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PHARMACY'S ATTEMPTS TO EXTEND ITS ROLES: A CASE STUDY IN SOUTH AFRICA

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Abstract—This paper examines the role expansion of community pharmacy in South Africa against the background of phenomena such as professional dominance and boundary encroachments. The study demonstrates pharmacy's thrust towards an extended and more meaningful role, making a clear distinction between the role extension concerning the granting of additional powers to prescribe medications, and that of a wider range of activities. It confirms previous claims that the opposition from the medical profession is particularly fierce when it relates to the pharmacist's ability to prescribe. The successful granting of special permits to a selected group of pharmacists to practice an extended role can be explained by the fact that it has been restricted to rural, under-served areas. The developments to date signify a partial success by the pharmacy profession towards its role extension. However, this is likely to remain limited due to the forces operating against it. Considering this context, the development of "health centres" might prove to be an alternative venue for the integration of pharmacists into the health care team. © 1998 Elsevier Science Ltd. All rights reserved

Key words—pharmacy, South Africa, prescription legislation

INTRODUCTION

Since its inception, pharmacy has been closely connected with medicine in providing services of fundamental value to society (Angorn and Thomison, 1989). Pharmacists have a long history as health advisors to the public (Smith, 1994), as well as custodians of medicines (McGhan, 1989). However, the development of industrialisation, the large-scale manufacturing of medical products, medical specialisation and increased medical technology have resulted in a substantial loss of functions for the pharmaceutical profession (Roberts, 1988). "In the span of about 50 years, the profession lost no less than three of the four functions that had been the mainstay of the work of pharmacists since at least the 8th century! The old mysteries of the art of apothecary, drug procurement, storage and compounding, had vanished" (Mrtek and Catizone, 1989, p. 30). Mrtek and Catizone maintain that "the loss of such deeply rooted functions endangered the identity of the entire profession...the changes in practice had left a limited role for community pharmacists, the simple dispensing of drugs on order of the prescriber, with its associated monetary transaction. Everything else had been swept aside by "progress"" (Mrtek and Catizone, 1989, p. 31).

The pharmacists found themselves overtrained for what they did and under-utilised in relation to what they knew. The profession's response to the loss of function and the resultant stress and role ambiguity has been a movement toward "re-professionalisation" (Birenbaum, 1982). A major feature of the process of re-professionalisation is the discourse around the so-called "extended" role of the community pharmacist, which is the main concern of this paper.

The process of re-professionalisation took on different forms, manifesting itself primarily in a gradual shift away from the technical paradigm, with the emphasis on drug products and their preparations, toward a more disease and patient orientated approach to pharmaceutical decisions. The development of "clinical pharmacy" in the hospital setting was one of the major strides in this direction (Gilbert, 1976; Hepler, 1985; Sogol and Manasse, 1989; Mesler, 1991; Ivey, 1993; Cotter *et al.*, 1994).

This shift in favour of a more active involvement with patient care was less successful in community pharmacy settings, the main reason being the pharmacist's lack of access to the patient's health status record, as argued by Mrtek and Catizone: "isolated as they are from an accurate and complete patient health status record, there is little that most community pharmacists can do to render clinical judgements that are central to drug therapy decisions" (Mrtek and Catizone, 1989, p. 36). Mrtek and Catizone (1989) insist that the development of the clinical paradigm for pharmacy has a real chance to operate only in those settings where access to health status information is provided to the pharmacist and where other health professionals are at hand with whom the pharmacist may interact as a respected peer.

Various attempts have been made to extend the role of the community pharmacist all over the world. In the U.K. the components of the pharmacist's

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extended role range from advising patients on minor ailments to diagnostic testing (Harding *et al.*, 1994), health education and promotion (Cunningham-Burley, 1988; Todd, 1993), primary care (Smith, 1990; Cunningham-Burley, 1994; Sheppard *et al.*, 1995) and record keeping (Britten, 1994).

In the U.S.A., the development of the concept and practice of "pharmaceutical care" (Hepler, 1989; Hepler, 1990; Hepler and Strand, 1990; Strand, 1996) represents an attempt to provide the community pharmacist with a more meaningful role, emphasising the concept of "caring" (Lowes, 1995) and commitment to patient care (Odedina *et al.*, 1995).

Williams claims that "if we really intend to re-professionalise the practice and implement the principles of pharmaceutical care, then we must give a high priority to obtaining enabling legislation or rules that will permit every pharmacist to best utilise his/her extensive pharmaceutical knowledge and prescribe drugs for patients" (Williams, 1995, p. 9). However, the reality is that some sort of prescribing by pharmacists is only taking place in seven states in the U.S.A. There are several models of pharmacists prescribing available in those states, from independent prescribing authority for a limited numbers of drugs in Florida, to more restricted set-ups in California, New Mexico, Oregon, Mississippi, South Dakota and Washington (Meyer, 1994).

The various attempts at "role expansion" for pharmacy depict a universal trend among other health professions (McGhan, 1989). According to McGhan, at least since the 1960s, each health profession, seems to argue that it is expanding its functions to better meet the needs of society. All professions manifest aspirations for greater responsibilities, larger incomes and enhanced status for their members (Selden, 1989). However, as argued by Freidson (1970), since medicine has maintained its dominance over all "medical functions", it always claims intrusion. Mumford maintains that "boundary disputes between professions take place over authority, who has the right to diagnose the problem, who has the right to decide which treatment, and who has the right to charge for services" (Mumford, 1983, p. 264).

At the heart of this issue is the question of professional autonomy, or the legitimated control that an occupation has over the content of its own work. According to Nettleton (1995), related to the notion of autonomy is professional dominance, which refers to the way in which certain professions not only control the content of their own work but can also define the limits of the work of other occupational groups (Freidson, 1970). This point is confirmed by Kronus, in the historical analysis of task boundaries between physicians and pharmacists, where she clearly portrays "the relative ability of the occupation to protect its task domain from encroachment and/or [to] encroach on others, as the central measure of power" (Kronus, 1976, p. 5).

Pascall and Robinson (1993) argue that boundary disputes between occupations and competition over work roles are an inevitable component of a complex health care system with an elaborate division of labour and a changing social and technological environment. Work roles are not comprehensibly defined in legal terms and overlapping responsibilities are common (Hardy, 1978). For this reason, para-medical occupations have had to negotiate boundaries with each other as well as with doctors when establishing spheres of competence and responsibility (Larkin, 1983).

Eaton and Webb (1979) referred to the extended role of community pharmacy as "boundary encroachment", claiming that it is an attempt to extend the boundaries of pharmacy practice into the territory of the medical profession (the boundary in this case being that between prescribing and dispensing). According to Halperin (1989), although pharmacists speak about emerging new roles and responsibilities in various areas, prescribing being among them, these roles have yet to be achieved, primarily due to strong opposition from physicians who resist the encroachment on their professional and economic turf (Lambert *et al.*, 1977; Lambert, 1995).

The opposition from the medical profession is extremely fierce, particularly when it comes to the "ability to prescribe" a component of the pharmacist's extended role. A prerequisite for prescribing medication for a patient is the ability to determine what is wrong or to diagnose the condition. It seems that the right to diagnose is at the centre of the struggle, since it is a deciding factor in the social control and reimbursement for services. Fitting evidence is provided by Mumford regarding the "struggle of nurses to establish the fact that they diagnose patients" (Mumford, 1983, p. 264), and optometrists fight "to diagnose eye disease...-which was energetically attacked by physicians" (Mumford, 1983, p. 265).

It is the aim of this paper to examine the role expansion of community pharmacy in South Africa against the above background.

METHODOLOGY

To gain an in-depth insight into this complex issue a combination of qualitative and quantitative research methods were employed. This paper is based on data collected through*:

(I) Interviews with key informers.

(II) Documentary analysis of published reports, minutes of committee meetings as well as official publications of The South African Pharmacy

*The data used for this paper are part of a larger study dealing with the role of community pharmacy in South Africa (see references).

Council (SAPC), professional associations and news paper articles.

(III) A survey conducted among a random sample of community pharmacists in the Johannesburg area*.

(IV) A survey conducted among pharmacists in possession of section 22A (12) permits.

THE SOUTH AFRICAN SCENARIO

The deliberations with regard to the future role of pharmacy did not bypass pharmacists in SA and several reports have suggested that the future of the profession will be determined by its ability to become "re-professionalised" and to shift its emphasis to a professional health-care service function, based on its specific expertise (Pharmaceutical Society of South Africa, 1980). A document of the Department of National Health and Population Development states that "the community pharmacist (private sector) plays an important role in the provision of health services...this role must naturally be entrenched and even extended where indicated" (Department of National Health and Population Development, 1990, pp. 5–6).

This is in line with the recommendations made earlier by the Commission of Inquiry into Health Services (The Browne Report, 1986, p. 120), which dealt with "extending the functions of the pharmacist and his role in primary health care". Evidence before the committee (The Browne Report, 1986) showed that the pharmacist was of the opinion that he or she could render and would like to render, extended professional services.

In South Africa, although giving advice has always been part of a pharmacist's professional function, the committee (The Browne Report, 1986) was perturbed that the pharmacist was generally seen as no more than a salesperson, since he was not remunerated for his advisory function.

The potential role expansion of pharmacists in South Africa is synonymous with what has been termed primary care drug therapy (PCDT) or pharmacotherapy by the South African Pharmacy Council (SAPC) and academic institutions. It is therefore important to trace its historic development (The South African Pharmacy Council, 1994). Before 1965, the pharmacist had the authority to compound and sell medicines with virtually no restriction (Ryan, 1986). In 1965, the Medicines and Related Substances Control Act, or Act 101, was introduced. This Act limited the pharmacist's discretion to medicines that fell into schedules 1 and 2. All other medicines in the higher schedules could only be dispensed by the pharmacist following a doctor's prescription.

In 1986 the Commission of Inquiry into the provision of Health Services in SA stated and recommended the following to the government: "The Medicines Control Council should consider in terms of past experience and taking cognisance of circumstances the desirability of rescheduling medicines presently available for prescription use only, in order to strengthen the armamentarium of the pharmacist so as to promote responsible self-medication and to acknowledge his/her professional role as health educator and promoter in the front line of primary health care. This can only be achieved if the pharmacist personally provides his/her patient with such medicines". It further reiterated that "the pharmacist has always fulfilled a diagnostic function but in this he was, however, curbed in what therapy he was allowed to give. Such curbing of the pharmacists' diagnostic abilities lies in the scheduling of medicines". The committee also suggested that greater freedom in the handling of scheduled medicines should be seriously considered in the light of changes in the curriculum. As a result of this recommendation, the curriculum of pharmacy was further adjusted to be more patient and clinically orientated.

The recommendations were accepted by the Government, pending legislative changes. In 1991, Parliament passed Act 94 with the objective of introducing the Browne Report's recommendations that the pharmacist's list of medications be expanded. The South African Pharmacy Council (SAPC) supported the recommendations, due to the shift to primary health care, the professional accountability of pharmacists, their underutilisation, as well as their willingness to provide the services (Van Niekerk, 1995).

The extension of the pharmacist's role was to have been given legal status by the Pharmacy Amendment Act (Act 101) which, according to its propagators, has the potential to "enhance [the community pharmacist's] role by granting [him/her] access to higher scheduled medicines, access to greater discretionary powers and access to reach [his/her] true potential" (PPAC, 1993, p. 503). The proposed changes would allow the pharmacist to prescribe certain medicines in schedules 3, 4 and 5 which at present may only be legally prescribed by doctors. However, access to these medicines would allow pharmacists to diagnose and treat certain illnesses; this has raised some concerns with regard to its appropriateness (Pharasi *et al.*, 1993), as well as fierce and organised resistance on behalf of the medical profession (Gordon, 1993; Van Wyk, 1993; Weiss, 1993; PSSA National Committee, 1994). This resistance emerged primarily on the grounds that "the legislation would have entitled pharmacists to diagnose and treat patients" and that the training would be offered by the SAPC, but that "only the South African Medical and Dental Council (SAMDC) may approve the training of

*As part of the larger study a random survey of community pharmacies in Johannesburg was conducted. For more details see Gilbert (1995a, 1997b).

persons to "diagnose, treat or prevent any physical or mental defect"" (Van Wyk, 1993, p. 821). The chairman of the federal council of the Medical Association of South Africa (MASA) said that [the proposed change to the law] "is likely to compromise quality health care because pharmacists are not trained to make proper diagnoses, which are essential prior to prescribing appropriate treatment" (Gordon, 1993). The pharmacists' diagnostic skills were questioned by The Dispensing Family Practioners' Association as well, when it declared that it had "grave reservations about granting diagnostic powers to pharmacists" (Weiss, 1993).

According to the SAPC, various presentations were made between 1991 and 1993 to the Medicines Control Council (MCC) with regard to the proposed changes in legislation. In anticipation of legislative changes, the SAPC supported and facilitated, in 1992, an application by rural pharmacists to extend the boundaries of their authority. In this period, certain pharmacists, after careful evaluation by the Council, were issued a Section 22A (12) permit which granted them legal authority to provide certain medicines in schedules 3 and 4 under specific circumstances, based on their own discretion. These permits were issued by the Director General of Health after consultation with the SAPC.

The proposed changes to the Medicines and Related Substances Control Act (101 of 1965), were gazetted on June 1993. However, due to pressure from the medical profession and the political uncertainty in South Africa, a decision was taken to suspend the changes in legislation. Indeed, all health-related legislation was put on hold in 1993–1994 until the commencement of the new government and legislative bodies. In 1994, the SAPC again addressed the MCC, which subsequently approved a final list of medicines for pharmacists. The council also recommended that certain regulations be published with regard to supplementary training. These regulations would make it obligatory for pharmacists to register their successful completion of a course in primary care drug therapy with the SA Pharmacy Council before exercising their rights in terms of Act 101 of 1965.

The general perception is clearly that changes in regulations will be translated into significant changes in the pharmacist's role (Kohn, 1993). In the meantime, community pharmacists have been preparing themselves, as shown by the call of the president of the Pharmaceutical Society of SA, Gary Kohn, in his presidential address: "Although we await the final regulations of Act 101, the Pharmaceutical Society of SA encourages members to undergo appropriate training to be ready when the new regulations are announced" (Kohn, 1994, p. 189). The Professional Pharmacy Awareness Campaign (PPAC, 1995, p. 256) has suggested changing the layout of pharmacies "by simply converting a semi-private counselling area to a private area", an idea which has been implemented in some pharmacies. By doing this, the pharmacists are altering the physical structure of the practice to facilitate an interaction with their patients which is similar to that of doctors and their patients. This is also likely to change the nature of the pharmacy by transforming pharmacies "from shops into community health centres" (Strachan, 1993).

In anticipation of the changes to the law Link chain of pharmacies have launched various plans to convert its pharmacies into "community orientated primary health care centres and to upgrade the pharmacists to pharmaco-therapists, qualified to diagnose and prescribe medications for a wide range of ailments", introducing "pharmacy initiated therapy (PIT)" (The Citizen, 1993). At the same time a campaign launched by Family Circle* pharmacies emphasised the benefits of PIP (pharmacist initiated prescriptions) (The Herald Times, 1992).

It seems that the pharmacy council, pharmaceutical societies and academics are united in their views that "the pharmacist can make a meaningful contribution toward making health care in this country more accessible and affordable" (Dreyer, 1994). Most key players propagating the proposed changes stress that "the principle where a pharmacist can assess a patient's medicinal needs and provide or recommend medicines is universally accepted and has existed for years: all that changes is that the list of medicines expands and will now include more effective medicine" (PSSA, 1994, p. 25).

The proposed amendments to the Pharmacy Act and the new Regulations to the Medicines and Related Substances Control Act (101 of 1965) were to be processed in 1995, but this has yet to materialise.

An additional initiative in this direction is the call of The Pharmaceutical Society of South Africa for new functions for pharmacists to be identified, developed and legalised (Pharasi, 1993). This includes training pharmacists to carry out functions currently performed by nurses at clinics, which will involve the pharmacist administering injections, providing preventive care services and caring for the chronically ill. The suggestions are that these functions will be performed by pharmacists in addition to the nurses in the clinics. This is so as to fully utilise existing health personnel in order to alleviate the crisis in health care†. Since 1993, over

*These two represent the big chains of pharmacies in SA.

†The South African health care service has been characterised by gross maldistribution of resources between private and public sector, between rural and urban areas as well as between the different racial groups. As a result, the majority of the population has been deprived of adequate services. The new government has been engaged in attempts to redress the imbalances created in the past by shifting the emphasis to Primary health Care in order to increase access to basic health care for all. For more details on the crisis in the South African health care services see Gilbert *et al.* (1996) and the SA Health Review (1995, 1996).

2500 pharmacists have undergone special training in family planning and can supply oral contraceptives without a medical prescription, on condition that the recipient sees a medical doctor within 6 months.

In 1996 the Department of Health announced the National Drug Policy, which was to be implemented in 1996. Although it speaks about the role of the pharmacists and the fact that "they also have a critical role to play in primary health care and preventive health services" (Department of Health, 1996, p. 18), it does not refer to the pending changes in legislation.

SURVEY OF SECTION 22A (12) PERMIT HOLDERS

Background

The fact that 66 pharmacists have been issued with this special permit, creates the opportunity to examine the nature of their practice and to analyse the issues involved based on their experiences. Most of them operate in out-of-reach places all over the country and this dictated the research method used to obtain the necessary information. Despite the advantages of a face-to-face interview (Neuman, 1994, p. 245), it was not feasible within the scope of this study to interview them all personally. A telephonic survey was considered, but the idea was dropped since the SAPC was in possession of a list of names and addresses but no telephone numbers. The assumption was that due to their special status, the pharmacists in possession of this permit would be willing to complete and return questionnaire. It was thus decided to do a mail survey of all of them. Questionnaires, which included a set of closed as well as open questions, were mailed to all pharmacists on the list. The package included an explanatory letter and an addressed, stamped envelope. Thirty two replies were received after 2 months and only one reminder. Since it represents 49% of the total population, it was considered to be an adequate response in a mail survey of this kind, particularly for the purpose of this study, which aimed only to explore their views and nature of practice in general terms. Huysamen related that "Bassa and Schlebusch (1984) and Bluen and Goodman (1984) report response rates of 37.19% and 36% in local postal surveys conducted on registered clinical psychologists and personnel practitioners, respectively" (Huysamen, 1994a,b, p. 149). A study published by Adamcik *et al.* (1986), in which the legitimacy of expanding the role of the pharmacist was studied through a survey of nurses, pharmacists and physicians in California, had similar response rates as described by Birenbaum: "In none of the samples was the return rate for the mailed questionnaire above 45% and the response rate for a sample of 200 randomly selected Los Angeles physicians was a mere 31%" (Birenbaum, 1990, p. 148).

The returned questionnaires were well completed. In some cases additional material was added in the open section, and telephone numbers were provided in case a follow up was necessary. Based on this and a comparable survey carried out by the SAPC, a decision was made that there was sufficient representative data to produce the necessary analysis*.

62% of all pharmacies with permits are situated in rural areas, which are generally under-served (Gilbert, 1996). Granting of permits to these pharmacies was thus intended to provide accessible primary care services to the people living in rural areas†. All of the pharmacies involved in this study have a private consultation area, making it possible for them to consult and/or examine their patients in a similar manner to other health professionals. 70% of the pharmacies are visited by more than 100 clients a day, which confirms their high level of utilisation. Most of these clients come directly to the pharmacy, without visiting the doctor first. 62% of the pharmacists reported that more than 40% of their patients did not have a doctor's prescription. Of significance in the SA context is the fact that many (54%) of these pharmacists reported having a high percentage (between 30–70%) of Black patients. This is a much higher percentage than that reported by community pharmacists in Johannesburg (Gilbert, 1997a) and might suggest that the permit holders are indeed serving the population in need.

Figure 1 gives an indication of the range of health problems dealt with by the permit holders.

It is clearly evident that they deal primarily with infectious diseases. In 40%, people were treated for upper respiratory infection and 22% for urinary tract infection. The rest were treated for various other, mostly contagious conditions. The 8% of "other" conditions included tick-bite fever, trachoma, acne and skin and soft tissue infections. In a country like South Africa where the main causes of morbidity and mortality, particularly in the rural, under-served areas, are communicable diseases (Gilbert *et al.*, 1996), this might be a significant contribution towards the provision of health care services to combat them, when considering that most of the patients treated by the permit holders used the pharmacy as a first port of call.

Basic demographic data about the permit holders was obtained in a pilot survey (Van Niekerk and Botes, 1995). Their mean age is 40.21 years, which raises doubts with regard to the appropriateness of their original training (Gilbert, 1997d). However, the fact that on average their practical experience was more than 12 years, gives them the benefit of long practical exposure in a pharmacy.

*Note should be taken that this is an exploratory study and its purpose is to add an additional dimension to the information outlined earlier.

†See (Gilbert *et al.*, 1996) with regard to the crisis in health care in SA.

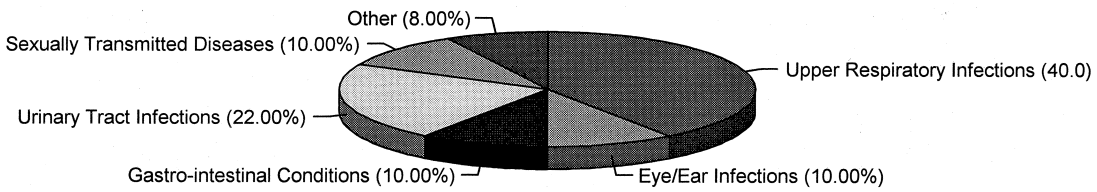

Fig. 1. Health problems dealt with.

Table 1. Responses to "What is a community pharmacist?"

Role component	Percentage distribution of rankings						
	1	2	3	4	5	6	7
			Pharmacists with a permit				
Health care professional	88	8	0	0	0	0	4
Health educator	4	58	25	0	13	0	0
Clinician	0	17	29	29	17	8	0
Manager	0	4	29	29	17	21	0
Businessman	4	13	13	21	42	4	4
Scientist	0	0	4	17	8	54	17
Technician	4	0	0	4	4	13	75
			Community pharmacists in Johannesburg				
Health care professional	74	19	4	2	2	0	0
Health educator	25	47	15	9	2	2	0
Clinician	6	13	30	13	15	6	17
Manager	13	8	21	26	23	8	1
Businessman	25	11	11	17	23	4	9
Scientist	0	0	4	8	4	38	46
Technician	0	4	2	9	11	21	53
			Students				
Health care professional	92	5	3	0	0	0	0
Health educator	3	66	21	11	0	0	0
Clinician	0	18	45	18	18	0	0
Manager	5	3	11	19	49	14	0
Businessman	0	8	13	40	24	13	3
Scientist	0	0	5	8	8	40	40
Technician	0	0	3	5	3	32	58

Nevertheless, 75% of them indicated that access to higher scheduled medicines should only be permitted to pharmacists who undertake structured, compulsory training, thus emphasising the indisputable link between role extension and undertaking of additional training.

What is a community pharmacist?

What characterises the transitional role of community pharmacy is a multiplicity of components, different dimensions as well as a lack of clarity with regard to its boundaries (Gilbert, 1995b). The dominant perception of what is meant by referring to the role of the "community pharmacist", is thus of utmost importance in the context of this paper.

To assess the prevailing perception of "what is a community pharmacist?" among this group, they were asked to rank the different components which theoretically make up the role of a community pharmacist, in order of importance from 1 (most important) to 7 (least important). In Table 1, their responses are compared to responses of a random sample of community pharmacists in Johannesburg (Gilbert, 1995a) and final-year pharmacy students*, who were asked to do the same.

It seems that the professional perception of the pharmacists with the special permit is less ambiguous than that of community pharmacists in Johannesburg; it in fact has more in common with the students' vision of the professional role. The general perception is that the pharmacist is least of all a technician (75%) and primarily a health professional (88%). What might be of interest is the identical ranking of importance allocated to "clinician" and "manager" by this group, signalling perhaps that an independent practice of this nature requires managerial skills as well as clinical ones.

Nature of daily activities

The questionnaire included a list of activities likely to be performed by community pharmacists, and pharmacists were asked to indicate to what

*The survey of final year students at the University of the Witwatersrand formed part of the larger study. More details are available in Gilbert (1997d).

Table 2. Extent to which pharmacists engage in various activities

Activities	Percentage of positive responses[a]	
	pharmacists with special permit	community pharmacists
Traditional activities		
Dispense according to a doctor's prescription	91.7	96.3
Counsel patients about the prescribed drug	100.0	88.7
Discuss the prescription with the doctor	20.8	11.3
Manage the pharmacy	91.7	83.0
Counsel patients about OTC drugs	95.8	90.5
Sell OTC drugs	87.5	84.9
Advise patients with regard to their personal health	79.2	75.5
Assess the patient's problem and refer to other health professionals	50.0	60.3
Provide drug information to other health professionals	20.8	11.4
Educate consumers (STD's, diet)	70.8	64.1
Attend to emergencies/casualties	29.2	16.9
Average	67.0	62.1
New activities		
Blood pressure monitoring	91.7	39.6
Cholesterol monitoring/testing	45.8	22.6
Glucose monitoring/testing	58.3	20.7
Train home-care patients	8.3	1.9
Monitor drug therapy of chronic patients	58.3	39.7
Prescribe in case of acute illness	91.7	13.2
Order laboratory tests	16.7	1.9
Immunisation	33.3	13.2
Developmental screening	16.7	0
Administer injections	70.8	11.3
Prescribe/administer contraceptives	58.3	43.4
Participate in health promotion programmes in the community	29.2	18.9
Average	48.3	18.9

[a]For this table, the top two responses, "most of the time" and "very often", were combined.

extent they engage in these activities. In order to present a summarised and simplified version of the responses, the different activities have been grouped into "traditional" and "new" and only the percentage of positive responses has been presented. Table 2 presents the responses of pharmacists with a special permit in comparison to those of community pharmacists in Johannesburg.

On the whole, the level of engagement of pharmacists with the special permit is higher in a wider range of activities. However, when all "traditional activities" are combined, their engagement seems similar to that of community pharmacists in Johannesburg. This is not evident when the "new activities" are concerned. On average, 48.3% of the pharmacists with the permit fully engage in the new activities, while only 18.9% do so among the community pharmacists in Johannesburg. The main differences between the two groups are with regard to "prescrib[ing] in case of acute illness" (91% vs 13.2%), which is the main activity that distinguishes between the two groups on legal grounds. Differences were found in other activities as well, particularly those concerned with monitoring of chronic conditions and the provision of basic primary health care (Table 2).

What emerges quite clearly from Table 2 is that the daily activities of pharmacists with the special permit differ from those without it. The nature of the activities mostly performed by those with the permit is more clinical on one hand and more comprehensive on the other, allowing the pharmacists a wider range of activities with greater responsibility. A corollary to this, is that their clientele is able to access the full range of primary health care services from the pharmacy.

Contact with other health professionals

A similar theme was explored in the survey of a random sample of community pharmacists in Johannesburg, which drew the conclusion that contact with other health professionals was minimal and its nature unsatisfactory (Gilbert, 1995a). The results of the survey of permit holders, however, expose a different scenario (Table 3).

58% reported having daily and 25% weekly contacts with the general practitioner. A high percentage also had at least weekly contact with a specialist (54.2%). As far as nurses are concerned, 42% employ one in the pharmacy, thus having daily contact, while the rest have at least weekly contacts. This is also quite different from the general pharmacy with no permit (Gilbert, 1995a). Most of them favour the idea of employment of a nurse (82%), maintaining that "it is a must in a primary health care orientated pharmacy", as articulated by one of the pharmacists with a permit.

The results show that these contacts with other health professionals are more frequent and meaningful than the ones taking place in a pharmacy without a permit. However, the permit holders indicated that it still is not enough; 73% would have liked to have more contact, primarily because they feel that they don't have enough data about the

Table 3. Contact with other health professionals

Health professional	Percentage distribution of frequency of contact				
	every day	once a week	once a month	less than that	none
General practitioner	58	25	13	4	0
Specialist	13	42	21	25	0
Nurse	42	38	4	17	0
Other	13	17	13	4	54

patients (52%) and that closer contact would facilitate a better flow of information.

Patient information

Although most of the permit holders feel that by taking the patients' history they have sufficient information to proceed with treatment, some feel that it is not enough. It was suggested that patients should carry a card where all information is kept, or that a computerised system would allow them to link to the doctor's data system. All of these suggestions seem impractical in the SA context and particularly in the rural areas, where most of these pharmacies operate. It seems that the best solution to this problem, as articulated by some of the respondents, is to have a "group practice" or a "health centre", where there is a central source which can provide the patients profiles and thus facilitate real team work. This is confirmed by the permit holders' wish to have more contact with other health professionals.

Mrtek and Catizone (1989) argue that the lack of access to complete patients' records is one of the main barriers hindering the implementation of a more meaningful role for the pharmacist in the community. This study seems to support this argument by highlighting that although pharmacists have access to higher schedules medicines, they still feel that in order to fully utilise their potential as care-givers, they would like to have the same access to patients' profiles as other health professionals such as nurses and doctors.

Future of community pharmacy

As evident in this study, the pharmacists with a special permit were granted an opportunity to practice pharmacy as envisaged for the future. For this reason, it was important to elicit their responses with regard to the nature of their experiences and the suitability of extending this kind of permit to all community pharmacists in SA.

Most of the respondents (71%) felt that all pharmacists should be given the opportunity to practice pharmacy as provided according to their permit. The reasons given were mainly that it facilitates "better and cheaper treatment of minor ailments", is a way to provide "cost-effective primary health care" and for the pharmacist it "increases one's responsibility and makes it more exciting". However, in most cases, a concern with regard to the "training and competence level" were expressed and qualifications were made that "training is essential before access is granted" or that permits should only be given "if they are trained and competent". Similar apprehensions were evident among the respondents who were against the extension of this kind of practice to all pharmacists.

The way most of the respondents envisage the role of the pharmacist in the future health care system in SA, is expressed as "a member of a health team", as well as "a provider of primary health care" and "pharmaceutical care". The declining role of the "dispensing only" pharmacists, referring to the traditional community pharmacy practice, was mentioned as a component to be addressed in the future scenario. This, "unless changes in legislation take place" and "appropriate education and training is provided".

Major problems mentioned related to the State and its role in regulations and the "intervention and prescription" of medical aid schemes, specifically in relation to cost of medications. Lack of recognition of the pharmacist's ability and competition from "postal services" as well as "dispensing doctors and nurses" were additional issues to arise.

DISCUSSION AND CONCLUSION

Holloway *et al.* (1986, p. 331) maintain that "the social construction of divisions within and between occupations...has to be seen as a historical process". Following this notion, it is argued that although the legislation and registration of the various professional groups determine their boundaries, they can, in principle, be altered at any time. However, this would involve a fundamental restructuring of the overall medical division of labour and "involve processes extending beyond the day to day occupational strategies of practitioners" (Holloway *et al.*, 1986, p. 331).

The attempts at role expansion of community pharmacy in South Africa, as presented in this paper, need to be viewed in both the historical as well as the social context, so that the situation is not seen in isolation, but rather as part of a dynamic process in a society in transition.

The rationale behind the attempts to extend the role of the pharmacist in SA, was to fill in the void in the pharmacists' range of activities in order to better utilise their expertise. However, associated with it were, on one hand, the need to alleviate the doctors' load of dealing with minor ailments and, on the other hand, to provide the consumer with access to a wider range of primary health care services currently not available to them (Gilbert, 1996).

The evidence presented in this paper demonstrates pharmacy's thrust towards an extended and more meaningful role. In its analysis, however, a clear distinction needs to be made between the role extension concerning a wider range of activities and that of granting additional powers to prescribe medications. It seems that the transition towards embracing additional professional tasks within the pharmacy, either by the pharmacist or with the assistance of a nurse, is relatively smooth and is gaining momentum (Gilbert, 1997b), with no serious resistance from the medical profession. An explanation to the lack of conflict here might be provided by the fact that these tasks have been

neglected by the medical profession and are not considered to be their exclusive domain. This is not the case with regard to the extension of discretionary powers to prescribe. As predicted by Halperin "the most likely area for physicians to exert their political and professional muscle will be in the newly emerging role of the pharmacist prescriber" (Halperin, 1989, p. 427). This reality was reflected in the editorial of the SA Journal of Pharmacy Practice, which stated that "the long-standing debate between the pharmacy profession and the organised medical profession on the issue of the pharmacist's right to diagnose and prescribe medicines has been intensified by the proposed changes to the general regulations of the Medicines and Related Substances Control Act 101 of 1965, which will allow pharmacists to prescribe specified schedule 3, 4 and 5 medicines, under certain defined conditions. The role of both professions concerning their respective rights to dispense medicines appear to overlap" (Editorial, 1994, Vol. 1, p. 4). Note should be made in this context that although doctors have almost exclusive control over prescribing, pharmacists do not have exclusive control over dispensing, as a substantial number of doctors all over the world and particularly in SA have rights to dispense (Britten, 1994; Gilbert, 1995a, 1997e).

In the U.S.A. and the U.K., the extension of the pharmacist's role has been more successful in hospital settings than in the community, mainly because it could be controlled by the medical practice as a form of delegation (Turner, 1987). This, however, cannot take place in separate community practices. Nevertheless, even in the hospital, "some of the trends alarm organised medicine. Pharmacists are a welcome addition to the clinical team, but the physician has the legal and moral responsibility for managing the patient" (Strickland, 1991, p. 42). This monopoly is strongly kept and enforced by the doctors' feeling that "if you want to get into clinical management of patients, you ought to go to medical school before you do that" (Strickland, 1991, p. 42).

The threat posed to the medical profession by enabling legislation for pharmacists to prescribe, is further illustrated in some of the protests in Florida and the suggestion to a solution as articulated by the editor of the Journal of the Florida Medical Association: "A rational way to have solved this problem could have involved the creation of a joint committee to find those prescription drugs which could be made nonprescription, so that pharmacists could counsel store customers on their usage, rather than authorising pharmacists to behave like physicians, which they are not...While physicians are educated and licensed to diagnose, operate, prescribe and dispense, it must be emphasised again that it is not within the education or training of pharmacists to examine patients and to make diagnoses and prescribe" (Feinstein, 1985, p. 1027).

This study confirms the claims made in the introduction that the opposition from the medical profession is particularly fierce when it comes to the pharmacist's "ability to prescribe". Permitting pharmacists to prescribe, as proposed in the changes to legislation, automatically grants them the ability to diagnose patients and this right is at the centre of the battle, as argued by Mumford (1983).

The successful granting of special permits to a selected group of pharmacists to practice an extended role can be explained by the fact that it was restricted to rural, under-served areas and therefore did not threaten the doctors, who in any case tend not to practice there (Gilbert, 1996). This might be similar to the scenario described by Nettleton (1995) when analysing the dual closure strategy with regard to women midwives. Birth-giving is time consuming and not particularly "exciting" to medical men and most women who called upon midwives were poor. There was thus no significant monetary or other gain to be had from attending to them. This was one of the reasons behind midwifery gaining partial autonomy from the medical profession in the U.K.

Larkin (1983, p. 7) argues that "legally recognized closure is one of the most powerful forms of exclusion exercised by an occupation, the ultimate legitimizing of a "task domain"". The proposed legislation (Act 101) is a direct encroachment on the boundaries between pharmacists and doctors. In this case, the pharmacists are the ones invading the doctors turf. Following the framework of professional dominance, it is unlikely that the pharmacists will be on the winning side, unless there is intervention from the State. This is one of the routes to counteract the medical hegemony discussed by Larkin (1983). The reality in SA seems to support it, since the new legislation has yet to materialise. In 1994, the president of the Pharmaceutical Society of SA (PSSA) declared in an interview: "The regulations have been written. They have been approved by the Medicines Control council. I believe the introduction of the regulations has been waiting for the new health care structures to be put in place. Now those structures are in place it should be approved within weeks. However, we have been talking "within weeks" for years" (Abramson, 1994, p. 10). Not much has happened since then and nobody seems to know what is going to happen, indicating a power struggle behind the scenes.

Considering this context, the development of "health centres" in SA might prove to be an alternative venue for the integration of pharmacists into the health care team (Pharasi and Price, 1993). It provides the pharmacists with the necessary access to patients' records, and interaction with other health professionals, thus facilitating the desired role expansion and allows the doctors overall supervision, which can then be interpreted as

delegation rather than boundary encroachment or loss of tasks.

As mentioned earlier, the extended role of the pharmacist is at the centre of the debate as far as community pharmacy is concerned. Although it is a discourse that the pharmacy profession worldwide is engaged in, it takes on a unique meaning in the South African context. Unlike in other countries where "the advisory role of the pharmacists to physician and patient is stressed; under no circumstances is the pharmacist to adopt the physician's role in diagnosing illness and prescribing treatment" (Eaton and Webb, 1979, p. 77), the SAPC has been saying that "the dispensing of medicine without the prescription of an authorised prescriber forms an integral part of the pharmacist's profession" (Van Niekerk, 1994, p. 4). The Registrar SAPC, further reiterated that "it would likewise be incorrect to say that a pharmacist is not entitled to treat a patient on own initiative" (Van Niekerk, 1994, p. 5).

The developments to date signify a partial success on the part of pharmacy towards its role extension. However, one can predict that it will remain limited due to the forces operating against it. Since doctors seem to define their domain as encompassing all areas of health and disease (McGhan, 1989), it is expected that they will continue to resist attempts by pharmacists to encroach on the traditional roles of prescribing and diagnosis. Adopting the "social power" model (McGhan, 1989), it has been recommended that the pharmacy profession continue to increase its control over drug therapy as well as drug knowledge, but remain within its traditional task domain. This might explain the more recent public expressions, which are less militant in their tone, as demonstrated in the latest speech of the president of the South African Pharmaceutical Society (SAPS), when referring to the expanded role of the pharmacist as "a role...which enhances clinical skills and is vitally necessary, and one which should not enable him to be a barefoot doctor, but rather allow him to make an educated assessment of when a patient needs to be referred to a doctor. He needs to know what he doesn't know. He needs to know where his sphere of responsibility ends and where someone else's starts" (Ambler, 1996, p. 300). Whether it signals a change of strategy by the pharmacy profession in SA and an admission of defeat with regard to their chances to change the legislation as proposed, remains to be seen.

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