



Original Research

Pharmacist's identity development within
multidisciplinary primary health care teams
in Ontario; qualitative results from
the IMPACT (†) project

Kevin Pottie, M.D., C.C.F.P., M.CiSc., F.C.F.P.^{a,*},
Susan Haydt, M.A.^b, Barbara Farrell, B.Sc. (Pharm.), Pharm.D.^a, Natalie
Kennie, B.Sc. (Pharm.), Pharm.D.^c, Connie Sellors, B.Sc. (Pharm)^d,
Carmel Martin, M.B.B.S., M.Sc., Ph.D., M.R.C.G.P., F.R.A.C.G.P.^e,
Lisa Dolovich, B.Sc. (Pharm.), Pharm.D., M.Sc.^f

^aDepartment of Family Medicine, University of Ottawa, 1 Stewart Street, Ottawa, ON K1N 6N5, Canada

^bÉlisabeth Bruyère Research Institute, 43 Bruyère Street, Room 704B-B, Ottawa, ON K1N 5C8, Canada

^cSummerville Family Health Team, 101 Queensway West, 5th Floor, Mississauga, ON L5B 2P7, Canada

^dDepartment of Family Medicine, McMaster University, Hamilton, P.O. Box 198, MacTier, ON P0C 1H0, Canada

^eNorthern Ontario School of Medicine, 238 Bruyere Street, Ottawa, ON K1N 5E3, Canada

^fCentre for Evaluation of Medicines, 105 Main Street East, Level P-1, Hamilton, ON L8N 1G6, Canada

Abstract

Background: Multidisciplinary team development generates changes in roles, responsibilities, and identities of individual health care providers. The Integrating Family Medicine and Pharmacy to Advance Primary Care Therapeutics (IMPACT) project introduced pharmacists into family practice teams across Ontario, Canada, to provide medication assessments, drug information, and academic detailing and to develop office system enhancements to improve drug therapy.

Objective: To analyze pharmacists' narrative accounts during early integration to study identity development within emerging team-based care.

Method: Qualitative design using 63 pharmacist narrative reports of pharmacists' experiences over a 9-month integration period. Four independent researchers with varied professional backgrounds used immersion and crystallization to identify codes and iterative grounded theory to determine and debate process and content themes relevant to identity development.

Results: The pharmacists' narratives spoke of the daily experiences of integrating into a family practice setting: feeling valued and contributing concretely to patient care; feeling underutilized; feeling like a nuisance, or feeling as though working too slowly. Pharmacist mentors helped deal with uncertainty and complexity of care. Pharmacists perceived that complementary clinical contributions enhanced their status with physicians and motivated pharmacists to take on new responsibilities. Changes in perspective, clinic-

†IMPACT: Integrating family Medicine and Pharmacy to Advance primary Care Therapeutics.

* Corresponding author. Tel.: +613 241 3344 (W); fax: +613 241 1846.

E-mail address: kpottie@uottawa.ca (K. Pottie).

relevant skill development, and a new sense of professionalism signaled an emerging pharmacist family practice identity.

Conclusion: Pharmacists found that the integration into team-based primary health care provided both challenges and fresh opportunities. Pharmacists' professional identities evolved in relation to valued role models, emerging practice-level opportunities, and their patient-related contributions.

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Introduction

Primary health care team development generates change in roles, responsibilities, and identities of individual practitioners.¹ The IMPACT project aimed to improve drug therapy using a practice model integrating nondispensing pharmacists as members of family practice teams. Individual pharmacists provided patient medication assessments, drug information, education detailing, and office system innovations.² This article presents the experience of 7 pharmacists with a focus on their professional identity as they integrated into family practice teams.

In response to challenges to professional autonomy, the pharmacy profession has shifted pharmacists from technical to clinical roles.³ The growth of the pharmaceutical industry has decreased the technical role of pharmacist but has simultaneously created a potential role for “drug brokers” who can help limit drug-induced illness (drug errors, overprescribing) and improve drug therapy.^{4–7} The emergence of clinical pharmacy and the pharmaceutical care ideology⁸ asserts that pharmacists not only provide drug education but also take responsibility for patient outcomes, leading to a more active and sustained role in patient care.^{9–12}

The majority of Canadian pharmacists (71%) work outside of clinical care settings. Community pharmacists in commercial settings lack access to patient records^{6,13,14} and regular face-to-face contact with other health care team members, which may make an active role in patient care difficult. Integrating pharmacists into team-based primary care involves *reskilling*, the reacquisition of knowledge and skills, is context dependent and influenced by mixed attitudes of enthusiasm and antipathy, approval and disquiet.¹⁵ Other authors have noted marked changes in professionals' sense of self while negotiating shifting professional roles and contexts.^{16,17} Related IMPACT

publications report on shifting medication-related responsibilities¹⁸ and physicians' perspectives.¹⁹ This article reports on the development of pharmacist's roles, responsibilities, and identities during their integration into primary care teams as part of the IMPACT project.

Methods

This study used a qualitative design using pharmacists' narratives of their intellectual and emotional experiences over a 9-month integration period.²⁰ Four researchers with varied professional backgrounds used iterative grounded theory to determine process and content themes. Research ethics approval was obtained from the Research Ethics Boards of the *Élisabeth Bruyère* Research Institute and McMaster University.

Practice settings

The project team recruited 7 physician-led group family practices (total participating physicians: 29 male, 15 female) in urban, suburban, and semirural communities in Ontario. Although 3 had recently introduced a nurse practitioner, none had developed a significant multidisciplinary team or worked with a pharmacist as an integrated professional in their practice. The pharmacists were all given an office within the practice, a cell phone to improve accessibility, and full access to medical records. These practices can be viewed as early adopters that would hypothetically enhance the integration process.

Participants

The project team selected 7 pharmacists to participate in the IMPACT project. Key factors for selection included flexibility, good communication skills, adaptability, and past experience in pharmaceutical care.²¹ The selection factors most likely limited the diversity of the pharmacists,

since there was no attempt made to balance selection for gender or age or past training. The selected pharmacists ranged in age from late twenties to late thirties. Six were female. Education levels varied from bachelor to doctor of pharmacy. They varied in their past and concurrent work settings [hospital, long-term care, and community (dispensing pharmacist)].

Each was formally paired with an external mentor pharmacist.²² All mentors had doctor of pharmacy degrees, had demonstrated high levels of collaborative working relationships with physicians, and had significant teaching and mentoring experience. The pharmacists were provided a job description formulated by pharmacists and physicians.²³ Pharmacists were charged with the following responsibilities: conducting patient medication assessments, providing drug information and education, and implementing approaches to optimize drug prescribing.²⁴ They worked an average of 2.5 days per week within the IMPACT practice sites and were employed by other community and hospital pharmacies for the remainder of their work week.

Narrative reports

In order to understand their everyday integration experience,²⁵ pharmacists were asked to write narrative reports and submit them on a monthly basis for 9 months (total 63 reports), starting with their first month in the practice; detailed methods and examples are described in related methods publication.²⁶ Questions for the first 4 months focused on their daily observations, interactions with physicians, and ways they felt they could apply their expertise. The fifth and sixth months asked for comment specifically on their developing role and identity as a family practice pharmacist. A summary of themes from the first 4 months was provided to the pharmacists at the seventh month, and the seventh narrative report requested feedback on this summary of themes: participant checking feedback. The eighth narrative asked for comment on their developing relationships with physicians and the final narrative asked for tools they felt were necessary to integrate pharmacists into their particular practice setting.

Analysis

Four IMPACT research team members with varied professional backgrounds (family medicine, pharmacy, and sociology) independently analyzed the monthly narrative reports as they

arrived. Each immersed themselves in the data, making notes in the margins and assigning codes that made sense to them as these began to “crystallize” out of the data.²⁷ These 4 analysts discussed and debated codes, using NVIVO qualitative data analysis program, during monthly meetings, and 2 additional team members provided feedback and encouraged reflexivity. Iterative grounded theory²⁸ was used on the first 6 narrative reports to determine process and content themes, with an active search for outliers, competing explanations, and meanings. The seventh, eighth, and ninth narrative reports were used to ensure reliability and relevance (participant checking and feedback) and to ensure saturation on emerging identity-related themes. Key themes from these reports that emerged from the preliminary analysis were focused on relationships and identities and were developed and refined through the analysis.

Findings

Early days: influences and supports

The first 2 narrative reports convey an “integration shock” experienced by some of the pharmacists in their first months in family practice. They noted feelings of disorientation, feeling like a nuisance in the busy new setting, feeling like an outsider, and in some cases, unvalued by people in the setting.

The first couple of days at the clinic were very unsettling. The clinic auxiliary staff, nurses, secretaries, etc [sic] were great, in fact everyone seemed really nice but I just kind of felt like I was getting in the way. Working as I do in a busy pharmacy, where I know everyone and feel very much like the most important person there, did not prepare me for this new role at all (PH01, NR#1).

The pharmacists’ roles were influenced by the research project and, to some extent, the physicians in the practices. The project itself had considerable influence on the formation of the role, and much of this was based on anticipated needs determined from previous studies.^{29,30}

The pharmacist’s sense of identity was influenced by the mentors. Evidence of this influence surfaced early and continued throughout data collection. Mentor pharmacists provided support and guidance, acted as role models, and helped pharmacists to develop skills and identify activities to carry out within the practice sites that would help them in the practice setting.

I've also found that having [my mentor] to talk to is good...he has provided a lot of helpful tips to me. I'm sure that I will be using his expertise as we progress along not only in the integration aspect but also clinical knowledge (PH05, NR#1).

Some pharmacists described mentors as “sounding boards” or “another pair of eyes”, someone to hear their ideas about patient care, reinforcing confidence in their own skills and often reinforcing what they already knew about patient care.

Pharmacists commented on physicians' expectations of them in the early narratives. These tended to focus on the physicians' practical and immediate needs. These ranged from asking pharmacists to perform administrative tasks to helping resolve issues for complicated patients and to taking on liaison role between the practice and local community pharmacists.

Doctors see a role for me to counsel patients on complicated regimens/medications because they may not have time to do so or the patient has outstanding issues despite doctor visit. (PH03, NR#1).

[Dr. #1] asked me to look into improving the process for medication renewals from the local pharmacies. He and a few other doctors have discussed how some of the renewal forms that are faxed to them are very difficult to read (PH06, NR#1).

Making inroads: demonstrating value

Narrative reports for months 3 and 4 show the pharmacists gradually making inroads into the practice and early signs of developing a family practice identity. Some described their relief at starting to feel more like a part of the team rather than an outsider:

I felt that this month was a little easier for me in terms of starting to feel like someone who worked at the clinic rather than a 'visitor' (PH05, NR#3).

Also at this stage, pharmacists started to gain confidence in their skills as they began to see concrete results from their work:

I had one patient who I put on compliance packaging, she benefited from it a lot and her diabetes medication was reduced drastically. This was very positive and rewarding to be able to make a difference (PH04, NR#4).

Progression toward insider status was neither smooth nor linear; pharmacists tended to follow different identity development trajectories. Some

likened their experiences at this stage to being on a “rollercoaster,” having successes one day and drawbacks the next. Sometimes there was tension between the goals of the physicians and the goals of the IMPACT project: the IMPACT management team suggested a focus on clinical skills-based activities such as patient assessments²⁹ and interprofessional clinical discussions alongside a lesser focus on technical office innovations, whereas physicians sometimes promoted a larger focus on technical office innovations. The influence of the physicians, the desire to become a valued part of the practice, and the tensions between practice and study goals thus figured prominently in the consciousness of some of the pharmacists at this stage.

Becoming one of the team: dual perspectives and professionalism

Later narratives (NR#5 and beyond) continued to show the pharmacists feeling more at home in the clinic setting, and their roles more recognized and appreciated by physicians and others:

I felt that in the beginning, I didn't really have an identity other than that I was pharmacist who was not there to dispense medication.... After 5 months of educating people about my role, through word of mouth and through example, I feel that I am now being seen as an integrated team player devoted to improving patient's drug related outcomes, and providing answers to drug related questions (PH02, NR#5).

Several of the pharmacists described everyday interactions that challenged them to see their own profession through others' eyes, particularly physicians. Frequently pharmacists saw the frustration experienced by physicians in communicating with community pharmacists, and, in learning the reasons behind these frustrations, began to develop sympathy for the physicians' views. In some instances, a dual perspective emerged and pharmacists found themselves explaining both sides of the story in their narratives.

Personally, I do not blame the pharmacies for their concerns [about a standardized fax renewal form], but after having seen what the doctors are sometimes [sic] faced with signing... I can see why the physicians want a simple form to read and fax back. It is both a positive and a negative experience that I am feeling because in one sense I feel bad for the pharmacies and their added work, yet I also empathize with the physicians that have to read a hard copy that has too much information (PH06, NR#3).

This discomfort suggests a shift in perspective and a realization that they no longer saw community pharmacy in the same way. Several of the pharmacists (PH03, PH05, and PH06) also noted that they began to see patients in more holistic terms in the family practice setting than in their past experiences:

My identity in the last six months has changed in my way of thinking about patient care. I always thought in “black” or “white”. Either there is evidence or there is no evidence. Patients should be on the best medicine based on the current evidence out there. Unfortunately, that sometimes does not factor in cost of the drug, patient adherence, doctors influenced by drug reps, practicality and what the patient wants. Asking what the patient wants with respect to their issues during the interview has helped me with my assessments (PH06, NR#6).

The language of the pharmacist here suggests changes in perspective: PH06 has changed his or her way of thinking to successfully carry out the new role in dealing with patients in a much more involved way. The pharmacists’ perspectives were further altered with the introduction of the reality of “uncertainty” in diagnosis and treatment. Initially uncomfortable with uncertainty, with time they learned to accept it as part of the skills needed for the family practice setting:

I was worried about how low diastolic blood pressure can go. I was trying to find the answer on my own and finally thought to ask the doctor about it... and we had a discussion about it. It’s not that I even got a really definitive answer but at least I found what the doctor was looking for from me for this patient and it was a little bit different from just telling him which drugs can cause hypotension (PH03, NR#3).

As the pharmacists were exposed to a variety of medication consultations, they began to develop practical and concise recommendations and accept new responsibilities as they considered how they could complement the existing team:

With another doctor, I recommended d/c (discontinue) metformin and adjusting insulin dose accordingly...He asked if I would be willing to “handhold” this patient for the insulin adjustments. Previous to writing this report, I was very uncomfortable with diabetic meds...my initial response to this doctor was evasive. I mentioned how the patient planned on following up with the diabetic clinic, so we would see if that was done when we were deciding on the metformin/insulin changes at

a future date. I re-read my recommendations and realized I do have the tools to adjust insulin doses, I just haven’t done it before. I caught up with this doctor and apologized for “waffling” on the insulin issue and that I would definitely be able to follow through with this patient in the adjustments and the monitoring. His response was positive, and I felt better knowing that I had taken responsibility for what I am able to do (PH03, NR#2).

Pharmacists also noted a number of significant differences in the family practice setting that enhanced their sense of professionalism. The family practice setting offered increased contact with other health professionals, more involvement in patient treatment, more patient contact, unprecedented access to patient information, new privileges (e.g., authorization to order laboratory work), and a move away from the dispensing/business role of community pharmacy:

Unlike community pharmacy practice, I have had the opportunity to work very closely in collaboration with other health care professionals including physicians, nurse practitioners and nurses. This facilitates a team approach to improving patient’s drug related outcomes (PH02, NR#5).

Discussion

The narratives provide pharmacists’ viewpoints, sympathies, skills, and sense of professionalism. They also suggest a shift toward a new family practice pharmacist identity. Time, adaptability, and support facilitated this achievement.

Team-based care comes with both challenges.³¹ The results show the interplay among the effects of setting, skills, and identity as pharmacists undertook a journey of integration into family practice settings. As team members, the pharmacists spoke of access to patient medical records, private space to meet with patients, and freedom from dispensing or commercial activities that allowed for more time to be spent on direct patient care. The pharmacists also spoke of daily interactions with staff and patients, which helped build understanding of primary care and relationships with other primary care professionals. This contrasted to their community pharmacy experiences with high patient contact but low physician contact and to their hospital pharmacy experiences with high physician contact but less patient contact. Over time, the frequency and immediacy of contact with the people in the clinic setting provided

pharmacists with new perspectives and new influences from other disciplines.

Setting influences skill and identity development.^{32–34} As noted by other authors,³⁵ the narratives spoke of the impact of the work settings on professionals' views of their own work and/or their perceptions of colleagues working in diverse settings. These developing interprofessional perspectives and identities can support team-based care.^{36,37} Various work settings, each with differing power structures and rewards, are capable of resocializing the professionals and changing their primary group affiliation.³⁸ The pharmacists' narratives suggest that given the support for skill development,³⁹ a shift in pharmacist identity from what was held as a conventional community- or hospital-based clinician emerged through everyday roles and activities in this new setting.

For Giddens,¹⁵ self-identity presumes self-awareness and is a result of the interaction between the individual's social context and the reflexive activities. The narratives show pharmacists' perspectives changing over time with changes in role. Ibarra^{17p765} asserts that “[b]ecause new roles require new skills, behaviors, attitudes and patterns of interactions, they may produce fundamental changes in an individual's self-definition.” Chreim et al.¹⁶ studied how physician professional identities changed after changing their practice model from a fee-for-service model to a fixed-salary model that integrated other health care professionals: professional identity manifested in new behaviors and attitudes, new ways of thinking, new meanings that allow the same attributes to be seen in different ways, and new relations among actors. In the pharmacists' narratives, identities emerged during the integration process through a range of forces related to setting, success, skills development, and changing perspectives. At the personal level, pharmacists became a known person to others in the clinic by actively demonstrating what they could do and that they could be trusted. At the professional level, they experienced a deepened sense of professionalism and accomplishment.

Limitations

We acknowledge the project supports available to facilitate role development and that these would have had some impact on pharmacist self-presentation. In addition, we acknowledge the limitation that the recruited pharmacists and family practices likely represent early adopters.

Finally, these results are based on the experiences of 7 pharmacists, 6 of whom were female. The limited number of male pharmacists did not permit a separate gender analysis.

Conclusions

Everyday elements shaped pharmacists' responsibilities and identities within these emerging team-based family practice settings. Setting, skills, and perspectives influenced professional identity formation. In addition, mentorship to support the integration into multidisciplinary teams surfaced as a key facilitator, and this has implications for the pharmacy profession and other initiatives aimed at developing team-based care.

Pharmacists integrating into family practice should consider taking time to learn about the setting and aim to demonstrate value over time and not expect quick success. Future research should examine the role of pharmacist training, age, gender, and practice experience and the effect of physician age and gender on developing interprofessional relationships. Furthermore, this should focus on patient perceptions and impact of these emerging professional relationships on patient experiences and ultimately health outcomes.⁴⁰ There is a need to develop and evaluate primary care-related educational initiatives during pharmacy training and interprofessional education initiatives between physicians, pharmacists, and other members of the primary care team.

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