



Original Research

The pharmacist as prescriber: A discourse analysis of newspaper media in Canada

Theresa J. Schindel, B.S.P., M.C.E.^{a,*}, Lisa M. Given, Ph.D.^b

^aFaculty of Pharmacy & Pharmaceutical Sciences, University of Alberta, 3-171 Edmonton Clinic Health Academy, Edmonton, Alberta T6G 1C9, Canada

^bSchool of Information Studies & Research Institute for Professional Practice, Learning and Education, Locked Bag 588 Charles Sturt University, Wagga Wagga, New South Wales 2678, Australia

Abstract

Background: Legislation to expand the scope of practice for pharmacists to include authority to independently prescribe medications in Alberta, Canada was announced in 2006 and enacted in April 2007. To date, very little research has explored public views of pharmacist prescribing.

Objective: This study analyzes newspaper media coverage of pharmacist prescribing 1 year before and 2 years after prescribing was implemented.

Methods: News items related to pharmacist prescribing were retrieved from 2 national, Canadian newspapers and 5 local newspapers in Alberta over a 3-year period after the announcement of pharmacist prescribing. A purposive sample of 66 texts including news items, editorials, and letters were retrieved electronically from 2 databases, Newscan and Canadian Newsstand. This study uses social positioning theory as a lens for analyzing the discourse of pharmacist prescribing.

Results: The results demonstrate a binary positioning of the debate on pharmacist prescribing rights. Using social positioning theory as a lens for analysis, the results illustrate self- and other-positioning of pharmacists' expected roles as prescribers. Themes related to the discourse on pharmacist prescribing include qualifications, diagnosis, patient safety, physician support, and conflict of interest. Media representations of pharmacist prescribing point to polarized views that may serve to shape public, pharmacist, physician, and others' opinions of the issue.

Conclusions: Multiple and contradictory views of pharmacist prescribing coexist. Pharmacists and pharmacy organizations are challenged to bring clarity and consistency about pharmacist prescribing to better serve the public interest in understanding options for health care services.

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Introduction

Changes in pharmacy practice are observed worldwide, as pharmacists have increasingly

adopted new roles in society including prescribing medications.¹⁻³ Pharmacists now engage in prescribing activities in a variety of practice settings,

* Corresponding author. Tel.: +1 780 492 6134; fax: +1 780 492 1217.

E-mail address: tschindel@pharmacy.ualberta.ca (T.J. Schindel).

including community pharmacies, ambulatory clinics (primary care or family medicine clinics), and hospitals.^{2,3} In a global survey of hospital pharmacy practice, 20 countries reported that hospital pharmacists were involved in some form of medication prescribing, usually under an agreement with a physician.⁴ Pharmacist prescribing, first pioneered in the United States,⁵ gained momentum after its introduction in the United Kingdom (UK) in 2003 first in a supplementary prescribing model then in an independent prescribing model in 2006.⁶⁻⁹ A variety of prescribing models exist depending on the jurisdiction around the globe.^{3,5,10-12} In Canada, Alberta was the first province to introduce an independent model of pharmacist prescribing in 2006.¹³ Other provincial jurisdictions in Canada adopted different prescribing models, including permitting pharmacists to extend refills, adapt prescriptions, or prescribe in collaborative environments.¹⁴⁻¹⁶ As pharmacists worldwide adopt prescribing, research on societal views of pharmacists as prescribers will aid in understanding pharmacist prescribing in the delivery of health care services.

Prescribing medications in Canada has largely been in the domain of medicine and dentistry professions. Some other health care professionals have been granted prescribing rights such as optometrists, podiatrists, midwives, and nurse practitioners.¹⁷ Before the approval for pharmacist prescribing in Alberta, pharmacists in some provinces had limited prescribing rights, for example, with emergency contraception.¹⁴ After approval in 2006, the pharmacist prescribing framework was implemented in Alberta in 2007 and consists of 3 categories of prescribing: (1) adapting a prescription written by another prescriber; (2) prescribing in an emergency; and (3) additional prescribing authorization.^{13,15} All practicing pharmacists in Alberta are permitted to adapt prescriptions and prescribe in an emergency. However, the third category, additional prescribing authorization, is voluntary and requires a formal application by the pharmacist documenting competencies in the area in which the pharmacist will be prescribing, additional education and training undertaken, letters of support documenting collaboration with physicians, and evidence of a patient care process through submission of patient-specific documentation. Unlike the approval process for supplementary prescribing in the UK, pharmacists are not required to complete a formal educational program to qualify for additional prescribing authorization. All prescribing applicants undergo a peer-review

process to be authorized for additional prescribing rights.¹⁸

Research on societal views of pharmacists' roles reveals that public awareness of pharmacists' roles appears to be low.¹⁹⁻²¹ A study analyzing the depiction of community pharmacists' societal roles in print media in Sweden reported little public awareness.¹⁹ Portuguese consumers reported poor understanding of pharmacists' roles and low expectations of community pharmacy services beyond provision of drug products.²⁰ Finally, a study on the images of pharmacy as a career showed that grade 12 students in the UK considered pharmacy an isolated profession associated with boring work.²¹ Until recently, very little research explored public views of pharmacist prescribing in any jurisdiction.²²⁻²⁴ In a study of the Scottish public in 2006, over half of those surveyed were aware of pharmacist prescribing, mostly through the media and health care professionals; a higher proportion reported a high level of comfort with pharmacist prescribing when compared with other health care professionals.²⁴ In a recent study in Canada, public opinion of pharmacist prescribing in Saskatchewan was favorable.²³ Similarly, a survey of public opinions conducted in Alberta indicated strong public support for pharmacist prescribing activities such as refilling a prescription or modifying medication dosages.²⁵ Similar scope of prescribing, such as treatment of minor ailments and prescription refills, was endorsed by the Scottish public.²⁴ However, knowledge and expectations of pharmacists' roles in prescribing were voluntarily mentioned by only 2% of the respondents in the Alberta survey.²⁵

The qualitative research reported here addresses the following question: how was pharmacist prescribing portrayed in the newspaper media 1 year before and 2 years after prescribing was implemented in Alberta, Canada? Researchers have reported that the media is a main source of public information about pharmacists¹⁹ and pharmacist prescribing.²⁴ Analysis of media discourse has become an important approach to the study of health information and illness in society,^{26,27} particularly as health care providers look for ways to best engage with members of the public. Mass media occupies a central position in society and provides opportunities to study sociocultural change.²⁸ Newspaper media are important sources of information about health to the public that have a powerful influence on public views on issues.²⁶ As changes in the profession of pharmacy occur over time, it is important to consider what information is communicated about pharmacist prescribing,

particularly how this information is communicated by the media and in the popular press.²⁹ Furthermore, attention to the way media discourse shapes cultural representations of pharmacist prescribing activities and the media's role in shaping public opinion and roles of pharmacists is required.²⁶ An analysis of pharmacist representations in the media has the potential to shed light on societal views of pharmacist prescribing, of the roles of pharmacists, and of the relationships between those involved in prescribing and the patients they serve. This research will inform pharmacists, leaders, and policy makers as they gain experience with this pharmacist prescribing model.

Methods

Social positioning theory

This research used social positioning theory to examine societal views of pharmacist prescribing in Canada.³⁰ Social positioning theory is associated with social constructionism, whereby individuals construct knowledge and meaning as they engage with the world, through relationships and social processes.^{31,32} A central tenet is that there is no one true interpretation of reality; rather, knowledge and meaning are constructed (not discovered), with multiple interpretations possible. This type of research requires interpretation of meaning by the researchers such that researchers themselves are embedded in the analysis, reflecting on their understandings of the phenomena. The approach demands that traditional modes of understanding and personal assumptions are questioned. A social constructionist approach to pharmacy practice has been used to explore patient counseling.^{33,34}

Social positioning theory recognizes the fluidity of social roles, which aligns well with the evolution of pharmacists' roles. Individuals and groups are "positioned"—or made to fit role expectations—by themselves, their colleagues, their families, or others in society; this happens in conversations, through media representations (and even within individuals' own minds) in confronting social expectations.^{35,36} Researchers have used positioning theory in studies of midwifery,³⁷ medical psychiatry,³⁸ and media representations in newspaper texts.³⁹ A recent study used social positioning theory to explore women's experiences seeking information and decision making related to menopause.⁴⁰

Social positioning is enacted through self-positioning (first-order positioning) or self-repositioning (second-order positioning in response

to position by another individual) and other-positioning, or positioning another individual (third-order positioning).³⁰ Positioning can be tacit or intentional. First-order positioning is usually tacit in that it is not a conscious act. For example, an individual may position himself/herself as an expert by handing someone a business card. Second- and third-order positioning are always intentional; for example, an individual states, explicitly, that someone lacks credentials, positioning that person as "unqualified." There are 4 forms of intentional positioning: deliberate self-positioning; forced self-positioning; deliberate other-positioning; and, forced other-positioning.^{30,36} Throughout the analysis, data reflecting various types of positioning were explored; including pharmacists' self-positioning (individually and as a profession), and other-positioning, by physicians, the public, and other key stakeholders. The results illuminate social perspectives on the "pharmacist as prescriber" discourse, presenting valuable findings that can inform the profession's approach to this issue.

Discourse analysis

A social constructionist view is that much of what shapes our understanding of experience is socially constructed and that language is at the center of the construction process.³⁵ Discourse analysis is a method associated with social constructionism; in this study, discourse analysis examines language use in social contexts to create meaning.⁴¹ A discourse is defined as "a set of meanings, metaphors, representations, images, stories, statements, and so on that in some way together produce a particular version of events."³⁵ Written and spoken language shapes understanding and impacts what individuals actually do and what they are able to do in society. As pharmacist prescribing was prominent in newspapers, discourse analysis was used in this study to analyze pharmacist prescribing as a socially constructed phenomena.

A discourse analysis approach⁴¹ was used to examine a purposive sample of newspaper texts published between January 2006 and December 2008, covering 1 year before and 2 years after prescribing legislation came into effect (on April 1, 2007). The sample included texts from 2 prominent national papers in Canada (*The Globe and Mail*, *National Post*), 2 Alberta papers from the 2 largest cities in the province (*Calgary Herald*, *Edmonton Journal*), and 3 regional Alberta papers (*Medicine Hat News*, *Red Deer Advocate*,

Lethbridge Herald) because of their coverage of a wide geographical area of the province, varied audiences of large/urban and regional/rural readers, and varied styles of reporting. By selecting national and local newspapers, the data set presents the issues as outlined for public consumption. The search terms “pharm*” and “prescrib*” were entered in NewsScan and Canadian Newsstand; a subsequent search using only “pharm*” (to check for missing documents) was performed. Duplicate texts were omitted, resulting in a final set of 66 texts for analysis. The texts included front page stories, news articles, editorials, and letters to the editor; they were considered relevant if the concept “pharmacist prescribing” appeared anywhere in the text.

The texts were read closely to identify passages on prescribing⁴¹ then reread several times to acknowledge various perspectives; for example, they were read as a member of the public with little fore knowledge of prescribing roles, as a pharmacist with specialized knowledge, and as another health care provider. Passages were coded for social positions emerging from the data, resulting in a set of positioning themes. Qualitative thematic analysis identified the representation of pharmacists as prescribers. Themes were recorded by 1 author (a PhD student with a background in pharmacy practice) and reviewed by the other (a health communication and qualitative research expert). To ensure that the data were analyzed in a reflexive fashion,³⁵ the authors documented their personal views and positions on prescribing (ie, supportive of this evolution), on socially constructed knowledge, and on media influence on the general public while acknowledging inherent limitations of depth of coverage of issues.

Rigor is assessed in qualitative research by establishing trustworthiness, through consideration of 4 elements: credibility, dependability, confirmability, and transferability.^{42,43} In this study, credibility is addressed through an in-depth, accurate presentation of results as demonstrated through the use of direct quotes. Dependability is accomplished through detailed methodological descriptions including the theoretical approach used in the study. The researchers’ disclosure of personal perspectives and the balanced presentation of negative instances address confirmability. For example, perspectives representing support for and opposition to pharmacist prescribing are represented. Transferability is addressed by describing the prescribing model in Alberta, Canada.

Results

Five positioning themes related to the media presentations of pharmacist prescribing illuminated by this research include qualifications, diagnosis, patient safety, physician support, and conflict of interest.

Qualifications

Media representations of pharmacists’ qualifications as prescribers took differing forms; pharmacists were portrayed as medication experts qualified to prescribe and paradoxically not appropriately trained for the role. In an example of deliberate positioning before the legislation’s approval, the Minister of Health described pharmacists as highly educated health providers: “expanding the scope of practice for pharmacists is an example of the innovation possible in the health system to enable competently trained health professionals to use all of their education and expertise to benefit Albertans.”⁴⁴ This image of a competent prescriber was repeated in the media, with calls for prescribing rights to be extended to pharmacists; for example, one national columnist noted “because of the pharmacist’s knowledge and accessibility, he or she should be able to prescribe drugs, at least for common conditions.”⁴⁵ However, the knowledge base of pharmacists working in different practice settings such as community pharmacies, hospitals, and primary care settings were not portrayed with equal prominence. In particular, pharmacists working in hospitals were characterized by a physician as having “encyclopedic knowledge of medications and are an extremely important part of the health care team.”⁴⁶ In some instances of second-order positioning, pharmacists described themselves as extensively trained in medications. For example, in a letter to the editor appearing in *Medicine Hat News*, a pharmacist noted: “pharmacists are important, trusted health care professionals with a long history of collaboration within the health care team. Patients trust pharmacists in part, because of their extensive university training, which makes them medication experts.”⁴⁷ This excerpt highlights an example of tacit, first-order positioning, as a pharmacist refers to the prescribing role in the context of a collaborative, team environment. Not all pharmacists’ comments highlighted in the newspaper texts supported the view that pharmacists were automatically qualified for prescribing roles. In other texts, second-order positioning statements by pharmacists

represent the view that additional training for prescribing was indeed warranted with statements such as “It’s definitely going to require more training.”⁴⁸

What is particularly striking is that the analysis revealed that pharmacists’ qualifications were under constant scrutiny. The adequacy of pharmacy education to prepare pharmacists for prescribing was challenged, particularly regarding training in physical assessment and diagnosis of illness. A physician stated that “it is difficult to see how health care professionals who are not trained to diagnose disease can safely prescribe appropriate treatment.”⁴⁵ A member of the public wrote (third-order positioning): “I thought one had to examine and diagnose before one could prescribe. Or will they [pharmacists] simply ‘prescribe’ what the customer wants?”⁴⁹ A national consumer advocacy representative stated that:

I can’t imagine my pharmacist being my prescriber. I just can’t imagine it. He doesn’t have anywhere near the knowledge required to make a meaningful decision about medication for me...it really isn’t possible for pharmacists to prescribe drugs as effectively as a physician because they aren’t as familiar with a patient’s medical history.⁵⁰

Members of the public also scrutinized education and training of medical students. In this example of third-order positioning, attention is drawn to pharmacists’ qualifications for prescribing while casting doubt on the preparation of medical students:

Until such time as medical students receive an adequate training in therapeutics, the public should be thankful that pharmacists are being allowed to provide a much-needed service, indeed one that they’re very highly trained to offer. There is no question as to who is better qualified to offer advice on medicines and their uses.⁵¹

Diagnosis

Positioning on the distinction between pharmacist and physician prescribing usually appeared in association with diagnosis. Some texts suggested that pharmacist prescribing eliminated the need for annual visits to the family physician⁵² tacitly positioning pharmacist prescribing on par with physician prescribing. Confusion was not unexpected given that many news items included statements such as this opening line of an article appearing on the front page of the *Calgary Herald*: “Albertans will soon be able to bypass the

doctor’s office and head directly to the drugstore to purchase some prescription medications from pharmacists.”⁵³ Most pharmacists cited drew a distinction (first-order positioning) between pharmacist and physician prescribing. This example highlights a community pharmacist reinforcing the need for physician diagnosis before pharmacist prescribing:

One lady thought it was going to be great that she would never have to go to her doctor for a prescription refill again. That’s a huge misconception. This isn’t taking away from your need to see your physician regularly. We don’t have the diagnostic and assessment skills to replace doctors.⁵⁴

This quote illustrates intentional second-order repositioning of pharmacists as having inferior “diagnostic and assessment skills” compared with physicians. In other second-order, forced repositioning statements, pharmacists noted that diagnosis was the physician’s role, stating that before pharmacist prescribing, a patient will need to “have the doctor diagnose what the condition is.”⁵⁵ In many texts, both pharmacists and pharmacy organizations reinforced the key message that pharmacist prescribing was dependent on prior diagnosis by a physician. However, there were some instances when diagnosis was associated with pharmacist prescribing. Pharmacists were quoted as mentioning a role in forms of diagnosis; here is an example of first-order positioning: “new legislation effective Sunday will allow pharmacists to prescribe most drugs and set up drug therapy plans, which could require some degree of diagnosis, like taking blood pressure, to ensure the drug treatment is appropriate.”⁵⁶

Patient safety

The theme of patient safety emerged as an issue related to pharmacist prescribing. Advocates positioned pharmacist prescribers as enhancing patient safety, whereas others considered this a risk to patient safety.⁴⁵ When pharmacists prescribing was announced in Alberta, some physicians and physician groups came out strongly opposed to the regulations. For example, *The Globe and Mail* reported that, “Canada’s doctors are bitterly denouncing the idea that pharmacists be allowed to prescribe drugs independently, saying such a practice places patients at risk.”⁵⁷ In reading the texts, language conferring caution and fear (eg, “danger,” “costly,” “risk”) was evident. Physicians also positioned (second order) pharmacist

prescribing for refills as a public safety issue. Patient advocates also questioned how the pharmacist prescribing process would ensure patient safety: traditionally, pharmacists have been watchdogs to ensure that the prescriptions being written by doctors are safe and appropriate, but giving them prescribing power removes pharmacists from this role—and means no one is acting as a watchdog over them.⁵⁰

One physician warned that the “quality of care and patient safety are a real concern in terms of pharmacists prescribing independently.”⁵⁸ Another called for more evidence to support pharmacist prescribing stating that “although it may be more expedient for a patient to access a pharmacist than to see a doctor, the notion that pharmacists can or ought to replicate the role that doctors play in the primary prescribing of medications is unproven and unsafe.”⁵⁹

In repositioning pharmacist prescribers as enhancing safety, arguments were made that patients would be afforded more time with their pharmacist, compared with time spent with their physician, and that a pharmacist prescriber working in collaboration with other health team members would ensure patient safety. To illustrate this, in an example of second-order, intentional positioning, a pharmacist stated that “limiting the ability of pharmacists to apply their knowledge jeopardizes the safe and effective management of patient drug therapy.”⁶⁰ Further attention was drawn, through third-order positioning, to risks associated with medical prescribing: “until drug safety and the problem of imprecise prescribing are brought under control in this country, physicians can hardly paint themselves as experts in the field.”⁶¹ These examples point to the dual nature of the discourse on patient safety, including the ideas that physician prescribing may also be subject to these opposing views on medication safety and associated with prescribing practices that compromise patient safety.

Physician support

Overall, media reports portrayed physician opposition to pharmacist prescribing more prominently than physician backing for pharmacist prescribing. However, some physicians were portrayed as lending support for pharmacist prescribing in collaborative team environments. A freelance article representing the views of physicians entitled “Let pharmacists prescribe, but doctors must diagnose”⁶² accepted pharmacists prescribing in the context of a collaborative treatment plan, citing

the UK model of supplementary prescribing. Some pharmacists in established practices suggested that having physician support for their role as prescribers was important and that pre-existing working relationships and experience on teams aided performance of their own prescribing activities. In this example of tacit, first-order positioning, a pharmacist with established working relationships with physicians in a team setting positioned herself as having physician support for her prescribing activities noting that: “physicians I work with would trust my abilities.”⁶³

There was support for pharmacist prescribing in team settings, although with some caveats. First, the medical profession positioned pharmacist prescribing as a delegated activity for which physicians were ultimately responsible. This view is highlighted in this example of first-order positioning in a quote from a representative from the Canadian Medical Association: “...within a multidisciplinary practice, delegated professional prescribing is only acceptable...when led by a physician clinical leader with ultimate responsibility for patient care.”⁵⁷ Further, it was asserted that “the doctor must continue to be the team quarterback for optimal patient care and safety.”⁵⁷ It was also acknowledged by physicians that “in the appropriate situation, [pharmacist prescribing] can be a very powerful tool.”⁴⁸ These excerpts point to physicians’ tacit and intentional positioning as bearing responsibility for prescribing in the contexts of teamwork and pharmacist prescribing within a delegated prescribing model in contrast to the independent prescribing model introduced in Alberta, Canada.

Collaboration was referenced by pharmacists in many of the newspaper texts. In instances of second-order positioning by pharmacists, the Dean of the Faculty of Pharmacy and Pharmaceutical Sciences at the University of Alberta emphasized the collaborative aspect of prescribing, stating that “prescribing is not done in isolation. We want to champion this interdisciplinary attitude, and the way to do this is to engage other health care professionals.”⁶⁴ Despite the independent model of prescribing in Alberta, prescribing was repeatedly framed as a team activity. When the first group of pharmacists received additional prescribing authorization pharmacists identified themselves as prescribers working in collaborative environments, contributing to patient care, and sharing responsibility with physicians. In some cases, the collaborative aspects of pharmacist prescribing were noted by pharmacists themselves, for example: “I think it is important, that sharing of responsibility. And

I think in terms of care for the patient, it [pharmacist prescribing] will improve care and efficiency and off-load some very routine things that might get hung up on a physician's desk, and they can focus in on more complex patients."⁶⁵ A pharmacist working in a community practice stated "I work always with the physician. [Prescribing is] never done without their knowledge and there's always follow up...The relationship between the patient⁶⁶ and doctor is still of the utmost importance." Overall, pharmacists were largely characterized as cautious and wishing to implement pharmacist prescribing in collaboration, to gain support from physicians.^{67,68} It was noted that while some pharmacists are authorized to prescribe medications, not all will pursue this in practice. Responding to the idea that the pharmacy profession and individual pharmacists were approaching the adoption of pharmacist prescribing with caution, the Registrar of the Alberta College of Pharmacists stated that "I think the time will come in Canada where [pharmacist prescribing] does become more accepted."⁶⁸

Conflict of interest

When pharmacist prescribing was first introduced, the benefits to the public as improved accessibility and providing options for health care services was emphasized.^{44,50,53} However, prescribing by both physicians or pharmacists was portrayed as susceptible to conflict of interest such as financial gain or influence by advertising of medications. Pharmacists were positioned as having a conflict of interest by various groups including health consumers and physicians. Concerns were related to financial gain by pharmacists who both prescribe and dispense medications, and the potential influence of pharmaceutical companies on pharmacist prescribing. A member of a patient advocacy group stated that:

...pharmacists will have an economic incentive to prescribe drugs and ask patients to come in for tests or screenings, even if they're useless or not needed. The problems that we have in Canada—with what some describe as out-of-control marketing and prescribing of drugs—it's not going to improve when we add hundreds, if not thousands of prescribers to the prescribing list. We have serious problems that have been very difficult to address.⁵⁰

In a letter to the editor, a member of the public stated that "the very people who profit from selling drugs are going to have the ability to prescribe

them."⁶⁹ A physician stated that "Some unscrupulous pharmacists might take advantage."⁴⁶ The editor of a large paper, *Calgary Herald*, positioned physicians (third order) susceptible to conflict in stating "some doctors are also vulnerable to slick drug sales pitches, trying out expensive new products they do not fully understand, when something else might work better."⁷⁰

Pharmacists and pharmacy organizations responded. A community pharmacist stated that he cannot "imagine pharmacists prescribing unnecessarily to make a profit. But if a patient with high blood pressure or other chronic condition can't get an immediate doctor's appointment, yet needs more medication, a pharmacist who knows the patient well would then be able to help."⁴⁸ Second-order, forced repositioning was used to refute accusations of conflict by a representative of the Alberta Pharmacists' Association (the provincial advocacy organization): "We just want to bring our expertise as drug therapists to the team...I don't know how this is objectionable."⁷¹ Further, second-order positioning by the Canadian Pharmacist Association (the national advocacy organization) placed the focus on evidence-based practice and patient safety in this statement: "The pharmacists are going to make evidence-based decisions. They're going to make sure they're prescribing the right drug for that patient."⁶⁷

Discussion

This is the first study to analyze newspaper representations of pharmacist prescribing using social positioning theory. The results illustrate self- and other-positioning of pharmacists' expected roles. Evidence of first-, second-, and third-order positioning was found in the newspaper texts on pharmacists prescribing and contributed to the identification of themes related to the discourses on pharmacist prescribing: qualifications, diagnosis, patient safety, physician support, and conflict of interest. Findings show that newspaper texts involved differing views of pharmacist prescribing representing individuals and groups of physicians, consumers, medical associations, pharmacy organizations, and pharmacists themselves. Further, these views represent discourses polarized across conflicting positions; for example, pharmacists were considered qualified to prescribe medications by some but inadequately trained as prescribers by others. Other discourses (eg, around patient safety, diagnosis, and conflict between the prescribing and

dispensing roles), shared a similar polarity. This may be expected, as multiple views of pharmacist prescribing roles coexist; however, the results highlight the importance of pharmacist-driven messaging of the collaborative nature of prescription management and of pharmacists' expertise and training. Social positioning theory facilitated analysis of stakeholders' complex views. For instance, the discourse on patient safety may position pharmacist prescribing as a danger to patients; however, the safety of physician prescribing was also questioned given the magnitude of drug-related problems occurring in jurisdictions without pharmacist prescribing. Through analysis of first-, second-, and third-order positioning in newspaper texts in this study, insight into how language shapes understanding of pharmacist prescribing was gained.

In any study of newspapers, influence of the media discourse on shaping public opinion is noteworthy.²⁸ The views put forward in newspaper texts in this study were undoubtedly influenced by choices made by the media. While providing a rich source of data, media discourse confers layers of complexity arising from the representation of events, beliefs, and opinions by reporters who are not directly involved with the story reported.⁷² In addition, the impact of quotes from members of prominent members of society, for example, physicians, Deans, Ministers, may carry more influence on the formation of views and attitudes toward pharmacist prescribing than letters written by the member of the public. Hence, the media representation of pharmacist prescribing is itself a social construction of discourses or beliefs about prescribing.³⁵ The representations of pharmacist prescribing reported here are glimpses of diverse public views. Typically, pharmacist prescribing was compared to prescribing by physicians, but not to prescribing by other health care professionals (eg, nurses, optometrists, dentists). This may be due to the historical context of medical prescribing, the relatively new status of nurse prescribers, and the specific, specialized prescribing by dentists and optometrists. Further, it is not known whether other expressed views were simply omitted from publication because of choices made by reporters or constraints imposed by word count or space limitations. The contradictory social positions may arise from an oppositional style of media reporting used to highlight conflict to produce interesting stories,^{73,74} or the complexity and uncertainty of social changes associated with pharmacist prescribing,²⁶ or from diverse views

in society. It is noteworthy that dichotomous public views of pharmacist prescribing are observed elsewhere.²² Finally, there was a little experience with pharmacist prescribing in Alberta at the time, on which the media could draw. As experience with pharmacist prescribing grows, it may be portrayed differently.

Although pharmacist prescribing models differ in the UK and elsewhere, much of the research on pharmacist prescribing supports findings of this study and may have influenced the discourse on pharmacist prescribing in Canadian newspapers. Studies of public views in other jurisdictions demonstrated a general acceptance of pharmacist prescribing and diverse views on prescribing.^{23,75} Patients experiencing pharmacist prescribing have expressed hesitation toward prescribing services in community pharmacy settings.⁷⁶ Overall, most research with consumers emphasizes the importance of a physician's diagnosis in association with pharmacist prescribing.^{23,77,78} Consistent with this study's findings, responses from the medical profession to pharmacist prescribing have been mixed. When pharmacist prescribing was approved in Florida, USA in 1984, media statements portrayed considerable opposition by the medical community.¹⁰ Although some UK physicians were supportive of pharmacist prescribing, research exploring physicians' mixed views echoed concerns observed in this study of a lack of knowledge, training, and safety risks.^{6,74,79-81} Here, there was more physician support for prescribing in situations of collaboration and physician leadership. This has been observed in other studies where levels of physician support were greater for supplementary prescribing than for independent prescribing, suggesting that supplementary prescribing is less threatening to the physician's role.^{6,74} The importance of pre-existing pharmacist-physician relationships and the maintenance of those, based on trust, has also been highlighted.^{6,76,80} It is important to acknowledge that with the introduction of a significant change such as pharmacist prescribing, the roles of other health care providers are impacted. Although this study focused on the positioning of pharmacists, it is recognized that the positioning of physicians is simultaneously occurring and medical prescribing too may be viewed from a variety of positions. The themes that emerged in this study (qualifications, diagnosis, patient safety, physician support, and conflict) could be further analyzed for positioning themes. Some researchers have brought attention to the effect of pharmacist prescribing on the medical profession

with attention to the perceived threat to medical dominance by pharmacist (and others') prescribing and the potential for expanding pharmacists' roles in diagnosis.^{80,82-84}

Possibilities for future research are plentiful. Research on prescribing processes and beliefs of physicians, pharmacists themselves, and other health care professionals would illuminate what prescribing represents to various professional groups. Further exploration of consumers' views will add more depth to our understanding of pharmacist prescribing. Further analysis of other public (or private) texts will provide another dimension to the understanding of pharmacists' roles in prescribing. A major point of disagreement among pharmacists with respect to qualifications and readiness for prescribing emerged in the findings, whereas some pharmacists positioned themselves as medication experts equipped to take on a prescribing role and others noted that more training was needed. Although this study was intended to shed light on public views of prescribing, views of individual pharmacists and the profession as a whole contributed greatly to the discussion in the social context of newspaper reporting. Examining pharmacists' apparent hesitation to embrace independent prescribing, preferring a collaborative or team approach, is also worthy of study. Pharmacists have been characterized as cautious⁸⁵ and "more self-conscious of their public image than other health care professionals, the result, some sociologists have suggested, of a massive inferiority complex borne of a functional subservience to medicine."²⁹ The power ascribed to prescribing is noteworthy as pharmacists may be viewed as challenging physicians' power and long-held traditions. Prescribing was defined narrowly in the texts analyzed in this study, often portrayed as an act after diagnosis. The role of diagnosis referenced frequently in the texts analyzed here also warrants further exploration.

Limitations

As this study examined pharmacist prescribing in Alberta, Canada, it is limited in its transferability to other practice settings. In assessing limitations of these qualitative study findings, the range of experiences brought by the researchers in the interpretation and presentation of the results must be considered in transferability. Alternatively, the researchers' experiences contribute depth to the analysis and to the social construction of pharmacist prescribing.

Conclusion

This study analyzed newspaper representations of pharmacist prescribing in Alberta, Canada. A discourse analysis using social positioning theory permitted a multiperspective view of pharmacist prescribing. Findings highlight many themes related to the discourse on pharmacist prescribing including qualifications, diagnosis, patient safety, physician support, and conflict of interest. A social constructionist approach provided a framework to explore multiple and contradictory views of pharmacist prescribing that coexist in society. The results highlight the tensions between pharmacists' and physicians' perspectives on prescribing roles. When these discussions occur in the media, the public and health care providers are given limited information about important topics (eg, qualifications, patient safety). The positioning of pharmacists as experts in their own right, as opposed to individuals who are subservient to physicians' prescribing roles, highlights the need to further explore the use of language in understanding prescribing roles. Pharmacist and physician education programs must examine the complementary roles to be played by both professions with respect to prescribing. In addition, communicating pharmacists' roles, particularly in prescribing, will advance understanding of options for health care. Pharmacist and pharmacy organizations efforts toward bringing clarity and consistency about pharmacist prescribing will benefit all stakeholders' understanding of pharmacist prescribing. When working with the media, a clear message may serve the public interest in understanding expectations of pharmacist prescribing.

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