



# Pharmacist and nurse : a team approach towards primary health care or a convenient “therapeutic alliance”?

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## Abstract

This paper explores the nature of the therapeutic alliance between nurses and community pharmacists in the South African context. To gain a better insight into the relatively new phenomenon, a combination of qualitative and quantitative methods was employed.

The partnership developed in S.A. between the nurse and the pharmacist allows the pharmacists to “expand” their professional activities without “invading” the nurses’ professional domain, and reaping substantial benefits in the process. These include potential increases in profits, enlarging the clientele base and improving the image of the pharmacy, by shifting the focus from a place of disease to a place of health, as well as creating the vision of the pharmacist as a team member in providing primary health care. As far as the nurses are concerned, it grants them the possibility to practice their profession in a very convenient set-up and affords them greater professional autonomy. © 1997 Elsevier Science Ltd. All rights reserved.

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## Introduction

The role and scope of the pharmacy profession has been contemplated and reconsidered all over the world (Adamcik *et al.*, 1986; Nuffield Foundation Committee of Inquiry, 1986), mainly due to a shift in day-to-day activities and loss of meaningful functions (Gilbert, 1995b). This process did not bypass South Africa and various suggestions were made to extend the role of the pharmacist. (The Report of the Commission of Inquiry into Health Services, 1986; Department of National Health and Population Development, 1990). At the same time due to the changing political dispensation, major developments have been taking place to transform the overall health care provision patterns (Department of Health 1995; Gilbert *et al.*, 1996; National Drug Policy for South Africa, 1996) with an emphasis on primary health care accessible and affordable to all.

All the above necessitated further rethinking of the

role of community pharmacists, which has been an ongoing process (Historic Developments in Primary Care Drug Therapy, 1994). Some of the proposed changes are being implemented at present while others are met with obstacles in their path, mainly due to fierce resistance from the medical profession, particularly where greater discretionary powers to prescribe are being sought (Gilbert, 1995a).

Throughout this process of transition, pharmacists in S.A., as in other countries, have been promoting themselves directly to the public as “front line” health and drug advisors via campaigns such as “Drug Wise”, “Ask Your Pharmacist First” and others<sup>1</sup>. Although pharmacists have been encouraged to become more active in health promotion, and studies suggest that a substantial part of their work consists of dealing and responding to general health advice sought by the public (Smith 1990; Gilbert 1996a), the reality is that by and large, “pharmacists are still considered to be only on the fringes of the primary health care team” (Smith, 1990a : 383).

This statement acquires a unique meaning in the South African transitional context, since the shift in philosophy and structure of health care towards primary health care has been dominating all decisions made by the various health sectors, and pharmacy is no exception in this regard. The profession was eager to seize the opportunity to fit in with governmental

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<sup>1</sup> These are some examples of advertising campaigns undertaken by some of the major chains of community pharmacies in South Africa.

guidelines and at the same time expand the scope of its activities and affirm its role as a "member of the health care team" (The South African Pharmacy Council, 1995a).

Consistent with its official declared commitment to primary health care, the South African Pharmacy Council proposed: "One way therefore, of reforming community pharmacy in South Africa is by pharmacists and nurses working in a therapeutic alliance to provide accessible and affordable primary health care" (The South African Pharmacy Council, 1995b: 2). In line with the above the Council maintains that "the community pharmacist should see himself, and encourage others to see him as part of a health care team working together for the benefit of the patient" and further that in general they have "the facilities and expertise available to provide for primary health care clinics in collaboration with registered nurses" (The South African Pharmacy Council, 1995b: 3).

A partnership between a pharmacist and a nurse has not been a common phenomenon in health care delivery patterns. In fact, a search for evidence of such collaboration yielded scant results. Some available studies investigated potential or existing collaboration between health care team members in a hospital setting (Mesler, 1991; Adamcik *et al.*, 1986), hospital patients (Rich, 1994; Tice, 1993), health centres (Harding, 1994) or teaching programmes (Morrow and Segelman, 1989) and mostly found it to be of some benefit to the health care team as well as to the patient. The role of the pharmacist in the primary health care team was explored by some researchers (Sheppard *et al.*, 1995; Smith, 1990a; Sutters and Nathan, 1993; Lustig and Zusman, 1994), but they did not focus on the partnership with the nurse.

Studies examining a similar partnership between a community pharmacist and nurses found very little meaningful contact between them (Smith, 1990b), except in the context of specific maintenance programmes (Capen *et al.*, 1994; Toelle *et al.*, 1993). However, there is evidence to suggest that the pharmacists would like to have more contact with other health professionals, nurses included (Lustig and Zusman, 1994).

It seems that this potential alliance has not been widely implemented and studied. However, in South Africa this partnership "between pharmacist and nurse is developing rapidly and already operates within many community pharmacies" (Pleaner, 1996). For this reason, this paper sets out to examine and analyse the nature of this therapeutic alliance in the South African context.

<sup>2</sup> Note should be taken that the data used for this paper form part of a larger study dealing with community pharmacy in South Africa.

<sup>3</sup> At the time the study was conducted the municipal boundaries of Johannesburg were in a transitional state. In order to simplify matters, the study was limited to the old boundaries of Johannesburg.

## Methodology

To gain a better insight into the relatively new phenomenon, a combination of qualitative and quantitative methods was employed, which included the following<sup>2</sup>:

- A documentary search and content analysis of official documentation and publications. The documents analysed included government as well as Pharmacy Council publications, minutes of meetings and reports.
- Interviews with all (15) the nurses operating out of pharmacies in the Johannesburg<sup>3</sup> area.
- Interviews with a random sample of 53 community pharmacists in Johannesburg.
- Interviews with 36 final year pharmacy students at the University of the Witwatersrand, Johannesburg.

These interviews were based on a structured questionnaire which included closed as well as open questions which dealt with the role of the community pharmacists as well as the anticipated partnership with the nurse. The open ended questions constituted 20% of the interview while the rest (80%) was based on closed questions. An example of a closed question is provided in Table 1, which is a summary of the nurses' responses to this question: out of a list of possible activities of a nurse in a community pharmacy, the nurses were asked to indicate to what extent they engage in those activities. The options presented to them were: (1) (A lot) most of the time; (2) Very often; (3) Not so often; (4) Seldom; (5) Very seldom; (6) Not at all. When the answer fell in category (5) or (6), the interviewer asked "why", and the answer was entered next to the activity concerned. Table 2 is also based on an analysis of responses to a closed question. The following question posed as part of the interview provides an example of an open-ended question: "What is your opinion about the incorporation of a nurse into the practice of community pharmacists? Who benefits the most out of it? Problems?" The answers to the questions were written down during the interview and details completed immediately afterwards.

At the same time, observations were carried out in the pharmacy before, during and after the interview, in order to ascertain the nature of activities taking place. The observation was based on a structured schedule which included a description of the area the pharmacy is situated, the structure of the pharmacy and in particular a description of the nurses' location and mode of operation within the pharmacy. The role played by the researcher was that of non-participant observer.

The data was collected mostly by the researcher conducting the study, with the assistance of a well-trained interviewer. The potential respondents were presented with the following introduction written on the questionnaire: "This interview is part of a study into the role of "Community Pharmacy" in South

Africa. The aim of the study is to explore the existing as well as the potential role of community pharmacists in the provision of health care. The combination of pharmacist and nurse as a "health team" is unique. Learning as much as possible about it, is therefore of utmost importance. It will be of great help if you could answer as honestly and as accurately as possible. This will, hopefully, enable us to produce a worthwhile study that can be of benefit to health care in South Africa. We would greatly appreciate your cooperation". There was no problem in gaining access to the pharmacies since both pharmacist and nurse were fully cooperative.

The following sections are based on information gathered from all the above sources. The quantitative data were analysed using SPSS PC, while the qualitative data based on the observation and open questions from the interviews were analysed by means of grouping and classifying according to the various topics covered, which is the accepted technique for this kind of analysis (Babbie, 1992; Neuman, 1994).

#### Pharmacy's declared policy

The prevailing atmosphere of a need to transform the role of the pharmacist on one hand, and the restructuring of the health services with a bias towards primary health care on the other, led to a series of initiatives by The South African Pharmacy Council (SAPC). Seven projects relating to pharmacy education and practice were accepted by the council for further investigation and implementation during 1995 (The South African Pharmacy Council, 1995c). "*Pharmacist and Nurse: A team approach towards community health care*" was one of these projects, which, according to the SAPC, seemed necessary in the light of: "greater need for medicine prescribing by nurses; improving accessibility of pharmacies; the acceptability of nurses in communities and the synergy that can be achieved by combining the knowledge and skills of nurses and pharmacists; bringing health services to all communities; the provision of screening tests and referral systems in community pharmacies; and minimum legal restrictions to implement such a team approach" (The South African Pharmacy Council, 1995c: 8).

In June 1995 Workgroup 3 submitted a discussion document entitled "*Pharmacist and Nurse: A team approach towards primary health care*" (The South African Pharmacy Council, 1995b). A final version of this document was published in July 1995 (The South African Pharmacy Council, 1995a). According to its recommendation, the range of services that could be provided to all communities by pharmacists and registered nurses working in close liaison from pharmacy premises, could be summarised as follows: health education and promotion; drug and alcohol abuse prevention; maternal and children health care immunisation; family planning; chronic disease management; various approved screening tests; emer-

gency medical services; home health care; advice on methods of administration of medicines; advice on storage and safe handling of medicines; and advice on safe and effective use of medicines.

It seems that all these services fall within the Scope of Practice of registered nurses, thus they should be covered by the various medical schemes. Following on from this the SAPC approved the employment of registered nurses by pharmacists and allowed a registered nurse to conduct a separate practice within the confines of a community pharmacy, with or on behalf of a pharmacist.

The council further reiterated that "the ease to which pharmacies can be converted to primary health care clinics where the pharmacist and nurse can act together as the "first line of defence" should be recognised and further developed by community pharmacists". It thus concluded: "Co-operation with specifically the nursing profession is therefore strongly supported by Council" (The South African Pharmacy Council, 1995a: 4).

#### Nursing policy

In line with the prevailing dominant approach in health care documentation in South Africa, according to the Nursing Council, the primary focus of nursing remained health rather than disease and that the nurse holds a key position in all dimensions of Primary Health Care as detailed in the WHO Alma Ata Declaration. The reality in S.A. confirms that "the success and efficiency of Primary Health Care rested largely on nursing" (Co-operation Between Pharmacists and Nurses, 1991: 33), mainly due to the number of its practitioners and their geographical distribution. This was further recognised in the Government's proposed health policy (Department of Health, 1995).

Although the SAPC prohibited the creation of "formal partnerships" between the two professions, the Nursing Council "imposed no such restrictions—in fact, its ethical rules made provision for partnerships between nurses and other health professionals". Professor Kotze, Chairperson of The Nursing Council further stated that it "had no objection, in principle, to co-operative partnerships between pharmacists and nursing sisters—especially those with specialised knowledge" (Co-operation Between Pharmacists and Nurses, 1991: 33).

Pursuing this favourable and accommodating approach, a joint committee of both Councils was looking at ways in which such co-operation could be more effectively implemented, and the final document of the SAPC, discussed earlier, is one of its outcomes.

#### The nature of the practice

To examine how the concept is being implemented, all nurses operating from pharmacy premises were interviewed and the pharmacy was observed before and after the interview. Twenty-two pharmacies in the

Johannesburg area, currently employ nurses on their premises. Since some nurses work in more than one pharmacy, on different days, the 15 nurses interviewed represent all the nurses, except one who refused the interview.

The study confirms some of the assumptions made retrospectively by the Council by revealing that some pharmacies have had nurses on their premises since as early as 1989<sup>4</sup>. This initiative seems to be gaining momentum, only lately, since most of the current 22 pharmacies who have a nurse operating on their premises, have been doing so for less than two years.

In an examination of the mode of operation of this collaboration, two main patterns emerge:

1. The initiative is on behalf of the pharmacy. The pharmacy (usually the big chains) employ a full-time nurse to provide the services (69%). In these pharmacies a general clinic is operating, providing monitoring of cholesterol and blood pressure, family planning, various medical procedures, injections as well as counselling with other ailments.
2. The partnership was initiated by a nurse who during her practice as a "private nurse practitioner" identified a gap in her ability to provide a comprehensive service, since she did not have direct access to the vaccines available in the pharmacy. At the same time due to the opening up of the public "city council clinics" to all races, they were being overcrowded, which created the need for an alternative, more convenient venue. According to an interview with a nurse, who currently employs other nurses working for her in pharmacies, this explains the success of these "clinics". These are mostly "well-baby clinics", run as a separate practice (31%).

All the services are provided free with no appointments to the public. However, the users pay for medications and materials used. In both cases all necessary medications are provided by the pharmacists as well

<sup>4</sup> Cape Town preceded Johannesburg with this initiative.

<sup>5</sup> This is a legacy of the previous regime in S.A., where people were classified into different population groups. Although, this legislation has been repealed, its social consequences are evident and will continue to be for a while. For this reason and its relevance to the issue of who benefits out of this service, it was mentioned in this context. A more in-depth discussion on this issue can be found in Gilbert L., *Community Pharmacy in South Africa—A Changing Profession in a Society in Transition*, paper presented at the 9th International Social Pharmacy Workshop, Madison, Wisconsin, 1996.

<sup>6</sup> There was one clinic in an Indian area, so it served mainly Indian customers.

<sup>7</sup> Health care delivery in South Africa, until the recent process of democratisation and universal franchise, was characterised by a two-tier system of a private health care funded by medical schemes, which covered up to 20% of the country's population, the vast majority of whom were from the White section of the population.

as all other products used. In addition all pharmacies are laid out in such a way that all products likely to be used by the "clinic" attenders are "on the way to the clinic" like baby or other health related ones, thus increasing the probability that they will be purchased while in the pharmacy.

The advertising of the provision of these services is done mainly in local newspapers and magazines, as well as pamphlets distributed in the community and hospitals. An analysis of some of this material reveals that, in addition to spelling out the kind of services offered, it emphasises its unique characteristics in terms of "A free community service" or "Good old-fashioned service". Some even refer to it as a "health centre". In both cases, the nurse operates out of a small room located near the dispensary, which is clearly marked. Some of the rooms are fully equipped with the necessary facilities and provide adequate privacy, while others are lacking in this regard. All nurses suggested that for maximum benefit, the layout needs restructuring and a bigger, fully equipped room with a waiting room is required. In fact their comments imply "building a clinic" inside the pharmacy premises.

Most of these pharmacies are situated in middle-class residential areas, drawing on clientele living in the vicinity. Some of them are in shopping malls where there is a substantial traffic of shoppers as well as people working in the area. The number of patients seen by the nurse varies, but most of them see between 10 to 30 patients a day. Due to the location of the pharmacies and the social history of South Africa, most of these are White females from middle-class backgrounds. This was 100% in the case of the "well-baby clinics". In instances where clientele from other population groups<sup>5</sup> were mentioned, they were mainly people working in the area<sup>6</sup>.

The ages of people using the service varied according to the nature of practice. In the "well-baby clinics", they were obviously young mothers with their babies and in the "general clinics" mostly elderly people. A group that can be singled out is of "young working Black and Coloured women" who use it for purposes of family planning.

The fact that according to the nurses, at least 95% of their patients belong to a medical insurance scheme, is further confirmation that the service is used mainly by middle-class people and that its clientele is not a reflection of the South African society<sup>7</sup>.

### The nurses' perspective

Ninety-two per cent of the nurses interviewed have had at least 10 years of working experience and seem to be very confident with their professional expertise and able to operate in an independent manner. The interviews reveal that the motivation to work in a pharmacy was mainly due to its offering better working conditions in terms of wages, regular hours and convenience. The difficult circumstances associated

Table 1  
Percentage of nurses who engage in the various activities

Activity	Percentage of positive responses*
Pregnancy tests	28.6
Determination of blood glucose levels	28.6
Urine analysis	21.1
Immunisation	57.1
Lung function tests	14.2
Family planning services	28.5
Determination of blood pressure	85.7
Cholesterol tests	57.1

\*For the purpose of this table the responses "most of the time" and "very often" were combined.

with work in the organised health sector, mainly in the hospitals was also mentioned in this context.

The range of problems dealt with is clearly related to the type of clinic the nurse is operating. Out of a list of possible activities of a nurse in a community pharmacy, the nurses were asked to indicate to what extent they engage in those activities. Table 1 is a summary of their responses.

It seems that the activities in which the nurses engage mostly are determination of blood pressure, cholesterol levels and immunizations. Since the study did not anticipate the existence of special "well-baby clinics", the questionnaire did not include specific activities. Nevertheless, some probing revealed that the activities of these nurses include developmental monitoring, nutritional and general counselling as well as dealing with sleep disorders and minor ailments.

Since this study is concerned with the "therapeutic alliance" between community pharmacists and registered nurses, it was important to examine the nurses

attitudes towards the collaboration between the two. A list summarising the range of services that could be provided by pharmacists and nurses working in close liaison from pharmacy premises was thus presented to the nurses. They were asked to make a choice and indicate next to each task whether, in their opinion, it should be carried out primarily by the pharmacist; primarily by the nurse or by neither of them. Table 2 summarises their responses.

There is an agreement among the nurses that the tasks traditionally allocated to the pharmacists in the domain of medicines are to be carried out primarily by the pharmacists. However, when additional tasks are concerned, what emerges quite clearly is that maternal and child health care (MCH), immunisations, various approved screening tests, family planning, home health care, emergency medical services as well as health education and promotion are perceived to be [by the nurses], the prime responsibility of the nurse. This is of particular significance since the literature dealing with the "extended" role of the pharmacist, considers these same tasks as the "new" activities to be undertaken by the pharmacist. Thus, it might explain the resistance by some of the pharmacists to the initiative to incorporate a nurse in their practice.

These results reflect the traditional view with regard to the role of nurse and pharmacist, and one might speculate that working together under the same roof with the pharmacist, did not lead to a change in the nurses' perceptions.

All the nurses were very positive about the incorporation of the nurse into the practice of community pharmacists. They saw it mainly as a "community service" where "everybody benefits". Particular emphasis was placed on the fact that the service is convenient, free and accessible and therefore the "patients benefit the most". It was stated often that "the pharmacist makes a profit" and particularly when employed by the pharmacist, some of the nurses men-

Table 2  
Team tasks—Percentage distribution of nurses responses to the question, "by whom should these tasks be carried out?"

Tasks	Primarily by pharmacist	Primarily by nurse	Neither one of them
Health education and promotion	14	79	7
Drug and alcohol abuse prevention	43	50	7
Maternal and children health care	0	100	0
Immunisation	0	100	0
Family planning	14	86	0
Chronic disease management	36	43	21
Various approved screening tests	7	93	0
Emergency medical services	14	71	14
Home health care	14	71	14
Advice on methods of administration of medicines	93	7	0
Advice on storage and safe handling of medicines	93	7	0
Advice on safe and effective use of medicines	100	0	0

tioned "being exploited to do other things in the pharmacy", which they objected to. The general response, however, was positive towards the pharmacists and their activities, but insinuated a negative attitude towards doctors. An additional reason given in support of the alliance was that "the pharmacist is too busy dispensing to have time to do all that a nurse does" or that by employing a nurse "it takes the load off the pharmacist". The demand for "this kind of old-fashioned service, where the nurse has the time to talk to you" was an additional advantage referred to.

It seems that the nurses see this collaboration as an easy and convenient outlet to practice their profession. At the same time they are aware that it provides them and the pharmacist with a "united front" against the doctor. As stated by one of the nurses... "instead of waiting for an appointment and going to the doctor, the patient can come here and get the pharmacist and the nurse at once and receive the same or even better treatment for free". The perception by doctors that they are competing with them was also mentioned by the nurses. This was articulated by the nurse running some of the "well-baby clinics": "it all boils down to rands and cents (money)". According to her, she was told by the doctors, while distributing pamphlets to "new" mothers, that she is "trading on our (their) territory" (the maternity ward) and that "we are threatened by you".

### The pharmacists' perspective

The study of a random sample of community pharmacists in Johannesburg exposed the professional isolation in which they operate. Not only was the contact with other health professionals minimal, its nature was unsatisfactory (Gilbert, 1995a). It was therefore, not surprising to find out that they would have liked to change that. Eighty-one percent indicated that they would like to have more contact with other health professionals.

Because the community pharmacist works in isolation from other health professionals, he/she is not able to make any meaningful intervention in the patient's therapy. For the pharmacist to realise a more effective role in the monitoring of drug therapy, a much closer relationship with the prescriber is required, as well as a more thorough knowledge of the patient's history.

In this context, the integration of the pharmacist into primary health care teams has been advocated (Pharasi and Price, 1993). The therapeutic advantages of having integral pharmacies in health centres are borne out of two studies conducted in the U.K. (Harding and Taylor, 1986; Harding and Taylor, 1990). According to Pharasi and Price (1993:421), "the presence of a pharmacist in a health centre has the potential of enhancing a collaborative approach to health care which has immense benefit to the patient... and from the pharmacist's point of view offers greater job

satisfaction and validates the pharmacist's professional status and training".

Although the development of "health centres" is on the agenda in South Africa, the scenario described above remains in the realms of the future in terms of its implementation. The collaboration with the nurse, however, might be seen as a small development indicating things to come. Thus the issues highlighted here might be of benefit when health centres become a reality in South Africa.

As mentioned earlier, the phenomenon of incorporating nurses into the practice of community pharmacy is quite unique to S.A. This would enable the pharmacy to extend its activities and include new activities not traditionally performed by the pharmacist. The pharmacists were required to comment on this by answering whether they would be in favour of the incorporation of a nurse into the practice of community pharmacists. Although 56.6% were in favour of the idea, the fact that 30% were against it and 13.2% not certain, suggests that the idea has not been fully accepted. The concerns raised by the pharmacist were related mainly to the financial viability of such an option, as articulated by one pharmacist... "to pay the nurse to give free service is not practical". Some responses included doubts with regard to the nurses' training and ability to contribute, while others expressed fears that it will... "usurp the role of the pharmacist" or that... "it makes the pharmacist look inadequate". "It can only work if the doctors will approve it, since they monopolise the profession", is an interesting comment related to the role of the medical profession in the success of this alliance. Although this study does not focus on this issue, it might prove to be a significant point.

When a similar question was put to final year pharmacy students, their response was more positive. Two thirds of the students thought that it was a good idea and only 22% did not think so, the rest were not sure. Their more positive response was further evident in their comments. They saw this as an opportunity to create a... "more health orientated environment" or afford people a better access to Primary Health Care, as well as, attracting them to the pharmacy. As stated by one of the students... "this will make people more positive towards coming to the pharmacy and the integration will ensure enhanced professional services". The potential benefit of the collaboration with the nurse was further developed by others... "it might be a means of showing the public and other health professionals that pharmacy is a Primary Health Care profession".

The negative remarks made by the students were similar to those of the community pharmacists and included reference to the fact that the pharmacist can perform all the tasks the nurse can as well as the question of profitability. "The pharmacist will have even less interaction with the patient", was a perceived threat posed by the incorporation of the nurse into the practice of community pharmacy.

## Discussion and conclusion

The underlying rationale for this association was that pharmacy needs to do something to extend its activities and enhance its image. At the same time there was a need to be seen doing something in line with the Government's health policies. The extension in the direction of more diagnosing and prescribing proved to be very difficult due to the resistance of the medical profession. Thus the alliance with nurses seemed logical since it introduces primary health care into the pharmacy practice. Collaborating with the nurse who is acceptable by the community and in touch, will enhance the pharmacists image and the legal, structural and attitudinal barriers to implement it are relatively few.

On the surface it seems that this partnership provides a valuable service to the public. The user gains easy access to a "comprehensive health care facility". Although according to the nurses and the pharmacists it is beneficial to all, it is quite clear that the potential for financial profit is one of the incentives. In addition this partnership, which is working well in reality, provides both "incomplete" professions with the ability to provide a wide range of services, otherwise provided by the general practitioner or a "public clinic".

As in other countries (Smith, 1990a), most pharmacies in S.A. are situated in residential areas (Gilbert, 1996b). It is thus, not surprising that the pharmacist's advice is sought on a range of health issues mainly by women. Among the problems presented to the pharmacist, those related to babies and young children feature quite prominently. The nature of the required and appropriate "treatment" in most of the cases is provision of information regarding "child rearing" and "problem solving", all of which fall within the realm of health education and disease prevention. However, according to research, pharmacists were not found to be active health educators (Smith, 1990a), while at the same time they are overloaded with the dispensing of drugs and administration. This reality was assessed by the enterprising nurse who identified an opportunity to slot in. For the nurse, the pharmacy provides a convenient and "popular" location in the community, while the nurse renders the service the pharmacist is unable to. The outcome is that prospective clients benefit from a comprehensive service not previously available to them. The benefit to the pharmacist is according to the Executive Director of Community Pharmacists in that "Utilising the joint skills of these two professions gives meaningful substance to community pharmacies as Community Health Care Centres" (Pleaner, 1996).

Theoretically, it appears to be a good solution to some of the problems of access to basic medical care in S.A. The reality in S.A., with its maldistribution of pharmaceutical establishments (Gilbert, 1996a), however, limits the scope of this alliance and its benefits to all. The real beneficiaries are, again, the same sectors of the population who have, and always had,

access to pharmacies in mainly "urban" and "White" areas and who enjoy membership in medical aid schemes (Gilbert, 1996b). The pharmacy with a nurse now offers them free services instead of using overcrowded "public clinics" or having to visit the private practitioner. At the same time, the people mostly lacking in access to organised health services, do not live in the vicinity of currently established community pharmacies. These are mostly utilised by people living in the area or working nearby as stated by the nurses as well as previous studies (Gilbert, 1996b).

According to Harding *et al.* (1994: 46), "The 'occupational control' thesis argues that, within the health care division of labour, the medical profession is dominant in relation to other health professional groups, who are deemed to be 'para professionals'". Within the framework of "boundary conflicts" and dominance of the medical profession, the use of language such as "first line of defence" in this context, can be interpreted as not only the "first line of defence" for the patient against disease but indicate the "war" situation between the medical profession and pharmacy. Consequently, this alliance grants the nurse and pharmacist more strength by presenting a "united front" against the medical profession.

The partnership developed in S.A. between the nurse and the pharmacist allows the pharmacists to "expand" their professional activities without "invading" the nurses' professional domain, and reaping substantial benefits in the process. These include potential increases in profits, enlarging the clientele base and improving the image of the pharmacy by shifting the focus from a place of disease to a place of health as well as creating the vision of the pharmacist as a team member in providing primary health care. As far as the nurses are concerned, it grants them the possibility to practice their profession in a very convenient set-up and affords them greater autonomy. Consistent with McGhan (1988: 146), who claims that "Nurses seem to be asserting themselves as the interface between man and health with regard to restoration, maintenance and promotion of health". The collaboration with the pharmacists provides them with just such an opportunity.

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