to perform the role through "learning by doing", which she referred to as learning how to perform the role by doing the role. The respondents summarised the processes through which pharmacists develop identity for their roles during the process of learning by doing as: 1) observing how their supervisors

and colleagues perform the role and imitating their role performance; 2) receiving feedback from supervisors and senior pharmacists; and 3) adjusting their role performances.

6.3.2.1 The Roles of Supervisor and Colleagues

Pharmacists' mentors and senior colleagues are influencers of identity construction. The respondents revealed that their mentors and senior colleagues acted as role models who demonstrated appropriate behavioural traits that they chose to imitate. For example, one respondent explained the traits of her senior colleague which she perceived as appropriate for her role performance, and how she imitated such traits to perform her role:

> *At work, there is a senior pharmacist. She has expertise and experience.*
> *She is thorough and caring. I see how she works and I try to be like her*
> (P13).

It is evident that the respondents had also observed professional values in their supervisor and had internalised the values to develop their professional identity. This evidence is seen in both work contexts. For example, a respondent in a private drugstore mentioned that she did not sell drugs just to increase sales because she had learned to care about patient safety from her supervisor. She said:

> *Some customers requested antibiotics, and in most cases it was*
> *unnecessary for them to use antibiotics, especially in children. I won't*
> *sell if I think the drug use is unnecessary, even though I could sell more*
> (P20).

She further explained that her supervisor influenced her thoughts about patient benefit. She said:

> *This kind of thing, I was taught by my senior. She told me to be*
> *concerned about safety first* (P20).

With regard to pharmacists using mentors and senior colleagues as role models, the data show that the respondents did not always specify a particular person as a role model, but they selected useful traits and behaviours from many people and imitated those behaviours in performing their role.

I don't have a particular role model. I observe how others solve problems or act and then I will choose what I think is good from many people (P11).

Another respondent also mentioned the role of her supervisor in her professional identity development, together with other people, especially her family. She said:

I learned from my previous supervisor. She acted like a lecturer. She nurtured professional value, gave me encouragement and gave me opportunities. So I have developed. But I also learned from many people. And I think part of it, I am the kind of person who would deal with a problem. I don't like to ignore a problem. I think I am who I am because of my family (P01).

Mentors and senior colleagues also acted as social validators who provided feedback on the pharmacists' practices. The respondents mentioned that they had received feedback from their mentor who trained them:

When I moved from the OPD to IPD, I was trained for the work of IPD. The head of the IPD department gave me training and she is the one who assessed my knowledge and skill and gave me feedback. If she found that I was not ready to work in terms of my knowledge for the IPD role, then I would have to train more for particular skills (P02).

Another respondent said:

My supervisor was good. She trained me at the beginning of my work. So it was useful because I got a chance to train in different service units of the pharmacy department and I also received feedback from her (P08).

The respondents mentioned that they used feedback from their supervisor to adjust their role performance. For example:

I think it is OK to make a mistake. When I made a mistake, my supervisor corrected it. But what is important is that we learned from our mistakes because our mistakes might relate to the safety of patients. So I will not make the same mistake again (P01).

6.3.2.2 Role-Related Relationships

Pharmacists performing their roles always have role relationships with other roles. For example, in a hospital, pharmacists on the patient ward interact with doctors and nurses, as well as patients. They learn the meaning of the pharmacist role through interactions with the roles of others. Similarly, in a drugstore, pharmacists interact with patients/customers who seek health advice and products. Hence, through these interactions, pharmacists learn about the meanings of their role, as well as about others' roles. For example, the interviews suggest that pharmacists learned about what other roles expected of their knowledge after they had been working for a period of time.

> *What doctors expect from us is they want to know whether we can make them an IV mixture for this individual patient. They don't want us to judge them on their clinical decisions* (P12).

From the above example, through working relationships with doctors on patient wards, the respondents gained an idea of what knowledge was required for their role.

Pharmacists also adjust their role performance by observing reactions from others. This was seen when pharmacists in public hospitals consulted doctors in a respectful way, resulting in gaining acceptance from doctors. For example:

> *We need good communication skills ... For me, I would rather have a face-to-face discussion than write a note because anybody can see a written note. It seems like I am pointing out their mistakes in public. And also, when you speak face to face, the other person knows the tone of your voice* (P06).

This respondent had learned how to communicate effectively with doctors and it can be seen that her way of communicating was different from other pharmacists, as she chose to have face-to-face discussions.

On the other hand, pharmacists learned that their behaviour was not appropriate if they received negative responses from others. This study has found that

inappropriate behaviour leads to poor collaboration between pharmacists, as well as a loss of trust by doctors.

> *The problem is the doctors did not trust us* [pharmacists]. *Lately, they have called us due to many errors we made. Most of the mistakes were made by the newly graduated pharmacists* (P01).

In summary, through role-related relationships between pharmacists and other roles, the pharmacists in this study learned the meaning of their role or came to know who they were as pharmacists by understanding what knowledge they were expected to be able to offer to doctors, and what approach they should use to contact doctors. Hence, the respondents developed professional identity through role-related relationships.

6.4   Summary of Part One

This part has provided evidence of identity reconstruction amongst pharmacist respondents during their macro role transition (transferring from student to pharmacist). It has identified a transition shock stage, in which pharmacists experience fear, frustration and uncertainty about role, expectations, organisational culture and work-life balance during the initial stage of role transition.

The section has further highlighted that the transition shock is resolved through two principal processes of identity reconstruction: firstly, anticipatory socialisation, which is their pharmaceutical education background; and secondly, a learning by doing process. Anticipatory socialisation provides pharmacists with theoretical knowledge and fundamental skills as well as nurturing professional values. The study also reveals the role of pharmacy lecturers as role models from whom the respondents selected good traits to apply when they became pharmacists.

The respondents also mentioned that they learned how to perform the role through a learning-by-doing process. In this process, the respondents observed role models, who were their supervisors, colleagues or lecturers, selected some good traits, and performed the role. They received feedback and used it to adjust their performance. The respondents also learned to develop professional identity through role-related relationships, in which the pharmacists learned the definition of their role through

role relationships with counter roles (with whom they interacted) such as doctors, nurses, patients and pharmacist friends.

This section has also pointed out a number of challenges facing Thai pharmaceutical education institutions. These include: 1) a discrepancy between what pharmacists are trained to be during their education and what they have to be in real life; 2) a lack of multidisciplinary training during their pharmacy education; and 3) the fact that pharmacy professionals often remain behind the counter, especially pharmacy lecturers who have never worked in a real organisation. As a result, lecturers' expectations of the pharmacist role is different from reality.

Having summarised Part One, which has discussed identity reconstruction processes during a macro role transition, Part Two will present in detail the pharmacists' experiences of micro role transitions in daily work and how they engage with micro role transitions in the light of identity construction processes.

Part Two: Daily Work

6.5   Engaging with the Consequences of the Role

The data suggest that the respondents had various experiences. Whilst a number of pharmacists felt that the role gives them a sense of pride and belonging because their practice contributes to society, others were in situations that they regarded as a "struggle" or "in-between-ness" or "at a crossroads" (P01). Moreover, some pharmacists reported that they "got bored" with the job (P03). These circumstances had led to situations in which some pharmacists discontinued the role. For example, some negotiated with their supervisor to avoid working in a particular role (P01), while others even left the organisation to do other jobs (P18, P19).

This section summarises the respondents' experiences of engaging with the consequences of the role in three circumstances: 1) Stepping out of their comfort zone and carrying on with the role; 2) stepping back into their comfort zone and discontinuing the role; and 3) struggling in the role.

6.5.1 Stepping out of the Comfort Zone and Carrying on with the Role

A number of pharmacists from both contexts – public hospitals and private drugstores – viewed pharmacists stepping out from behind to counter to deliver roles in patient care as professional development. Hence, this group of pharmacists attempted to take on a patient care role and to acquire clinical knowledge by attending more training as well as self-learning, even though they had previously had less experience in patient care:

> *Pharmacists being involved in patient care is now the global trend. I don't resist this movement. I am ready to learn the knowledge and skills to fulfil this role of pharmacists* (P08).

She further explained how she prepared herself to take on the new role:

> *My current role is related to chemotherapy drug preparation but I have been attending more training about patient care. I don't resist the change of our pharmacy practice toward patient care. I think this movement will move the profession forward* (P08).

When asked about any challenges in taking on the role, this pharmacist expressed various difficulties, including gaining cooperation between pharmacists, gaining trust and acceptance from doctors to involve pharmacists in the team, and preparing pharmacists to be ready to take on the role. Nevertheless, this group of pharmacists expressed their readiness to face any challenge.

> *I have never felt discouraged. It takes time to develop the pharmacist's role in patient care. But I don't give up because we can see the contributions to patients from our role. Currently, the pharmacy department has proved that pharmacists decrease the incidence of adverse side-effect cases in patients who receive chemotherapy drugs* (P08).

Another respondent who met resistance from his colleagues in setting up a counselling clinic, yet still persisted with his role in counselling, said:

> *I was the only one who counselled patients. Other pharmacists did not want to do that because they thought running the clinic would add extra*

workload, while they would only get paid the same. But as I said, this [counselling] *is our responsibility or we have not fulfilled our role. I didn't care that other pharmacists were against me. I just did my job* (P14).

Thus, this group of respondents included those who carried on the role even though they experienced difficulties in work knowledge, gaining acceptance and cooperation.

6.5.2   Stepping Back into the Comfort Zone and Discontinuing the Role

Although a number of pharmacists carried on with the role, several felt discomfort in the role. For example, one pharmacist was not happy with the role on the patient ward as she viewed it as being stressful. She thus said:

> *... After a month, I didn't feel happy. It was even worse than being a checker at the OPD. What I see every day is illness, people who are suffering, moaning patients. It was stressful. I knew this job was not for me. I was not happy seeing those every day. I then talked to my boss. I asked to swap with the new pharmacist who had just graduated in clinical pharmacy and was happy to do patient care on the patient ward, someone who loves to do this job. This would be beneficial to both the pharmacist and the patients. Then I came back to be a checker* (P01).

This pharmacist had gained knowledge and confidence to fulfil the role of patient care on the patient ward. Nevertheless, she expressed unhappiness about performing a role on the patient ward because she found the work related to stressful situations of illness. Hence, she requested a move back to the outpatient department, where she worked mainly behind the counter and had less contact with patients with severe illnesses.

Similar circumstances which led to respondents discontinuing a role were presented in private drugstores. Two pharmacists discontinued their roles in private drugstores as they reported that they felt "guilty" about profiting from their practices. For example:

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I used to run my own drugstore but I don't think I am suited to a business role. I knew that some patients didn't have much money and I felt guilty about charging them too much for drugs. But the business needed money to survive (P08).

This pharmacist closed down her drugstore, yet she retained her role in a public hospital. As she stated, "the hospital job suits me better" (P08).

Conversely, two pharmacists resigned from hospital jobs to become full-time pharmacists in private drugstores. The reasons for their resignation were poor collaboration and lack of support from the pharmacy department, even though they felt interested in the role. For instance:

I was interested in working in patient care. So I went for training myself. It was a short training course, at the end of which I received a diploma. Then I returned to work at the cancer centre (P18).

This pharmacist had already gained knowledge through a short training programme and had shown eagerness to apply her knowledge to work. However, later in her autobiography she reported that there was a lack of support from her supervisor. She said:

I was the only one who went to the ward. I think it's OK. But what upset me was the lack of support from my supervisor. She did not seem to acknowledge the contributions of this role to patients. She even said to me that it was impossible for pharmacists to do the ward round. I cried, you know (P18).

This pharmacist later resigned due to lack of support, encouragement and cooperation from her supervisor. Another pharmacist also identified lack of cooperation as the reason for her resignation. She said:

There was no cooperation in the hospital. There was a heavy workload, and nobody wanted to do more jobs (P19).

To summarise, this group of pharmacists discontinued their roles for two main reasons: firstly, identity mismatch for those who said that this job was "not for me" and those who felt guilty about performing the role of drugstore pharmacist; and

secondly, poor cooperation from pharmacist colleagues and lack of support from supervisors.

6.5.3 Struggling in the Role

Struggling in the role was presented only in the public hospitals. This is because the respondents could choose not to work in a private drugstore; however, it is harder to leave a public hospital job, as the job gives the respondents a sense of security.

A number of hospital pharmacists expressed their experience as a "struggle" or "bored" because they were in situations implying contradictory identities, specifically mismatches between self-identity and role identity ("this job is not for me"), conflict between another social role identity and professional identity (such as being a mother and being a pharmacist), or lack of a sense of belonging (lack of cooperation).

Firstly, there is evidence of conflict between self-identity and role demands. This was observed when pharmacists said that the pharmacist role was "not for me". For example:

> *Personally I don't like a job that requires me to talk to people. That is why I chose work oriented to production. But as quality control is emphasised in the hospital, I also had to give counselling to patients who received cytotoxic drugs. It can be quite stressful, especially when there are many patients* (P13).

This pharmacist remained in the role, although she described the role as "quite stressful". Her additional explanation reveals her insecurity about leaving her current job. As she does not like talking to people, the role of drugstore pharmacist does not interest her. Nevertheless, she has been working for nearly ten years in the same hospital as a result of a compulsory contract and she has been trying to fit in. She further explained:

> *I don't think I would like to work in a drugstore because in this hospital at least I still work in the production unit. But a hospital job can be stressful because now I have been pushed to give counselling as well* (P13).

She continued:

Sometimes I think about resigning, especially because there are increasing demands and workload, but I am also not sure what job I should go for. A job in a public hospital is also more secure (P13).

In addition to conflict between self-identity and role identity, there is evidence of conflict between social and professional roles in some pharmacists. For instance, P09's account demonstrates conflict between the roles of mother and pharmacist:

Regarding low salaries compared to workloads in the hospital, I have to accept the way the system is. I trade off the workload with security, because the hospital is close to my house and it is my home town. I also need to work in a hospital because I have a child and there is a lot of expense (P09).

She further explained:

Today I left my kid with my mom and I get to see them this Sunday. I miss them. About my feelings now, yes, I did not want to work in this inpatient department tonight. I want to be with my kid instead, but I had no choice (P09).

It was a Friday night when I interviewed P09. She was working extra hours at the inpatient dispensary unit, and she had a baby whom she was still breastfeeding. She was on duty in the inpatient department that day; hence, she had to leave her child with her parents.

The quotation suggests that the respondent's other social identity, being the mother of a newborn baby, has a particular impact on her professional role. During her rotation hours at the hospital, she left her baby with her parents. This social identity as a mother causes her tension and struggle with the role demands expected of her professional career. The role of a mother is caring for her children, whereas the role of a pharmacist is caring for patients. As can be seen from P09's account, she cannot avoid being allocated to a difficult situation in which she has to work extra hours. Her struggle is due to moving between social roles which are contradictory in terms of identity; that is, between mother and pharmacist. However, at the same

time her role as a mother also influences her decision to maintain the role of pharmacist, as she stated:

... I trade off the workload with the security because the hospital is close to my house and it is my home town. I also need to work in a hospital because I have a child and there is a lot of expense (P09).

In summary, this group of pharmacists can neither avoid nor discontinue the role because the role in the hospital provides them with a sense of security. Their experience is consequently seen as struggling due to mismatches of identity.

Having discussed the experiences of the pharmacists in engaging with the consequences of the role, it is concluded that there are three types of circumstance: 1) stepping out of the comfort zone and carrying on with the role; 2) stepping back into the comfort zone and discontinuing the role; and 3) struggling in the role. Section 6.6 will highlight the discourses on which pharmacists drew to construct their identities.

6.6   Discourses and Identity Construction

This thesis identifies from the pharmacists' accounts the discourses on which they drew to construct identities. These discourses include professional value (being patient-centred), business value (profit), sense of security value, and sense of belonging.

6.6.1 Professional Value (Being Patient-Centred)

Professional value is the dominant discourse presented in both work contexts. All the respondents from public hospitals and private drugstores stated that the goal of their practice is the benefit of patients.

The respondents from the public hospitals strongly identified the professional value as the reason for continuing the role at the hospital, even though they are on fixed salaries at the hospital. One pharmacist said:

Although money is relatively low, I am happy to be able to help patients, to ensure safety (P07).

Another respondent also identified the professional value as her reason for continuing in the role:

I think about the benefit of the patients. I chose to return to my home town and work in the public hospital because I want to do something for others (P08).

Respondents who worked in private drugstores also drew on the professional value of being patient-centred to form the identity of their role as a professional, as distinct from that of non-pharmacist sellers. For example, one respondent valued patient safety; hence, she refused to sell drugs for abusive purposes:

If I suspect that they will buy drugs for abusive purposes, such as pills for abortion, I will not sell them to them, and I will tell them that it is against the law to use those drugs (P12).

Thus, the professional value discourse was employed by all respondents, in both public hospitals and private drugstores, to describe the goal of their role as being patient-centred. The pharmacists in public hospitals drew on the professional value to justify why they maintained their role at the hospital even though the payment was fixed and relatively low. Similarly, pharmacists in private drugstores also drew on the professional value to guide their practice in an ethical and professional way, thus also distinguishing themselves from non-professional sellers.

6.6.2   Business Value (Profit)

All the respondents (four full-time pharmacists and eight dual-role pharmacists) who work in private drugstores stated that profit is important to maintain their job. Thus, the business value (profit) presents as a dominant discourse in the private drugstore context. The respondents used profit to distinguish private drugstores from public hospitals. Thus, the business value presented only in the private drugstores, not in the public hospitals. A respondent said:

I think the focus of work at the hospital and in the drugstore is the same, in that both focus on patient care. But what differentiates pharmacists in a community drugstore from those in a hospital is that, whether you are an owner or an employee, you have to think about how to make a

profit. If you work in a hospital you don't have to care about profit because you have a fixed salary (P02).

Another respondent also talked about the business discourse on which pharmacists drew in the private drugstore context:

It is impossible for pharmacists in private drugstores not to think about profit because we have to maintain our business. As the owner of a drugstore, I think a pharmacist in a private drugstore will choose products to sell that will give them the highest profit. But in hospitals, the drugs of choice will be the ones that are the most cost-effective (P03).

Thus, the business value discourse distinguishes the two work contexts. In addition to the professional value, the respondents who worked in private drugstores drew on the business value to construct their identity as a business owner or businessperson. The situations in which the respondents drew on these conflicting values have already been discussed in Chapter 5. In situations in which pharmacists perceived low risk to patients, they would draw on the business value to guide their practice as a businessperson, whereas in a situation in which the risk was high (e.g. drug abusive), pharmacists would draw on a professional discourse and refuse to sell medicine, as well as providing educational advice to customers. In Section 6.7.1, the process of negotiating conflicting identities will be further explained.

6.6.3 Sense of Security

Sense of security emerges as the dominant discourse for respondents in the public hospital context. All respondents who felt bored and struggled in the hospital stated that they remained in their hospital job because it gave them a sense of security. For example, one respondent is a full-time pharmacist in a public hospital and operates her private drugstore part-time. She said that she felt happy at the drugstore:

I retain two roles – at the hospital because it is my job and at my drugstore because it is my happiness (P01).

She continued that the hospital job provides her with a sense of security:

I think the main reason that I don't quit my job at the hospital is because I am afraid. I am afraid of not feeling stable after quitting. I am not sure if I quit and only work at my drugstore, whether I would feel bored or not, or whether I would earn enough if I did not have customers all day (P01).

Other respondents from the public hospitals (for example P03, P12, P09, P11, P04, P05) also identified security as a reason for them remaining in their hospital jobs.

It should be noted that the respondents who work full-time in private drugstores did not mention a sense of security in their interviews; however, the pharmacists who maintain two roles – full-time hospital pharmacist and part-time drugstore pharmacist – used a sense of security discourse to justify remaining in their hospital roles. For example:

If I didn't have to take care of my family, I would have quit this job [hospital job] *to work alone in my drugstore* (P03).

Nevertheless, there is insufficient evidence to conclude that a sense of security is available only in the public hospital context. This is because the pharmacists who work full-time in private drugstores might have used a sense of security as a reason for maintaining only a role in the private drugstore if they were generating sufficient sales and profits.

6.6.4 Sense of Belonging

Sense of belonging is evidenced as a discourse that impacts on whether respondents remain in the role. Respondents from both work contexts identified sense of belonging as a significant reason for remaining in the job or loving their job.

In the public hospital context, respondents who drew on a sense of belonging stated that the teamwork of pharmacists gave them a sense of being a part of the team. For example, P06 said that she enjoyed the work at the hospital and she felt happy that she could help patients. She also mentioned the good collaboration between pharmacists,: "I feel I am a part of the team" (P06).

Another respondent said:

We have good teamwork here because everyone has the same goal, which is to increase patient safety (P08).

She also continued about how her job at the hospital enabled her to contribute to people in her community, which implies that she was drawing on a sense of belonging: "I think I live in the society and I should contribute to people in my community".

As can be seen from the above examples, a sense of belonging creates positive feelings toward the role. In contrast, lack of a sense of belonging is evidenced as leading to boredom in the role. For example, analysis of the laddering up interviews also identified a core value of respondents as "sense of belonging" (P03 and P04). Pharmacist P03 gave a sense of security as a reason for maintaining his role in the hospital. In his interview he pointed out that lack of teamwork amongst pharmacists in his hospital creates boredom for him in his role.

What I see is there is no teamwork. Everyone just does his/her own job. No one is willing to give a helping hand. For example, there is a heavy workload in the outpatient dispensary, but those who are not in the outpatient dispensary wouldn't come down to help (P03).

He continued:

I think my motivation has dropped. It is because of the lack of teamwork. I wanted to make a change, but when I met this kind of poor cooperation, I couldn't help feeling discouraged with my job at the hospital (P03).

A sense of belonging is also a discourse on which respondents in the private drugstore context drew. The respondents mentioned "being a health centre for people in their community" (P10), and people acknowledging them as "being a doctor of the community" (P11).

The respondents who work in private drugstores also identified a sense of belonging in society as something that made them happy to be drugstore pharmacists. For example:

Sometimes the return is not only the money. But for example, I feel happy when customers return to my drugstore because they see that I can help them (P10).

This section has discussed the significant discourses on which the respondents drew to construct their identities. Table 9 provides a summary of the discourses, the contexts in which they were available and how the pharmacists used them in identity formation.

Table 9: Discourses and identity construction

Discourses and Identity Construction		
Discourse	**Work context**	**Identity Construction**
Professional Value (being patient-oriented)	Public hospital and private drugstore	Construct identity as a professional. Justify the role as being patient-centred.
Business Value (profit)	Private drugstore	Construct identity as a business person. Justify the role of business owner.
Sense of Security	A dominant discourse in the public hospital context. May or may not be significant in the private drugstore context.	Self as being a mother Self as being responsible for family's financial security.
Sense of Belonging	Public hospital and private drugstore	Self as being a part of a team. Self as being a part of the community.

6.6.5 Summary

Four discourses have been demonstrated as reasons on which the respondents drew to adjust or construct their identities. Specifically, the discourses were used to give the pharmacists answers to the question "why am I doing this job?" The findings identify a multi-discursive characteristic of the different work contexts which impact on pharmacists' identity construction. That is, in a public hospital context, the respondents can contribute to patient safety. The role of pharmacist in a public hospital also provides a sense of security and a sense of belonging which impact on the pharmacists' reasoning for maintaining their hospital roles. On the other hand, in a private drugstore context, the respondents' role is to be a health advisor for the community. The pharmacists in the private drugstore try to maintain their

professional value, while they also have to use business techniques to make profits for their business.

This thesis has thus identified the main difference between the two contexts as being the business discourse (profit).

6.7 Negotiating Multiple Identities: Professional Value versus Business Value – Evidence from the Private Drugstore Context

6.7.1 Compartmentalisation

Two conflicting discourses have been indicated that guide pharmacists' practice in private drugstores. One is being patient-centred, which has been identified as a professional value, and the other is profit, which has been identified as a business value. Being guided by different values, pharmacists in private drugstores clearly have mixed identities between professional and business persona. These hybrid identities are obviously incompatible because the different values guide pharmacists' practice in either an ethical or non-ethical way. When pharmacists draw on the patient safety value, they adopt the identity of a professional delivering a pharmacy service in an ethical way. On the other hand, when pharmacists draw on the profit value, they construct and perform the identity of a businessperson; hence, their practice is aimed at their own rather than patients' benefit.

This thesis finds that, in order to cope with conflicting identities, pharmacists in private drugstores choose to maintain both identities and perform different identities in different situations. This circumstance can be explained using Pratt and Foreman's (2000) term "compartmentalisation", which refers to the mechanism by which an individual preserves conflicting identities without achieving synergy between them.

In situations in which pharmacists perceived low risk to patient health, they would advertise products or supplements to increase sales. In such situations, pharmacists performed the identity of a businessperson. Drawing on a business discourse (profit value) in the identity construction process, pharmacists used sale techniques to increase profits for the business.

On the other hand, in situations in which drug misuse or abuse were presented, pharmacists drew on their professional value of patient safety to construct the identity of a professional and deliver their service ethically. Hence, it is clear that the private drugstore pharmacists maintained both identities and chose to perform each in different situations.

6.7.2   Dis-Identification, Identification and Integration

On the other hand, it is evidenced that some pharmacists were unable to balance the conflicting identities of being a professional and a businessperson. Hence, they left the role in which they were unable to identify their personal identity with their role identity, and maintained their other role which was congruent with their personal identity. Evidence is provided by a pharmacist who used to run her own drugstore whilst being a full-time public hospital pharmacist.

> *I used to run a drugstore but I closed it down because I think the role at the drugstore does not match with myself. I feel guilty about making profit from my work. I like to work in a hospital more because I think I can help people* (P07).

This pharmacist perceived the business goal as conflicting with her personal value, and having to draw on the business goal in her service caused her to feel guilty. She could not reconcile the conflicting goals; hence, she decided to leave one role and maintain her public hospital role, which had a role identity more congruent with her personal identity.

> *The goal of business is to make profit but I feel guilty about selling drugs at expensive prices for them. I know that if they go to the hospital, they will pay much less than they pay in the drugstore. So I always recommended patients to the hospital instead of coming to my drugstore* (P07).

When asked why she liked to help others she further explained that:

> *... Since I was a child, my family taught me to believe in morality. Personally, I also like to help others* (P07).

From her accounts, it can be seen that her personal identity, which was nurtured by her parents, is congruent with the role identity of a public hospital pharmacist. Thus, she formed a professional identity by integrating her personal identity with the role identity of a pharmacist in the public hospital context. Her interview reveals that the businessperson identity of a private pharmacist did not match her personal identity. Thus, she felt guilty about make a profit, because the profit value was mismatched with her personal value of helping others.

Another pharmacist also experienced a mismatch between personal and role identity.

> *I don't like to work in business. I think I am more suited to a hospital role* (P08).

She added:

> *I like being able to help other people. I also feel guilty about making money from other people's illness* (P08).

Both pharmacists expressed conflict between the role identity of a businessperson and their personal identities. Neither was able to trade off their professional value against the profit value, so they left one role and remained in the role of hospital pharmacist, which was more congruent with their personal identity.

The terms "dis-identification" and "identification" are borrowed from social identity theory to explain the identity construction processes evidenced in the above examples. When personal identity and role identity were in conflict, the pharmacists dis-identified themselves from the role identity and chose to identify themselves with the role of public hospital pharmacist, which was more congruent with their personal identity. They also integrated their personal identity with the role identity of a hospital pharmacist to strengthen their professional identity.

It is worth noting that the two respondents have personal values which are congruent with their professional values. Their professional value of being patient-centred is seen as being rooted in their family background, as they said that their parents played a role in nurturing their moral values. Family-influenced identity construction will be discussed in Section 6.8.

In conclusion, pharmacists who work in private drugstores acknowledged two conflicting identities – being professional and being businesspeople. These two identities require different behaviours. Those who remain in private pharmacist roles may be able to balance the two conflicting values, or may trade off their professional value against their business value. The process used to maintain both identities without achieving synergy between them is the compartmentalisation mechanism. Hence, pharmacists who perform both roles may maintain both identities and perform each of them in different situations.

On the other hand, two pharmacists who were unable to balance these conflicting identities dis-identified themselves from their business identity and identified themselves with the hospital pharmacist identity, integrating their personal identity with the identity of hospital pharmacist. Thus, they left one role and remained in the other which was congruent with their personal identity.

6.8   Role of Family and Identity Construction

What emerges unexpectedly from this study is the role of family in the respondents' identity construction. This study finds that the role of family includes parents' occupations influencing how pharmacists choose their professional career, and parents' role in nurturing personal values.

Regarding the role of parents' professional careers in respondents' professional careers, two respondents stated that they chose to study pharmacy because their parents were also pharmacists. These two pharmacists stated that they grew up seeing their parents as owners of drugstore businesses, and this had an impact on their choice of education programme. For example:

> *I chose to study pharmacy because my parents are also pharmacists.*
> *They operate a drugstore and they are successful, and I grew up in the*
> *drugstore which is also my house. So it seems I knew since I was very*
> *young that I was going to study pharmacy* (P04).

This pharmacist returned to his home town and, although he works full-time as a hospital pharmacist, he also operates a drugstore part-time alongside his full-time

job at the hospital. However, he stated that he prefers working in the drugstore as it suits his personality better. He clarified:

I like talking with people. At my drugstore, the work is about advising people about drugs and diseases, whereas in the hospital I basically check the prescriptions (P04).

Another said:

I chose to study a pharmacy because my mother is a pharmacist (P19).

Another pharmacist grew up in a family which runs a retail business. She stated that she has liked selling products and talking to people since she was a child. This pharmacist ran a drugstore business as soon as she graduated because she did not have a contract with the government. When asked why she decided to operate a drugstore straight after graduation, she explained that:

I like to sell and talk to people. Since I was a child I have seen my family running a business. I think I like this kind of job (P21).

Hence, the findings suggest that respondents drew on the professional careers of their parents in deciding their own careers.

With regard to the role of family in nurturing personal values, the findings reveal that family background plays a crucial role in influencing the values of the respondents. The data demonstrate that respondents whose families operated drugstores and retail businesses internalised and drew on the business value of profit to construct their identity as a businessperson, while they also drew on the professional value from their professional education. For example one respondent stated:

A drugstore is also a business, so I have to think about profit, otherwise the business would not survive (P21).

When asked about how she maintained the professional role together with the business owner role, she explained:

As a pharmacist, I choose the right drug for their condition. I make sure that they understand their health condition and I make sure they are

safe in their drug use. So I give advice and counselling. These are the
roles of a professional. But as a business owner I also have to make a
profit. I will give them some vitamins or supplements together with the
drugs, so these products increase sales (P21).

As can be seen, the pharmacists accepted two conflicting values – self-benefit and patient benefit – to guide their practices. The previous respondent constructed her identity by drawing on two conflicting discourses: professional value and business value. Her identity is seen as a hybrid of a businessperson and a pharmacist.

Two pharmacists who were not from a business background used to run their own drugstores. However, they both closed down their drugstores even though they earned more money than from their public hospital jobs. They both stated that they felt guilty about making a profit. One said:

I used to run a drugstore but I closed it down because I think the role at
the drugstore does not match myself. I feel guilty about making a profit
from my work. I prefer to work in a hospital because I think I can help
people (P07).

Similarly, another pharmacist (P08) also explained that the reason she closed down her drugstore business was that she felt guilty.

When asked what made them both more concerned about patient benefit than self-benefit, both identified family as an influential factor on their values. One said:

… Since I was a child, my family taught me to believe in morals.
Personally, I also like to help others (P07).

Another respondent (P06) stated that who she has become was rooted in her family:

… And I think part of it, I am the kind of person who would deal with a
problem. I don't like to ignore a problem. I think I am who I am because
of my family (P06).

Thus, it can be seen that family also plays a role in nurturing personal values at an early stage of individual identity construction. This value is regarded as a core value on which pharmacists draw to construct their personal identities. If their personal

values were mismatched with their role values, the pharmacists in this study chose to discontinue the role (P07 and P08).

In summary, parents' professional careers influence pharmacists in choosing their education and future jobs. Family also plays a role in nurturing personal values at an early age. The pharmacists from business families internalised business values at an early age, together with professional values from their education. Thus, they were able to draw on conflicting values to construct hybrid identities. On the other hand, respondents who were not from business families might have found it more difficult to internalise business values. As evidenced in this thesis, they drew on a sense of morality gained from their parents and integrated this value with their professional values. Figure 10 provides a model of identity construction by the pharmacists.

Figure 10: Model of identity construction by pharmacists
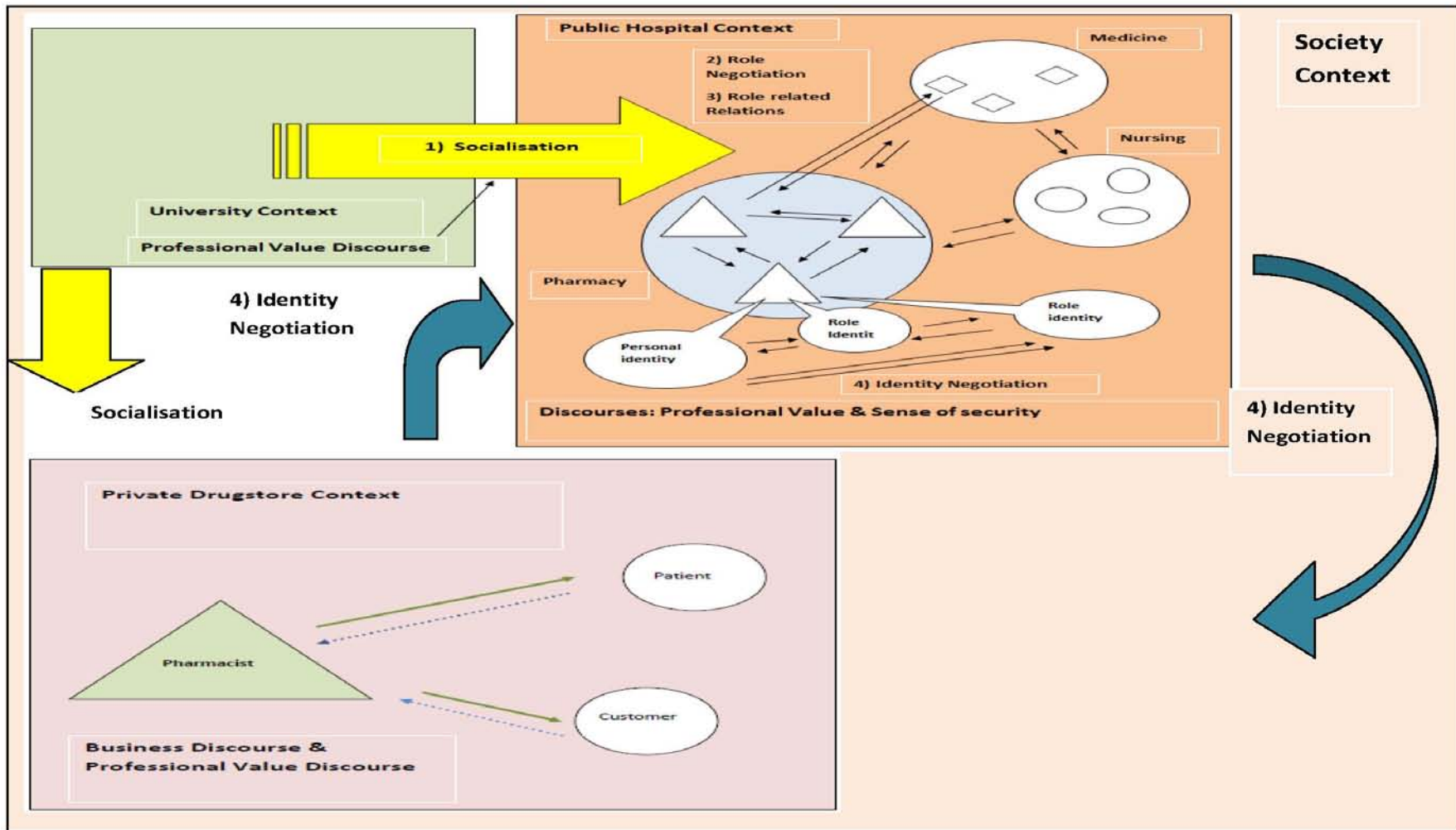
6.9   Summary of Part Two

Part Two of this chapter has examined identity work in the light of professional and work contexts. The identity work concept involves "people being engaged in forming, repairing maintaining, strengthening or revising the constructions that are productive of a sense of coherence and distinctiveness" (Sveningsson and Alvesson, 2003, p. 1165:1165).

Individual pharmacists' identity work has been explored by examining how they engage with the consequences of the role. The results suggest three different experiences: 1) stepping out of the comfort zone and carrying on with the role; 2) stepping back into the comfort zone and discontinuing the role; and 3) struggling in the role.

Four dominant discourses available in the respondents' work contexts have also been identified: professional value (being patient-oriented), business value (profit), sense of security, and sense of belonging. It is concluded that work contexts are multi-discursive. In public hospitals, where salaries are fixed, the respondents drew on professional values to guide their practice. They also drew on a sense of security and a sense of belonging as reasons for maintaining their hospital roles.

On the other hand, in private drugstores professional and business values present as two conflicting discourses. Respondents who work in private drugstores drew on both discourses to construct their identities. The process of identity construction using two conflicting values is known as "compartmentalisation", through which respondents drew on each value to construct different identities in different situations.

There is evidence that those who cannot draw on these two conflicting values will leave the role of private drugstore pharmacist and remain in the other role, which is more congruent with their personal values. The processes through which these pharmacists constructed their identities are dis-identification, identification and integration.

6.10 Discussion and Conclusion

The literature review identified a gap in the existing literature in that there is limited understanding of what situations or processes are involved in identity construction (Pratt et al., 2006; Ibarra, 1999).

The previous literature has addressed various aspects of identity construction. For example, Sluss and Ashforth (2007) propose a model in which individuals construct a relational identity interactively influenced by role-based identity and personal-based identity between a role holder and a complementary role holder. However, this model cannot explain how individuals construct identity during the initial stage of enacting a new role. Furthermore, the model lacks consideration of the effect of cultural discourses, which also play a role in shaping individuals' identity.

Previous studies have found that socialisation is a crucial process during macro role transitions (e.g. Ibarra, 1999); however, these studies lack consideration of micro role transitions. They have also assumed that individuals construct their identity through adaptation to fit into an organisation, yet there is a lack of consideration of how individuals' identities are shaped by the effect of cultural discourses within the organisation.

Thus, a gap in the previous literature has been identified, in that previous studies have often considered only one aspect of identity construction. This chapter has provided an understanding of how pharmacists reconstruct their identity in and around work contexts, using the concept of *identity work*, which refers to individuals being engaged in dynamic characteristics of identity construction and reconstruction (Sveningsson and Alvesson, 2003), conceptualising identity construction as dynamic.

The findings have highlighted identity reconstruction during macro role transitions (Part One of this chapter) and during micro role transitions (Part Two of this chapter).

With regard to identity construction during macro role transitions, the findings have highlighted the role of pharmaceutical education as a place for anticipatory socialisation, a stage at which the respondents learned broad pharmacy knowledge,

observed good traits of their pharmacy lecturers, and internalised professional values. The second mode through which the respondents acquired the expected identity of the role of pharmacist was through a "learning by doing" process. In this process, the findings have highlighted the role of supervisor and colleagues as role models who exhibit good traits for the pharmacists to observe and imitate by performing the role, receiving feedback and adjusting their performances. In this learning by doing process, the pharmacists also learned who they were or, in other words, developed a sense of their professional identity through role-related relationships. That is, they learned the meaning of their role by interacting with counter roles, including doctors, nurses and patients.

With regard to identity construction during micro role transitions, this chapter has examined how the respondents constructed and reconstructed identities to deal with micro role transitions in day-to-day life, for example from being a mother at home to being a pharmacist at the hospital, or from being a full-time hospital pharmacist to being a part-time drugstore pharmacist.

The outcomes highlight the role of discourses in work contexts in the process of identity construction. These discourses include professional value (being patient-oriented), business value, sense of security and sense of belonging. The business value presents as a discourse which distinguishes the private drugstore context from the public hospital context, and thus determines the hybrid identity of pharmacists in private drugstores.

This chapter has also identified the processes involved in negotiating conflicting identities with which pharmacists engaged to construct identities. These processes include compartmentalisation, dis-identification, identification and integration.

This chapter has therefore provided a more complete model of the identity construction processes which occur during macro and micro role transitions. The identity construction model in this study includes the role of discourses within work contexts, on which pharmacists drew in the process of identity construction. Furthermore, the

model highlights negotiation between personal and role identities, and how this impacts on identity construction in the light of identity work.

The findings have also demonstrated the role of family, which acts as a resource on which the respondents drew in choosing their professional careers and constructing their identities.

The next chapter will draw conclusions from this study.

Chapter 7: Conclusion

7.1   Introduction

This research was conducted to fill gaps in two ranges of literature: the pharmacy profession and identity theory. With regard to the pharmacy profession, the profession is being directed toward patient care practice, but it has been criticised from a sociological perspective regarding its semi-professional status and mixed image (Denzin and Mettlin, 1968; Edmunds and Calnan, 2001). Moreover, the majority of studies in the existing literature on the pharmacy profession have focused on the effectiveness of pharmacists' interventions (e.g. Nkansah et.al., 2010; Hanlon et al., 1996), while there has been a lack of empirical studies addressing how pharmacists construct their identity in making this transition.

It is important to understand how individual pharmacists construct their identities, and how they behave or react within role boundaries. Identity theory has previously been used to study individuals within organisational contexts (see, for example, Ibarra, 1999; Pottie et al., 2009). However, there has been a lack of empirical studies addressing specific processes and situations of identity construction at an individual level, especially in the professions (Sveningsson and Alvesson, 2003). Relatively few studies have addressed how individuals whose careers are regarded as professions construct identity in and around their work and organisations (Ibarra, 1999; Pratt et al., 2006). However, these studies analyse identity from a single perspective. For example, Ibarra (1999) and Pottie et al., (2009) analyse identity construction through socialisation. These studies considered the interactions of individuals in constructing identity, yet have lacked consideration of the impact of discourse and context. Similarly, Pratt et al. (2006) consider identity construction as a result of work- integrity identity violations or the mismatch between what physicians did and who they were. This study also lacks consideration about discourses in influencing identity construction.

Consequently, there is a need to address how professionals construct their identity. In order to provide an understanding of identity construction processes/situations in professionals, this research was conducted within the context of the pharmacy

profession, which has been extensively criticised in the existing literature for being an "incomplete", "semi", or "marginal" profession (Edmunds and Calnan, 2001).

In this thesis, identity has been conceptualised as identity work, a concept which refers to individuals being engaged in dynamic processes of identity construction. These are processes through which identity is formed, repaired, maintained, strengthened or revised to provide a sense of coherence and distinctiveness (Sveningsson and Alvesson, 2003). Identities are consequently viewed as dynamic.

Thus, following a review of previous literature on the negotiation of role boundaries and identity construction, the following research questions were established:

1. *How do pharmacists negotiate the establishment of role boundaries in the light of professional transition?*

2. *How do pharmacists engage with the consequences of the role within the boundaries of pharmacy?*

In examining how pharmacists negotiate the establishment of role boundaries, this thesis employed negotiated order theory (Strauss et al., 1963) and the social arena concept. It employed an inductive approach, with the aim of discovering themes from the data, as well as used narrative data derived from interviews, autobiographies and a focus group.

The chapter proceeds as follows. Section 7.2 presents a summary of the findings and the contribution of these findings. Section 7.3 discusses the policy implications for Thailand, whilst Section 7.4 discusses the limitations of this research, and makes recommendations for future study.

7.2 Summary of Results and Contribution of the Study

This thesis has presented a detailed analysis of pharmacists' negotiations to establish role boundaries, and their processes of identity construction. Chapter 2 provided a review of the exiting literature, revealing that there is concern about boundary conflict between medicine and pharmacy professions in pharmacists' role expansion into

patient-oriented practice, as well as a lack of literature demonstrating how pharmacists negotiate to establish their role within a patient-oriented paradigm.

Chapter 3 presented the research design and methodology used in this thesis, and Chapter 4 provided background information about the work contexts and the pharmacists who provided data for this study. The main empirical findings of the study have been presented in Chapters 5 and 6. A summary of the empirical findings and their contributions are seen next.

7.2.1 Establishing Pharmacy Role Boundaries across Work Contexts

Using negotiated order theory and the social arena concept, this thesis has offered a comparative analysis of pharmacists' roles and social resources, as well as the negotiation strategies they mobilise in the establishment of role boundaries in two different work contexts; public hospital and private drugstore.

The findings highlight differences of the social arenas between public hospitals and private drugstores. The social arenas in the public context involve multidisciplinary professions which include doctors, pharmacists and nurses, who in turn negotiate to set a boundary of their role. In the public hospital setting, pharmacists must negotiate not only with doctors to gain acceptance and establish role boundaries, but also with nurses and pharmacists as well, as the success of role establishment is also influenced by negotiating with these groups. On the other hand, in a private drugstore context, the social arena includes a pharmacist as the sole professional and their service users as social actors. Subsequently, the study demonstrates that, in order to establish pharmacy role boundaries and claim professional identity in patient oriented practice, Thai pharmacists must negotiate successfully with not only doctors, but also nurses, pharmacists as well as service users.

The findings in this thesis are different from the existing empirical studies about pharmacists negotiation because this study points out that the conflict does not include only pharmacy-medicine boundaries but also pharmacists have to negotiate with other social actors in the hospitals, especially amongst the pharmacists themselves. The thesis also identified the arena rules including the hospital accreditation programme

and the rotation policy as facilitating pharmacists role boundary expansion. Workload within public hospital context is seen as a supporting factor as well as a prohibiting factor for pharmacy role establishment.

Concerning workload as a supporting factor, this thesis points out the workload has caused nurses to willing to delegate counselling role and cytotoxic preparation role to pharmacists. Regarding workload as a prohibiting factor, this thesis finds that workload has cause poor cooperation amongst pharmacists. Consequently, pharmacists were not willing to do more work when they have fixed salaries. Thus, the challenge is seen as pharmacists have to win negotiations amongst themselves to be able to allocate tasks.

With reference to the commercial setting, specifically a private drugstore, this thesis finds that pharmacists have to negotiate with their service users (patients and customers). The thesis further points that the Thailand Drug Act is the arena rule which influences negotiations, with the Act restricting the sale of controlled drugs to pharmacists only. However, due to weak enforcement, pharmacists in private drugstores work hard to distinguish themselves from other layperson sellers, in order to create a professional image and trust, and consequently gain successful negotiations.

This thesis contributes to knowledge by demonstrating the use of negotiated order theory, firstly in an institutionalised hospital context in which the professions are administered by division of labour, and secondly in the commercial setting of private drugstores.

7.2.2 Identity Reconstruction

By using identity theory to examine how pharmacists engage with the consequences of the role, this thesis has examined identity construction through the lens of both macro and micro role transitions.

During a macro role transition – the transition from student to pharmacist – this thesis identified identity shock, owing to discrepancies between the identity of a new graduate and the expected identity of a professional. Pharmacists use a socialisation process to reconstruct identity and resolve transition shock. In addition, they construct identity

through interaction with others. Specifically, they learn about their meaning of self through learning the meaning of the counter role, for example, a pharmacist learning the meaning of his/her role as a subordinate, through interaction with a doctor.

Micro role transition considers moves from one social role to another, for example from a production role to a dispensing role, from a hospital role to a drugstore role, or from being a mother at home to being a pharmacist at work. With regard to micro role transition, this thesis identifies identity construction as resulting from the interplay of individuals, discourses within contexts (work context and society) and professional values interacting to shape identity. The outcomes highlight the role of discourses within work contexts which influence identity construction. The study thus demonstrates different processes of identity construction by pharmacists in public hospitals and private drugstores.

This thesis also highlights a business value discourse and a professional value discourse as two conflicting discourses in private drugstores. In dealing with these conflicting discourses, some pharmacists construct identities through a compartmentalisation mechanism, while others construct identities through dis-identification, identification and integration. Consequently, at the theoretical level, this thesis offers a more comprehensive model for considering identity construction.

7.3   Policy Implications

The results of this study highlight implications for Thailand and suggest improvements for the Thailand pharmacy profession. In this regard, the thesis demonstrates that Thai pharmacists must negotiate not only with doctors, but also with nurses, service users and other pharmacists to establish their role boundaries and claim their position in society.

As already mentioned in the literature review, in different situations and interactions, pharmacists have different power, as well as negotiating processes, depending on whom they interact with. For example, in a situation where a pharmacist negotiates with a doctor, who has higher class power, a pharmacist must be able to exercise their

other social resources, particularly comprehensive pharmacy knowledge and communication skills, in the negotiative process to gain acceptance and trust and make claim of their role boundary.

The thesis however reveals the case in which newly graduated pharmacists failed to exercise their unique pharmacy knowledge and communication skills when negotiating with doctors. The thesis finds that this was due to pharmacists being unaware of their role as a pharmacist and the role of doctors. Hence, newly qualified pharmacists often perform the role which contradicts the role of doctor, in particular in prescribing roles. Consequently, conflict between the medicine and pharmacy profession often occurred. The thesis identifies this problem of pharmacists not knowing their role and the role of others as due to identity discrepancy between the identities pharmacists nurtured during their education, and the role identities pharmacists were expected to perform.

Furthermore, the findings in a private drugstore setting reveals public health problems in Thailand, specifically drug abuse, and antibiotic resistance. These were due to malpractice of laypersons in the private drugstore setting. In particular, this thesis found that law enforcement in Thailand is ineffective. Although the Drug Act restricts dispensing services of dangerous and prescription drugs to licensed pharmacists only, laypersons still illegally dispense drugs. This has led not only to public health issues but also to mixed images between professionals and shopkeepers. Thus service users cannot distinguish between pharmacists and laypersons. Subsequently, it is difficult for pharmacists who work in the private drugstore setting to gain trust from the community or society and to be able to establish their professional boundary.

To ameliorate these problems, three recommendations are listed as follows:

First, the thesis found that there is lack of multidisciplinary learning during the pharmacy educational programme. Consequently, pharmacists were unaware of the roles of other professionals in the hospitals when they first entered the workplace. This thesis thus suggests adding a multidisciplinary learning programme which would help pharmacy students learn the role of other professionals as well as their role in the early

years of pharmaceutical education, in order to prepare pharmacists for entering the world of real work. Besides, it is found that there was a lack of standard of pharmacy educational programme amongst universities in Thailand, as it is evident that pharmacists were trained differently during their education. As a result, new pharmacy graduates were varying in their knowledge and skills, as well as the perceptions of who they are. This thesis suggests that pharmacy lecturers together with the pharmacy council should ensure that there is a standard of curriculum vitae for every pharmacy college.

Second, this thesis found that pharmacists viewed pharmacy lecturers as knowing a lot about theoretical knowledge, yet they may lack work experience. Consequently, pharmacy lecturers may not be aware of the work culture in hospital settings, where health professionals have different status and power. To prepare pharmacy students awareness of hierarchical culture in the hospital setting, this thesis thus suggests extending the role of pharmacists in hospitals and drugstores, to providing training to pharmacy students.

Lastly, a suggestion is recommended for the practice of pharmacy in the private drugstore setting where law enforcement is ineffective. This thesis advises employing strong law enforcement to reduce malpractice in the private drugstore setting. This is to limit dispensing of dangerous drugs and prescription drugs to pharmacists only. Laypersons should therefore only sell over the counter drugs. Besides, pharmacists who work in the private drugstore should also wear a dress code to distinguish themselves from shopkeepers, in line with what is being promoted by the Thailand pharmacy council.

7.4   Limitations and Recommendations for Future Research

This thesis offers an understanding of how pharmacists negotiate the establishment of their role boundaries and how they engage with the consequences of the role. However, there are some limitations which future research might examine further.

With regards to the interviews and autobiography, participants may have been less than candid in the opinions they expressed and attempted to express views which are perceived as socially desirable and representative of what they believe the interviewer wishes to hear (Saunders et al., 2012). Therefore, a complete picture of opinions may not have been given. Nevertheless in using triangulation, including the use of a focus group interview, it is suffice to say that the research questions have been adequately answered.

Besides, the researcher experienced difficulties in applying repertory grid interviews to all respondents. This was due to the rating which was difficult for the respondents. Repertory grid interview and analysis can be useful to generate personal construct, however the technique requires time from the respondents in order to learn how to use it. Time was the key issue because pharmacists are generally busy. Thus, by the time the researcher finished the repertory grid interviews, the respondents were running out of time, and had to go back to their work. Thus, the interview data were limited to around the discussion about the elements from the repertory grid interview.

Subsequently in applying the use of repertory grids to the study of identity in the future, one should firstly consider the issue of time. The repertory grid interview limits interviews to only the elements on the form. In effect using the method alone might not be enough to get all aspects of individual identity construction. Thus, future research could consider using the technique with a combination of other methods, for example in-depth interviews and autobiographies, in order to gain historical data and allow unexpected themes to emerge. The grid could also be applied to different types of stakeholders, for example pharmacy lecturers and policy makers, to identify any mismatch of constructs between pharmacist practitioners and those who produce pharmacists. If done in combination with a focus group, the results could be useful to academia and policy makers with regard to policy implementation.

Last but not least, this thesis in collecting data, employed individual interviews, autobiographies and a focus group interview. Although these methods together provided rich data for this study, future research should consider using an observational study to examine identity construction, as this would establish what happens in a

natural setting. Interview and autobiographical data contain information self-selected by the respondents, however an observational study would allow the researcher to observe interactions happening in a real setting.

Appendix

Appendix A1: The Summary of Core Values

The summary of P04's Ladder interview

Opposite pole   Preferred Pole

Lack of sense of belonging   Sense of belonging

(Being unaccepted by the   (Being accepted by others)

society)

Don't understand   Understand others

others

No chance to communicate   Have chance to communicate

with people   with people

Non-family background   Family background

Non-business role   Business-oriented role
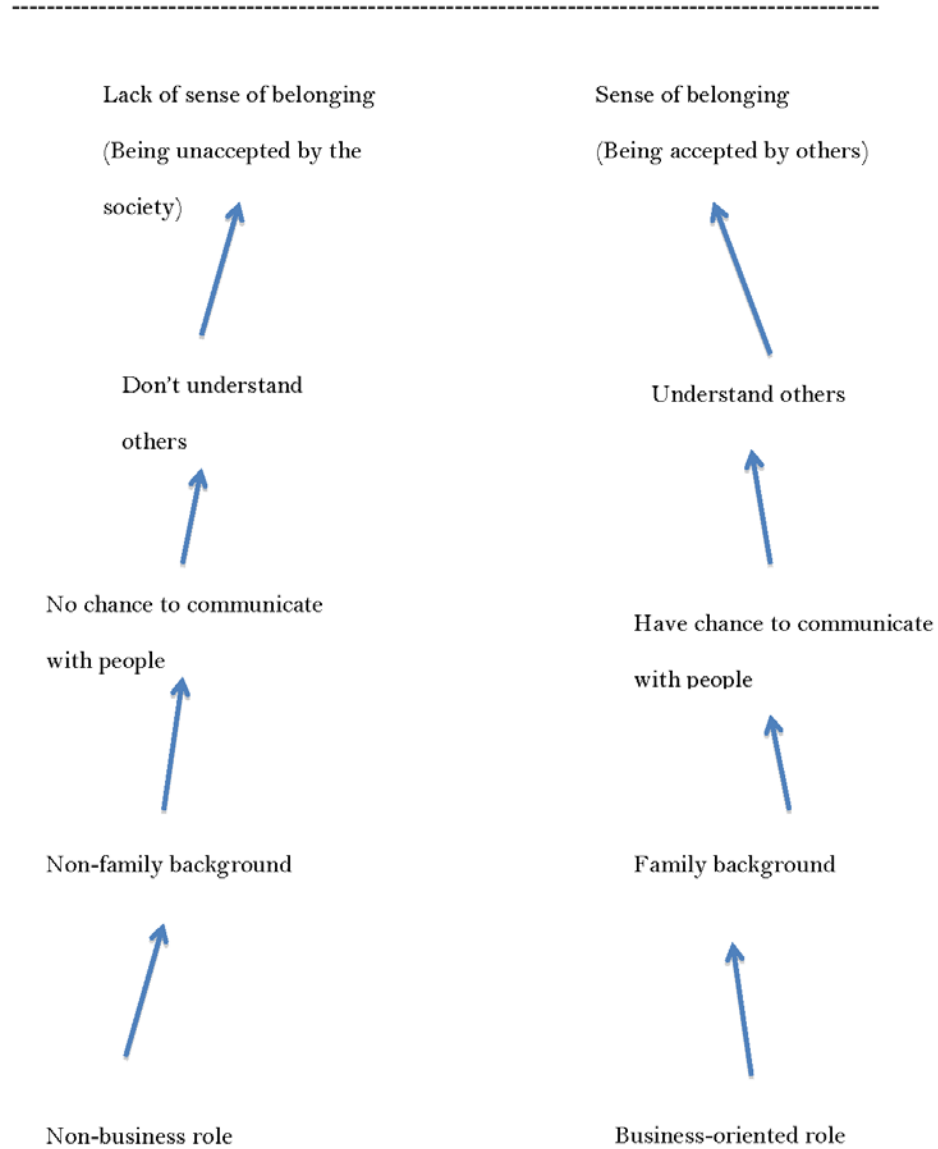
The summary of P13's Ladder interview

Opposite pole   **Preferred Pole**

Lack of sense of security   Sense of security

↑   ↑

Harmful to patients   Safe to patients

↑   ↑

Unsure whether   Know whether my practice
my practice was right or wrong   was right or wrong

↑   ↑

Outcomes are not fixed   Fixed outcome

↑   ↑

Patient care role   Production role
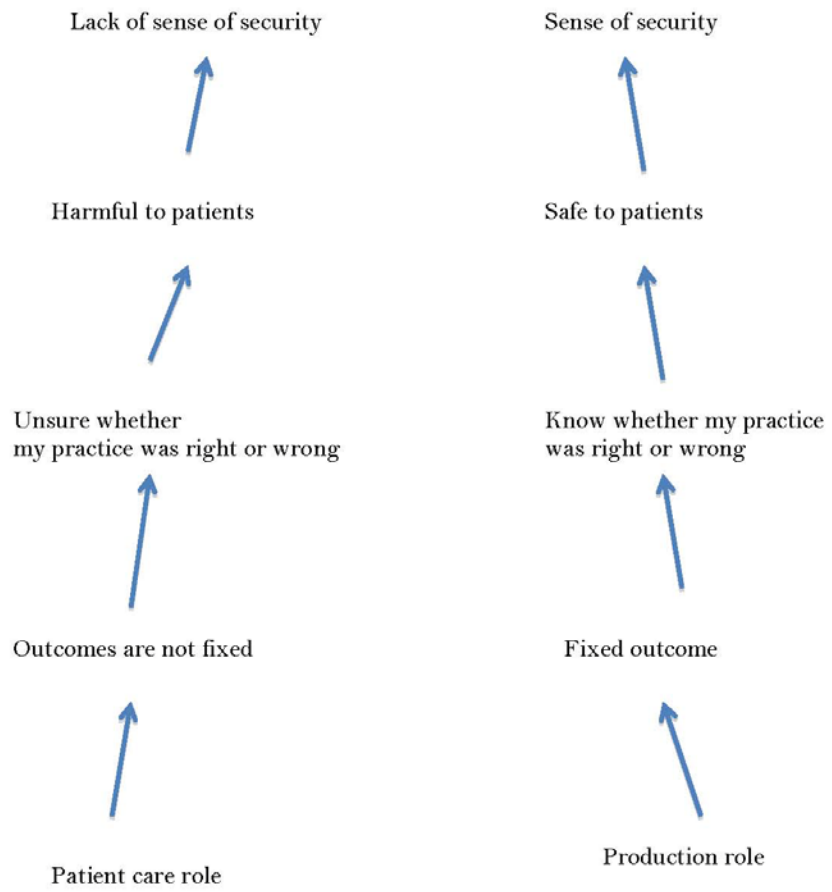
The summary of P03's Ladder interview

Opposite pole   **Preferred Pole**

Lack of sense of belonging   Sense of belonging

Having negative image   Well-known and having good
In the society   image in the society

Feeling discouraged   Feeling encouraged

Receive negative feedback   Receive positive feedback from
from customers   customers

Self-benefit   Benefit is the
(profit)   wellbeing of others

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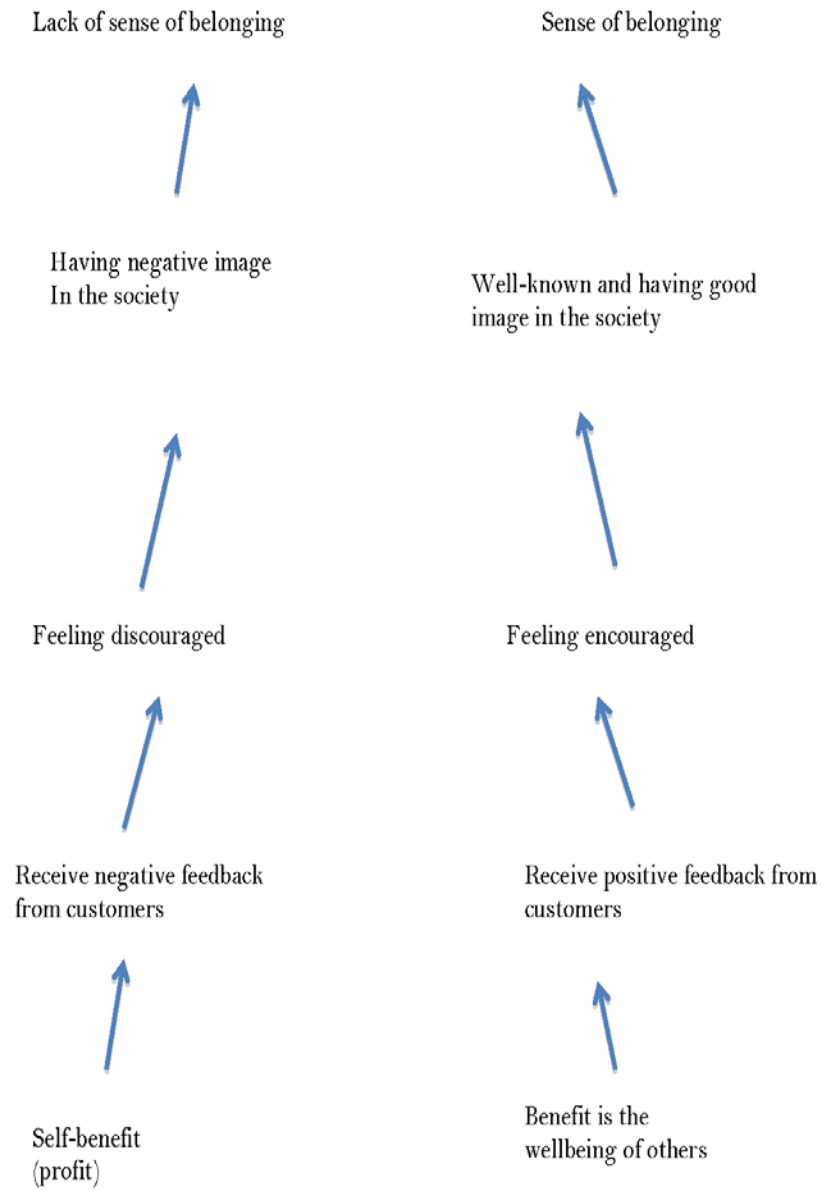
The summary of P02's Ladder interview

Opposite pole   **Preferred Pole**

Lack of sense of security   Sense of security

There was none whom   People are willing to help me when
I could ask for help when I needed.   I need help.

Can't live well   Live well with other
with others in the   people in the
society   society

Concern about   Concern about public benefit
self-benefit

The summary of P12's Ladder interview

Opposite pole   **Preferred Pole**

No sense of security   Sense of security

Extinguishing of the role   Survival of the role

Not being acknowledged of the role   Being acknowledged and accepted
in the society   by others in the society

The action may cause error   No mistake (or very small)
to patients' lives
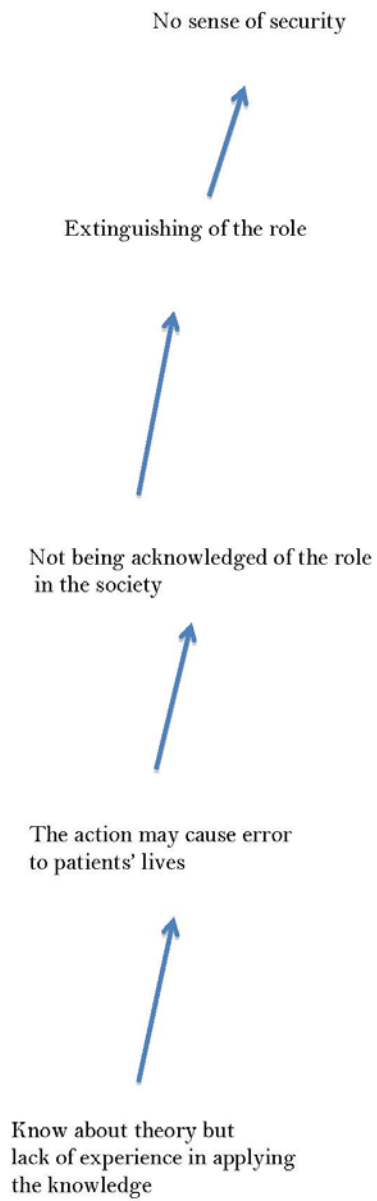
Know about theory but   Know how to apply knowledge
lack of experience in applying   into practice.
the knowledge
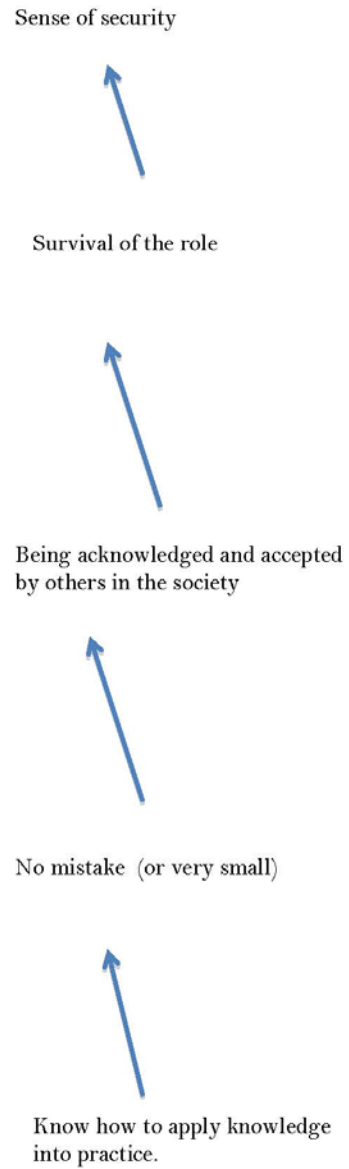
Appendix A2: Examples of a Thematic Analysis

Open coding

"Regarding the returns, I just traded off with the low salaries because there is workload but the money is fixed. But there is security because the hospital is near my house. I can be with my baby. In the past, I left my baby with a maid.

There is a mother role, too. But I have to work because there is more expenditure at home. Now I leave my kid with my mother. I don't think I'd quit because there is more security in the public sector and it's near my house (P09)

"I am a kind of person who can adjust. Although I didn't like to work in a hospital especially about clinics, I would try to adjust myself, learn, so I never thought of quitting. I can do any work" (P10)

- Security
- Hometown
- Mother role (High expenditure, need money)
- Trade off
- Low salaries
- Workload

Perception about self

Final Theme

Retaining the Role

How the themes relate to Identity construction?

"In my university, there was no track. Every student studied the same and was trained in every types of business. The training includes manufacturing, drugstore, and hospital. Each place included training" (P09)

I studied analytics as my major and the programme relates to research and development." "It was a 5 year programme" (P12)

"I took a scientific track during my study. The pharmacy programme was divided into major tracks including clinics, analytics and administration"

Educational Background

Discrepancy between education & Role

"I did pharmaceutical administration but I started working in a hospital. I had nothing in my head. No idea

Perception about role

I don't like clinics. I think it was difficult. But when I started working in the hospital, I was allocated to clinics which was opposed to what I like (P10)

Appendix B1: Consent Form

CONSENT FORM   **The York Management School**
                                          University of York
Reference number: «Ref_Number»   Freboys Lane
                                          Heslington
                                          YO10 5GD
                                          Tel +44 (0) 1904 325062
                                          Fax +44 (0) 1904 325021

Professional Identity Construction amongst Thai Pharmacists

Researcher: Fon Ninkhate

		Please tick each box
1.	I agree to participate in this study	
2.	I understand that my participation in this study is voluntary and I am free to withdraw from the research at any time without giving any reason and without any detriment to myself and my organisation	
3.	I confirm that I have read and understand clearly the information sheet for this research and have had the opportunity to ask questions about the study. These questions have been answered satisfactorily by the researcher.	
4.	I understand that the interview will be audio-taped	
5.	I understand that only the members of the research team have access to the information collected during the study	
6.	I am aware that the information collected during the interview will be used to write up a PhD thesis, and may be used in future research	
7.	I understand that information collected during the course of the research project will be treated as confidential. This means that my name, or any other information that could identify me, will not be included in anything written as a result of the research	
8.	I understand that when this research is completed the information obtained will be retained in locked filing cabinets in a storeroom in the York Management School, University of York, for 5 years and will be destroyed thereafter	
9.	I would like to be informed of the outcome of the research via a report summary, and/or be informed of any future publications	

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

Appendix B2: Participant Information Sheet

Participant Information Sheet   **The York Management School**
                                            University of York
Reference number: «Ref_Number»   Freboys Lane
                                            Heslington
                                            YO10 5GD
                                            Tel +44 (0) 1904 325062
                                            Fax +44 (0) 1904 325021

<u>**Professional Identity amongst Thai Pharmacists**</u>

You are invited to take part in a research study which is being conducted as part of a Doctoral Research degree at The University of York by Miss Fon Ninkhate, Professor Stephen Linstead and Professor Jill Schofield. We appreciate your participation which we believe will greatly enhance the findings of this study.

Before you decide whether or not to take part, it is important for you to understand why the research is being undertaken and what it will involve. Please take time to read the following information carefully and do ask if there is anything that is not clear or if you would like more information.

Purpose of this Research

Despite the popularity of identity theory, there is still lack of in-depth understanding about the detailed processes of identity construction at a personal level. Besides, the current literature also reveals that there is limited understanding in applying identity construction in those who deliver esoteric knowledge like professionals.

Pharmacy is a profession that has transformed the roles from product-oriented to performing patient care since the clinical pharmacy concept was initiated in the 1970s. Like other countries, Thailand has been promoting clinical roles of pharmacists in both hospitals and drugstores. The new roles include counselling, ward rounds with doctors, working in a multidisciplinary team. As a result, Thai pharmacists perform new roles, whilst they also have to maintain a traditional dispensing role. In this transformation stage that has been forced by health reforms,

there is no evidence of how they react to the political forces and how this reflects in their identity work.

Therefore, Thai pharmacy provides a case of a profession that has undergone role change for this study.

The aim of this research is to explore the specific processes and situations which affect individual pharmacists in constructing identity in and around their work.

Your Involvement

As a hospital or retail pharmacist, you have been identified as a potential participant in this study for your knowledge of pharmacy and your extensive working experience in the profession.

Your participation is entirely voluntary. You are free to withdraw from the research at any time without giving a reason and without any detriment to yourself or your organisation.

If you decide to take part in the research, you will be interviewed or asked to write an autobiography regarding yourself as a pharmacist or both. The interview will take approximately an hour to two hours and, with your permission, will be audio-taped. Before we start the interview, you will be given an opportunity to ask questions and I will ask you to sign a written consent form confirming that you are happy to take part in the study. If you decide to provide an autobiography regarding yourself as a pharmacist, you will be asked to write a story about yourself regarding your experiences as a pharmacist. There is no limitation to your writing but you should cover your role's responsibilities, your routine, and working relationships with colleagues and other professions.

Possible Benefits

This is an opportunity for you to share your professional knowledge and experience to inform research into your professional roles with the public. The findings of this study will help to reach a better understanding of the identity of your profession and may in the future suggest to policy makers the training and education that are required to support Thai pharmacists.

The Information You Provide

Your interview transcripts and the narrative writing will be kept strictly confidential and are available only to the researchers. Interview tapes will be transcribed. All tapes and transcriptions will be locked in a safe place. All information collected during the course of the study will only be viewed by the research panel committee, and will remain strictly confidential. The confidential handling, processing, storage and disposal of data will be in accordance with Data Protection Guidelines.

At the end of the study, this information may be used to write up a PhD thesis, and may be used in publishing articles in professional and academic journals and conference presentations. The names of the people who have taken part in the research, or any other information that could identify them, will not appear in the thesis or in other written forms when the study is completed.

All who take part in the research will be sent a summary of the final report, if they indicate so. When the study is completed, all the information will be kept in a locked filing cabinet in a storeroom of the York Management School, University of York for 5 years and will be destroyed after that time.

What is the Next Step?

If you are willing to participate in the study, please complete the reply slip and return in the provided envelope. We will contact you after receiving your reply slip to arrange the date and time of the interview. A consent form can be signed on the day of interview. The consent form will not be used to identify you. It will be filed separately from all the other information. However, you may keep this sheet for reference.

Further Information

If you have any concerns or questions about this study, please feel free to contact the main researcher, Miss Fon Ninkhate on 074-073-06641 or e-mail fn502@york.ac.uk

Appendix B3: Reply Slip

The York Management School
University of York
Freboys Lane
Heslington
YO10 5GD
Tel +44 (0) 1904 325062
Fax +44 (0) 1904 325021

Reference number: «Ref_Number»

Professional Identity Construction amongst Thai Pharmacists

Name: «First_Name»«Last_Name»

Phone Number: «Phone_Number»

Email Address:«Email_address»

Address: «Address_Line_1»

  «Address_Line_2»

  «City»

  «Post_Code»

- I am interested in taking part in the above study and willing to be contacted by phone or email to discuss possible participation. *(Please tick box)*

Appendix B4: Semi-Structured Interview Topic Guide

Semi-Structured Interview Topic Guide

(To be used by the researcher)

<u>**Investigator:**</u> Fon Ninkhate

<u>**Research Title:**</u>   Professional Identity Construction amongst Thai Pharmacists

<u>**RESEARCH BACKGROUND AND AIMS**</u>

- Identity has been widely studied; however there is limited research about how identity is constructed amongst professions. This research is interested in processes of professional identity construction amongst Thai pharmacists.

- The scope that the study will explore is relevant to pharmacists' day-to-day tasks, their interactions with other professionals and patients, their perceptions of what it means to be a pharmacist.

- This thesis will use a repertory grid form (attached with this document) to elicit perceptions of pharmacists on different segmentation of their profession. The repertory grid will be used with an aim to explore how individual pharmacists perceive roles or attributes of pharmacists in different segments. It also aims to derive the values of pharmacists.

- Apart from using a repertory grid interview, this study will also interview pharmacists about their lives as pharmacists. The data from the interview will be used to explore how professional identity has been constructed and also to answer, "How do acts (in deed and thoughts) of pharmacists in their workplaces construct meaning regarding their professional identity?"

<u>**ASSURANCE OF ETHICAL CONDUCT**</u>

- All information will be treated confidentially and no information will be transmitted to any 3rd party.

- Respondents' names will not be revealed in any part of the report and their identity obscured.

- The respondent may choose not to answer any particular question.

<u>**PROCEDURES**</u>

First, each interview will use a repertory grid form to guide the interview. The form is shown below:

Appendix B5: Repertory Grid Form

To explore pharmacist's perception "what it means to be a pharmacist?"

Negative pole	Myself when I just graduated	Myself as I am now	My ideal self	Hospital pharmacist	Drugstore pharmacist (owner)	Drugstore pharmacist (employee)	Medical representative	Pharmacy lecturer	My pharmacy boss	An ideal pharmacist	An ethical pharmacist	A non-ethical pharmacist	Manufacturer pharmacist	Positive Pole

To use this repertory grid form in an interview, I will pick three elements and will ask each participant to compare two of them with the other one. I will use a triadic method, asking them to compare two elements with another element. The question I will ask them is "amongst these three, please pick the two that are most similar and tell me why and also tell me why it is different from the other one". I will pick three elements and ask these questions until there are no more elements left and the interviewees run out of constructs. After each individual completes the grid, they will be asked to rate each element using a 1-5 scale.

After each grid is completed, value priorities of each individual will be identified.

Value priorities can be obtained by using a laddering up technique. From the constructs derived from interviews, constructs from both ends (implicit pole as well as emergent pole) will be laddered upwards. In order to ladder up, the questions that I will ask include "which end of the constructs do you prefer?" and "why is it important for you?" These questions will be asked until the participant runs out of constructs.

After finishing the repertory grid interview, other related questions will be asked of individual pharmacists in order to gain deeper insights into their professional identities. Those questions are presented below:

THEMES AND ISSUES FOR INTERVIEWS

Background of respondent and workplace

- How long have you been working?

- Have you ever changed a workplace or role?

- Please describe your main tasks/job functions at your workplace. Which job function do you consider to be the most important?

- To what extent does your work involve a patient care team? Please describe your role within the team.

Respondents' perceived professional identity

- In your view, who is a pharmacist?

- What roles/functions do you perform? Which of your roles as a pharmacist would you consider to be the most important?

- What are the important skills and training specific to your role as a pharmacist?

- Would you say that medicines can be dispensed by a non-pharmacist?

Respondents' perceived/experienced dual identity and conflicts

(If pharmacists change their jobs from hospital to drugstore and vice versa or work in multiple workplaces)

- Is there any difference in terms of tasks that you perform at different workplaces? If yes, how and to what extent are they different?
- Is there any difference in regard to expectations from doctors, nurses and patients in different workplaces? If yes, what kind of expectations are they. How do you meet those expectations?
- Is there any challenge from customers' demands in your workplace? If yes, what are they and to what extent do those demands constrain your professional values and career goals?
- How do you negotiate demands from doctors, nurses and patients?
- Do you experience any performance pressures, e.g. workload, time constraints, and profit to maintain your business and how do these affect you?

Respondents' professional values and career/personal goals

- How would you describe your professional values in the pharmacy profession? How would you describe your career and personal goals? Is there any conflict? If yes, how would you resolve this?

Respondents' concept of patient care

(Patient care is the current direction of pharmacy education and training)

- How would you describe the work in patient care?

- Based on your experience, to what extent does your role relate to patient care?

Respondents' perceptions of multidisciplinary work

(Multidisciplinary work is encouraged by the World Health Organization and health policies globally to improve patient care)

- How would you describe your role in the multidisciplinary team? Have you had any issue of trust in interactions with others (doctors and nurses) in the team?
- How is the relationship with others (pharmacists, doctors and nurses) and how does the relationship impact on your work performance?
- What are your perceived barriers for multidisciplinary team working?

Respondents' concept/experience of ideal pharmacist or role model

- Based on your experience, what is an ideal pharmacist and what roles does he/she have? Is this different from what you experience in your workplace?

- Did you have any pharmacist role model and, if so, who was he/she, and why?

- How did your role model affect your work performance?

Respondents' views/experience of training and working

- How have perceptions of being a pharmacist changed since you started your work?

- What training have you had, and did it provide relevant skills you need to perform your work?

Appendix B6: Narrative Report Topic Guide

Investigator: Fon Ninkhate

Research Title: Professional Identity Construction amongst Thai Pharmacists

RESEARCH BACKGROUND AND AIMS

- Identity has been widely studied; however there is a limited research about how identity is constructed amongst professionals. This research is interested in processes of professional identity construction amongst Thai pharmacists.
- The scope that the study will explore considers their day-to-day tasks, their interactions with other professionals and patients, their perceptions of what it means to be a pharmacist.
- The narrative report will be used to explore motives of pharmacists and to answer the following questions: "How is professional identity constructed?" and "How do acts (in deed and thought) of pharmacists in their workplaces construct meaning regarding their professional identity?"

ASSURANCE OF ETHICAL CONDUCT

- All information will be treated confidentially and no information will be transmitted to any 3rd party.

- Respondents' names will not be revealed in any part of the report and their identity obscured.

- The respondent may choose not to answer any particular question.

THEMES AND ISSUES FOR NARRATIVE REPORT

Pharmacists are encouraged to write freely about themselves as pharmacists; however, they will be asked to cover their tasks, relationship with their colleagues and other professions.

- Please write a story about yourself as a pharmacist.
- You may consider writing about your main role, and how you perform the role.
- Please describe your relationships with other professionals, for example other pharmacists, doctors and nurses as well as patients in your daily work. Please explain how your role relates to those professionals and patients.

Appendix B7: A Focus Group Interview Guide

(To be used by the researcher)

Investigator: Fon Ninkhate

Research Title: Professional Identity Construction amongst Thai Pharmacists

A focus group will be conducted after gaining saturation of data from the interviews and narrative reports. The topics that will be asked for discussion in the focus group will depend on the emerging topics from the interviews and narratives. The broad themes of the discussion will cover pharmacists' nature of work, relationships with other professions, professional goals and ethics, training and education of the profession, and their perceptions about policies and regulations that control the profession.

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